One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Submission - SAMHSA Consultation

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

Not Started | In Progress | Complete

Package Header

Package ID	WV2016MH0003O	**SPA ID**	WV-16-0008
Submission Type	Official - Review 1	**Initial Submission Date**	2/8/2017
Approval Date	5/4/2017	**Effective Date**	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation

12/8/2016

Health Homes Intro

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

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Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

West Virginia's State Plan Amendment (SPA) is health delivery model targeted for the treatment of members with Pre Diabetes, Diabetes, and Obesity who are at risk of Anxiety and/or Depression The Health Home model is person-centered, primary care-based, behavioral health integrated, and case-managed by an interdisciplinary team.Regardless of the Health Homes Programs that a member may qualify for based on diagnosis, they will be allowed to be enrolled in one (1) Health Home at a time.

Goals of this Health Home SPA include improving the health care experience, improving the health of populations, reducing per capita costs of health care, and promoting the integration of behavioral health into primary care. Objectives include a reduction in emergency department use, hospital admissions and re-admissions, health care costs, reliance on long-term care facilities, and improving the health care experience, quality and outcomes for the individual and providers.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Population and Enrollment Criteria

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [x] Medically Needy Eligibility Groups

Mandatory Medically Needy

- [x] Medically Needy Pregnant Women
- [x] Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

- [ ] Medically Needy Children Age 18 through 20
- [ ] Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- [ ] Medically Needy Aged, Blind or Disabled
- [ ] Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

The state elects to offer Health Homes services to individuals with

- [ ] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another

Specify the conditions included

- [ ] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [x] Diabetes
- [ ] Heart Disease
- [x] BMI over 25
- [x] Other (specify)

Name	Description
Pre-Diabetes	n/a
Anxiety and/or Depression	n/a

Specify the criteria for at risk of developing another chronic condition

Evidence published indicates that individuals with Pre-Diabetes, Diabetes, and Obesity represent a patient population at high risk for: anxiety; depression; statistically high mortality rates compared to the general medical population; developing comorbid medical diseases because of lifestyle; substance abuse; and/or other related physical and mental health diagnosis. These individuals have a pattern of poor treatment compliance.
The diagnosis of Diabetes increases the members risk of developing many other serious health problems to include: Skin complications including wound healing; eye complications and deteriorating vision; neuropathy; foot complications to include numbness, burning, stinging and weakness; Ketoacidosis; kidney disease to include kidney disease; high blood pressure stroke and/or other cardiovascular diseases; Hyperosmolar Hyperglycemic Nonketotic Syndrome (HNNS); gastroparesis; along with having effects on pregnancy and members overall mental health.
Prescription medication costs for individuals with Pre Diabetes, Diabetes, Obesity, in West Virginia average approximately $3,000 per year, per individual. If the individual concurrently suffers from anxiety and/or depression and is receiving the most current treatment, yearly prescription medical costs can be significantly higher. For example, about 25% of West Virginia's antipsychotics, antidepressants, and/or antianxiety medications are attributed to this patient population. Overall medical cost for this patient population can easily exceed $30,000 per individual, per year.
An estimated 10% of the total West Virginia Medicaid population is diagnosed within these target diagnosis. However, there is reason to believe that Diabetes is severely underdiagnosed in West Virginia due to members not receiving routine health care, and the average person is estimated to have diabetes 5 years, or more, before they are diagnosed. For the reasons noted, targeted treatment of this population meets the needs of West Virginians and is highly aligned with the three main goals to: improve the experience of care, improve the health of our population, and to reduce per capita health care costs.

☐ One serious and persistent mental health condition

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ○ Opt-In to Health Homes provider
- ◉ Referral and assignment to Health Homes provider with opt-out
- ○ Other (describe)

Describe the process used

Claims based information for automatic assignment based on prior relationship with Health Home provider or, in the absence of relationship, Health Home that is geographically closest to patient. Patient notification completed by mail and by health home for options including opting out.

☑ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
WV HH 03 _Diabetes_ MEMBER LETTER HH ASSIGNMENT 2016_Approved	1/20/2017 2:43 PM EST	
..	Date	–

Health Homes Geographic Limitations

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

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- ○ Health Homes services will be available statewide
- ◉ Health Homes services will be limited to the following geographic areas
- ○ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ◉ By county
- ○ By region
- ○ By city/municipality
- ○ Other geographic area

Specify which counties

1. Boone
2. Cabell
3. Fayette
4. Kanawha
5. Lincoln
6. Logan
7. McDowell
8. Mason
9. Mercer
10. Mingo
11. Putnam
12. Raleigh
13. Wayne
14. Wyoming

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management is the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each member. The care plan design will be developed with input from the interdisciplinary team of providers on the basis of 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 comprehensive risk assessment will also include mental health and substance abuse screenings using standardized tools. HH Providers will be required to update the clinical/medical/social data received during an assessment at least every four months.
The individualized care plan will include integrated services to meet the member's behavioral health, rehabilitative, long term care, and social service needs, as indicated. The care plan will be developed with input from the interdisciplinary team of providers; identify the primary care physician, other health and behavioral health care providers, Care Manager, and other health team providers directly involved in the individual's care; and also identify community networks and supports needed for comprehensive quality health care. The Care Manager is a member of the team and responsible for the maintenance of the care plan document and ensures the client receives a copy of the initial care plan and any time that changes are made. 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 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Penetration of HIT adoption in WV is variable at the current time, although a growing number of providers are adopting EHR's in response to the federal incentive program and BMS has partnered with the WV Regional Extension Center to further promote the use of HIT within the Medicaid provider community. Providers will be expected to demonstrate a commitment to the use of HIT by all members of the Health Home team, as part of the application to serve as a Health Home. At minimum, a certified EHR is required at the primary care site; the EHR is expected to document the elements of an individual care plan for each Health Home member. The use of HIT is also encouraged in the identification of individuals who are at highest risk and in need of more intense care

management services; this will be done through analysis of population level reports of member characteristics and utilization patterns. This may also be done through electronic responses to a health risk assessment tool.
To facilitate communication about care coordination and care management activities, various systems are being explored; however, none is expected to be in place prior to SPA implementation.
As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Nurse Practitioner

- [x] Nurse Care Coordinators

  Description

  Under the supervision of the primary care physician or advanced nurse practitioner, the nurse care coordinator supervises and facilitates the coordination of health care to the member. Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [x] Nurses

  Description

  Under the supervision of the primary care physician or advanced nurse practitioner, the nurse care coordinator supervises and facilitates the coordination of health care to the member. Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Medical Specialists

- [x] Physicians

  Description

  Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Physician's Assistants

- [ ] Pharmacists

- [x] Social Workers

  Description

  Eligible as behavioral health specialist.
  Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Doctors of Chiropractic

- [ ] Licensed Complementary and alternative Medicine Practitioners

- [ ] Dieticians

- [ ] Nutritionists

- [ ] Other (specify)

Care Coordination

Definition

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 manages 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members.
Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member's condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Nurses
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Medical Specialists
- [x] Physicians
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Physician's Assistants
- [ ] Pharmacists
- [x] Social Workers
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Health Promotion

Definition

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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members.
Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member's condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Nurses
  Description

Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [x] Medical Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Physicians
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Physician's Assistants
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Pharmacists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Social Workers
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Doctors of Chiropractic
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Licensed Complementary and alternative Medicine Practitioners
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Dieticians
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Nutritionists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Other (specify)

Provider Type	Description
Care Coordinator; Others	Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive Transitional Care is care coordination services designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility.
For each enrollee 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. The transition could include any inpatient care to home and community based services and supports. This is accomplished 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home providers will be encouraged to develop partnerships that maximize the use of HIT across various caregivers and care settings. The provider will be encouraged to use HIT when available to communicate with health facilities and to facilitate interdisciplinary collaboration among all care team members. Providers will be encouraged to share information through the statewide HIE once that capability becomes available. Providers will also be encouraged to provide enrollees with web-based access to their records that can follow the enrollees as they transition to different care settings.
To facilitate post-hospital follow-up, BMS will be exploring a means of communication to health homes about enrollees who have been admitted to a hospital. The QIO will provide via its web-based system a notification to the assigned Health Home when a non-MCO member has had a request for medical or psychiatric hospitalization made/authorized. The MCOs will be encouraged to provide like information to the Health Homes for their members served by a Health Home.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators
  Description

- [x] Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Medical Specialists
- [x] Physicians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Individual and Family Support (which includes authorized representatives)

Definition

Individual 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 support members' knowledge about the member's diseases, promote member's engagement and self-management capabilities, while assisting the member to adhere to their care plan.

A 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home providers will be encouraged to utilize their EHRs and/or patient portals to link to health information and resources applicable to the member's condition. The use of a patient portal or PHR is encouraged to provide for patient/ family interaction with the care team and for development and monitoring of shared care plans.
Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Medical Specialists
- [x] Physicians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians

- [ ] Nutritionists
- [ ] Other (specify)

Referral to Community and Social Support Services

Definition

Referral to Community and Social Support Services includes the identification of available community resources, active management of referrals, access to care, including long term services and supports, engagement with other community and social supports, coordination of services and follow-up. This may include but not limited to, Alcoholics Anonymous and/or Narcotics Anonymous.

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 and community-based resources, and the member.

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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home providers will be encouraged to utilize HIT as feasible to initiate, manage and follow up on community based and other social services referrals.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Nurses
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Medical Specialists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Physicians
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Physician's Assistants
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Pharmacists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Social Workers
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Doctors of Chiropractic
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Licensed Complementary and alternative Medicine Practitioners
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Dieticians
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Nutritionists
  Description
  Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.
- [x] Other (specify)

Provider Type	Description

Care Coordinator; Others	Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

The admission continuing stay criteria for Tier 1 will be: Medicaid Eligibility and documented diagnosis of a Bipolar Disorder that are determined to be at risk for becoming infected with or currently have Hepatitis B and/or C.

Name	Date Created	Type
HH3FlowChartShort10.14.16	12/21/2016 2:50 PM EST	

Health Homes Providers

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

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Types of Health Homes Providers

☑ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☑ Physicians

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed health care practitioner

☑ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed health care practitioner or group

☑ Rural Health Clinics

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed rural health clinic

☑ Community Health Centers

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed community health center

☑ Community Mental Health Centers

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed community mental health center

☐ Home Health Agencies

☐ Case Management Agencies

☑ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed community or behavioral health agency

☑ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards
WV Medicaid enrolled licensed federally qualified health centers

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

West Virginia's provider infrastructure will include a designated primary care physician or advanced practice nurse practitioner, working with multidisciplinary teams in a variety of possible settings: primary care and solo medical practices; comprehensive community behavioral health centers with a primary care service base; providers who serve special populations; academic medical centers; other entities meeting established qualifications.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. 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
10. 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
11. Establish a continuous quality improvement program, and collect and report on data 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

Description

The State will provide support to providers using a variety of media. Specific programs will be developed and determined based on feedback from providers and identification of needs. This will include face to face training on the requirements and expectations of the SPA, including outreach, assessment, documentation, invoicing, and reporting. Scenarios will be used to illustrate the expectations for care coordination and other health home services.
A website has been set up to provide additional information about the SPA and will include access to recorded training webcasts as well as provider manual and FAQ's.Providers will have a specific QIO trainer consultant assigned to their agency in which they may request training and/or technical assistance. The QIO trainer consultant will be on the provider's site at least one time every twelve months providing training based upon the findings of a record review and certification audit. The findings of these reviews will be analyzed to determine a training plan for all Health Home Providers.
The State will provide support to providers using a variety of media. This will include face to face training on health home requirements and expectations for all providers prior to the effective date of the SPA, including outreach, assessment, documentation, invoicing and reporting.
A learning community of health home participants will be set up to allow for regular sharing of experiences among health homes providers and teams. Qualitative information about program implementation will be collected through this community. and Lessons learned will be harvested through the health home learning community.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

1. Health home providers must enroll or be enrolled in the WV Medicaid program and agree to comply with all Medicaid program requirements.
2. Care coordination and the other five health home services, as identified by CMS, will be provided to all health home enrollees by an interdisciplinary team of providers. As described in the Provider Infrastructure section above, each health home will define its multidisciplinary team in a manner that assures capacity to provide or arrange for the six defined health home services. However, at minimum, each team shall include a primary care provider (physician or advanced practice 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 SMI). Each team shall include an individual who is designated as a care coordinator but who may also fill other roles. The care manager leads the health home team and is accountable for assuring that patient needs are identified and that an integrated care plan is developed and coordinated for each enrollee and is carried out by assuring access to medical and behavioral health care services and community social supports as defined in the care plan. Additional members of the health home team may include physicians, physicians' assistants, nurses, nurse practitioners, pharmacists, social workers, mental health workers, health educators, community health workers, and others, dependent on the delivery model of the health home.
Specific qualifications for the required team member roles are as follows:

- Provider---MD, DO, or Advanced Practice Nurse licensed in the state of WV;
- Behavioral Health Specialist ---Masters prepared individual licensed in the state of WV in counseling, psychology, or social work;
- Nurse---Registered Nurse licensed in the state of WV;
- Care Manager---Registered Nurse or licensed Behavioral Health Specialist. Completed an internal credentialing process through a provider designation as a health home;
- Care Coordinator---Licensed Registered Nurse or Bachelor's Degree in a social science with some applicable patient care or counseling experience.Completed an internal credentialing process through a provider designation as a health home.

The health home provider must identify the means for care plan documentation, communication, and integration across the various service delivery components of the health home.
Health home providers can either directly provide or subcontract for the provision of health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor. The health home provider is required to describe the methods and processes for providing the health home services. Where contractual relationships are to be used, the health home provider must demonstrate that formal written agreements are in place at the time health home services are initiated.
3. Health home providers are expected to establish a medical neighborhood of local community providers that will serve as referral providers for various medical, behavioral health, and facility services, and as applicable to managed care, the medical neighborhood must include providers that are part of the

contracted network of the managed care entity. At minimum, each health home must either include provision of behavioral health services or must establish a formal partnership with a behavioral health entity in order to assure appropriate access to a range of behavioral health services for all of its health home enrollees. Services will be available 24 hours a day/7 days a week. Hospitals that are part of a health home neighborhood 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 health home or other facility based settings to ensure coordination of all aspects of transitional care for current and eligible recipients. Documentation describing the medical neighborhood and hospitals' referral commitment must be provided.

4. Health home providers must demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.

- 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 informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including the promotion of mental and emotional well-being and the prevention of substance abuse.
- 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.
- 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 on data 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.

5. The health home provider must use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, and which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. Providers may also access the The West Virginia Health Information Network (WVHIN), which is an interactive network.

6. As a condition of being a designated provider, the health home must agree not to refuse enrollment of eligible potential health home enrollee referred by Bureau for Medical Services (BMS).

7. As a condition of being a designated provider, the health home is subject to all audit and monitoring systems currently in place for Bureau for Medical Services programs. Documentation of health home services for enrollees is subject to audit by a Bureau for Medical Services contractor. In addition, the provider understands that BMS will monitor outcome measures and the provider is subject to discontinuation of designation as a health home if measures are not reported as required, or if anticipated outcomes are not achieved.

8. Health Home provider qualifications will initially be assessed and approved by the DHHR Bureau for Medical Services. Once a provider gains Health Home provider status, the provider record in the State's MMIS will include this designation. Subsequent Health Home provider recertification, conducted by QIO, will occur within thirteen months of the Health Home designation anniversaries. The QIO is under contract with the Bureau for Medical Services to provide utilization management for certain Medicaid-covered services, including prior approval for inpatient hospital admission.

Name	Date Created	Type

No items available

Health Homes Service Delivery Systems

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

Not Started | In Progress | Complete

Package Header

Package ID WV2016MH0003O

SPA ID WV-16-0008

Submission Type Official - Review 1

Initial Submission Date 2/8/2017

Approval Date 5/4/2017

Effective Date 4/1/2017

Superseded SPA ID N/A

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

      Describe below

      described below
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Health Homes providers will be paid a flat rate per member, per month for indicated services. This rate will be the equivalent of the Tier One payment in the State's Pilot Heath Homes for individuals with bipolar disorder and risk of hepatitis b and/or c in 6 counties and Health Homes II for individuals with bipolar disorder and risk of hepatitis b and/or c in 49 counties.

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Reimbursement will only be made for health home services not covered by any other available Medicaid reimbursement options. The criteria required for receiving a monthly PMPM reimbursement is:

a) The member meets health home eligibility criteria and is so flagged in the MMIS;
b) The member is enrolled as a health home member with the health home provider billing for the service reimbursement;

c) At least one of the core health home services has been provided during the previous month and documented in the member's medical record.
By submitting the basic or intense health home service code for reimbursement, the provider is attesting to the fact that at least one of the six health home services has been provided during the month.
The following steps are used to determine the rates:
I . The State will use West Virginia wage specific data obtained from the Bureau for Labor Statistics (BLS) for each Health Home designated multidisciplinary team professional.
2. Salary will be adjusted for fringe benefits and assigned at a rate of 40 percent of the average BLS annualized salary for each wage classification.
3. The fringe adjusted annual salary is converted to an hourly rate per wage classification assuming 2,080 work hours.
4. The hourly rate for each wage classification is adjusted for each multidisciplinary team member's level of participation in the health home team for payment by dividing the team members assigned level of participation by the total assigned monthly participation for the health home team.
5. The monthly health home team level of participation assigned is two hours PMPM for individuals with target diagnosis. Health home participation levels will vary based on each targeted health home condition.
6. The PMPM rate will equal the sum of hourly rates for each health home multidisciplinary team member that has been adjusted for fringe benefits and participation level.
Payment for Health Home services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically notes otherwise in the plan the state developed rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule. Rates will be published on the Bureau's website at: www.dhhr.wv.gov/bms. The agency's fee schedule rate was set as of July 1, 2014, the start date of WV 1st Health Home program, and is effective for services provided on or after that date. All rates are published on the agency's website.

Payment will be made on a per member per month (PMPM) basis for each health home enrollee. The Health Home service code is intended to cover the provision of all of the six health home services, as determined to be appropriate to meet the member needs. At the time of enrollment, the Health Homes requests prior authorization of the service for each enrollee through a web-based prior authorization system managed by the contracted QIO. Both at initial enrollment and at the time of each service request, the QIO verifies the person's Medicaid eligibility. Payment will be made based on the presence of the Health Home attribute in the member's MMIS record, the member's Medicaid eligibility during the service month, a prior authorization in the MMIS including the service month and the submission for payment through the MMIS of the service code. The benefit package for all Health Home enrollees includes eligibility for services covered by the basic health home code.

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved There will be a contractual agreement with Health Home Providers and other providers, such as waiver services providers and targeted case management providers, regarding non-duplication of similar benefits. In addition, Bureau for Medical Services does periodic retrospective reviews for these services.

☑ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression - WV - 2016

Not Started | In Progress | Complete

Package Header

Package ID	WV2016MH0003O	**SPA ID**	WV-16-0008
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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Data Source: MMIS
Measurement Specifications: Compare total cost of care for health home members to costs of care for similar cohorts not enrolled with a HH. Calculations will

exclude claims for high cost outliers more than three standard deviations from the mean annual cost and will include incremental HH reimbursement. HH member costs will also be compared pre- and post- HH implementation.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

West Virginia currently has several HIT initiatives in place and underway that will support the provision of health home services and improvement of care coordination across the care continuum.

- The state is in the process of implementing a statewide health information exchange that will facilitate the sharing of information across various care delivery settings. All health home providers will be expected to participate in the HIE as it is implemented across the state. The HIE will be used to capture meaningful use measures and several of these are incorporated into the information that will be used to monitor and evaluate health home services. Until the HIE is fully in place in the state, each health home provider will also be expected to use their EHR to generate a Continuity of Care Document (CCD) that can be shared with other providers in order to facilitate transitions in care and care coordination across care settings.
- A pharmacy data warehouse is in place that will provide for monitoring of patient adherence to prescribed drug regimens as well as appropriate use of pharmaceutical agents.
- A data warehouse/decision support system has been implemented to capture MMIS claims data as well clinical data that will flows through the HIE. This data warehouse will be the primary source of evaluation information for the health homes initiative.
- A web-based vendor system will be used for documentation of medically necessary services and authorization information.
- Information on hepatitis will be shared with the West Virginia Bureau for Public Health: the Office of Epidemiology and Prevention Services maintains a data base of information regarding incidence of hepatitis in the State.

Quality Measurement and Evaluation

☑ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state

☑ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals

☑ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS

☑ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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