FAQ Tribal Health Home (HH) Program

Why should my tribe be interested in the HH program?

- States provide Health Home benefits and care coordination services to high-cost, high risk Medicaid and Medicare/Medicaid (duals) eligible participants.
- Offers a set of services to individuals living with a chronic condition that can lead to additional chronic conditions if not managed.
- The participant, their specific health needs and goals are central to service delivery.

Who benefits from the program?

- The participant
- The family and their supports
- The Medicaid system

What do I have to do to qualify to receive HH CC services?

- You must be eligible for Medicaid
- You must be diagnosed with at least one chronic condition that puts you as risk for another
- You must have a PRISM predictive risk score of 1.5 or higher

Who is not eligible for the HH Program?

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

What is PRISM?

- **PRISM** (Predictive Risk Intelligence System) is a DSHS tool that looks at medical, behavioral health, substance use disorders, and long-term care service claims data to predict what future medical costs might be.
- A **risk score** is assigned to the participant based on this data. The risk score is one way to measure the participant's risk of higher-than-average medical costs, using historical cost data.

PRISM provides:

- a secure profile of a participant's past use of Medicaid and Medicare health services.
- clinical support tools like drug adherence screens and risk factors.

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- assist care coordinators to identify areas where participants have opportunities to create change and improve their health.

What is a Health Home?

- It is a set of services designed to assist participants in accessing medically necessary services.

What are the services the HH program offers?

1. Comprehensive care management;
2. Care Coordination;
3. Health promotion;
4. Comprehensive transitional care and follow-up;
5. Individual and family support; and
6. Referrals for community and social services support

How does the program work?

- Assists participants in accessing medically necessary services.
- Services may be delivered face to face or telephonically, but you do need to meet in person at least once a month to bill for the IHS encounter rate.
- Participant and care coordinator can meet at a location of the participants choice: a clinic, the participants home, or other community location.
- Each person who qualifies for the HH program has the option to opt in or out.
- Opting in can look different for each person receiving services.
- There are 3 tiers of service.

What is a Tier?

- The 3 tiers include the initial contact, the more hands-on portion, and then the last phase is where the participant has the tools and skills to maintain their current health with the CC present to assist when needed.
- **Tier 1** is the initial in person meeting between the participant and the CC to complete the required assessments and develop the Health Action Plan (HAP) with individually centered goals and action steps to achieve those goals. (Ex: I want to increase the distance I can walk and be able to attend social outings.)
- **Tier 2** the CC will meet at least once a month face to face with the participant to revisit goals and address any concerns. This is the intensive HH care coordination phase. Aside from meeting to revisit goals and adjust as needed, the CC will also be available to talk via phone, attend appointments, and provide health education and coaching to the participants and their supports.

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- **Tier 3** is the phase where the participant has gained the skills and knowledge to be able to continue to maintain their current health while being able to re-adjust as needed to meet their changing needs. The CC is still present to provide support as needed but they are less hands on in this phase. A participant can opt out of the program during this or any of the 3 phases, but they can continue to connect monthly or more as needed with their CC to create new goals and actions steps as their health needs change.

What is the value of this program?

- Reduce the progression of chronic disease for participants
- Decrease the likelihood of additional chronic conditions
- Decrease emergency department visits and preventable hospital readmissions
- Improve health and self-management of chronic conditions for the participants
- Ensure care coordination and care transition for participants returning home after a health event
- Reduce medical expenditures for both the state and federal governments

Who can provide HH services?

- **Community organizations** and Managed Care Organizations (MCOs) contract with HCA/DSHS as "Lead" Organizations. Leads may provide participant services or sub-contract with community organizations and tribes.
- "Care Coordination Organizations" (CCOs) include mental health clinics, area agencies on aging, chemical dependency providers, HIV/AIDs networks, child social service agencies, community health centers, and tribes.
- **Tribal Nations can choose to provide services as a Lead, CCO, or both.**

What does a Lead Organization do?

- Leads are responsible for administrative oversight.
- Leads are responsible for ensuring participant records are created and maintained.
- Leads must provide quarterly reports to the HCA.
- As a Lead Organization you take on a lot more financial risk and have a lot more administrative staff and expenditures.

What does the Care Coordination Organization do?

- Subcontract with the Lead agency.
- Hire Care Coordinators (CC) and assign them to provide the HH services.
- Ensure HH CC actively engage participants in developing a Health Action Plan (HAP) centered around their individual needs and goals.
- Assist participants in getting the right care, at the right time, in the right setting, to avoid duplication of services.

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- Establish methods to share critical events with the HH CC within established time periods.
- Use the Lead Agency provided software platform to track and share participant information and care needs across providers to:
    - monitor processes of care and outcomes,
    - initiate recommended changes in care, and
    - address achievement of heath action goals.
- Use informed interventions that recognize and are tailored for the:
    - medical, social, economic,
    - behavioral health, substance use, function impairment, and
    - cultural and environmental factors affecting health and health care choices.
- Provide culturally competent Health Home services that address health disparities.
- Ensure HH CC's will discuss with the treating/authorizing entities:
    - time sensitive situations that may impact the participant current status,
    - changes in participant circumstances, conditions, or HAP
    - need for changes in treatment and services.
- **Once you have mastered the CCO world, it becomes easier to work towards becoming a Lead agency. There are many requirements to fulfill in becoming a Lead agency and as a CCO initially, you will possess a better understanding of the financial and programmatic risk you take on as a Lead agency.**

Who can be a HH CC?

- Care Coordinator is the central person developing and updating the HAP and must be a "professional" according to our State Plan Amendment.
- Indian Health Services (IHS) Certified Community Health Representatives (CHR).
- Register Nurse (RN)
- Advanced Registered Nurse Practitioner (ARNP)
- Licensed Practical Nurse (LPN)
- Psychiatric Nurse
- Psychiatrists
- Physician's Assistant (PA)
- Clinical Psychologists
- Licensed Mental Health Counselor (LMHC)
- Agency Affiliated Certified Mental Health Counselor

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- Licensed Marriage and Family Therapist (LMFT)
- Master's or Bachelor's in Social Work (MSW), Psychology, Social Services, Human Services, or Behavioral Sciences
- Certified Chemical Dependency Professionals
- Certified Medical Assistants with an Associate Degree
- ***If you hold a license to practice, it must be current to meet the qualifications.***

Who can our Tribal CCO serve?

- AI/AN participants must give their consent to be enrolled
- When contracting as a Care Coordination Organization or a Lead Agency, Tribes can specify what eligible participants they will serve

- ❑ AI/AN participants only
- ❑ Dual Eligible coverage only
- ❑ All eligible participants
- ❑ Fee for Service participants (FFS)
- ❑ Managed Care Organization participants (MCO)
- ❑ Both FFS and MCO participants

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