North Central Accountable Community of Health

Health Home Demystified

Frequently Asked Questions

What are the overarching goals of the Health Home program?

The program's overarching goals are to (1) improve the health and independence of clients, (2) reduce their health care costs, and (3) help them become more engaged in their own health care.

Who is the Health Home program for in Washington State?

To be eligible for the Health Home Program, residents of any age with Apple Health health insurance (including Medicaid/Medicare dual eligible clients) must:

- Have at least one chronic condition
- Be at risk of poor health outcomes in the future based on age, gender and diagnoses (based on a risk score of 1.5 or greater)

What kind of chronic conditions meet the eligibility criteria?

Washington Administrative Code (WAC) 182-557-0100 defines elements of the Health Home program. According to this statute, "chronic condition" means mental health conditions, substance use disorders, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions.

How does the risk score work?

The State's department of social and health services (DSHS) developed an algorithm calculating the expected costs of health care a Medicaid client is likely to incur in the next twelve months. The predictive risk score is generated using information in the State's Predictive Risk Intelligence SysteM (PRISM), including Medicare and Medicaid health care claims and encounter data, diagnosis codes, prescription drug codes, and demographics. A risk score of 1.5 or greater predicts 50% higher healthcare costs in the next 12 months, compared to the average Medicaid client with disabilities.

Does an eligible person need to pay for Health Home services?

No. Eligible clients who opt in to the program receive Health Home services at no cost.

How would someone know if they are eligible for this service?

The Health Care Authority (HCA) sends newly eligible residents a Health Home Booklet to let them know they are eligible for the program, and to provide basic information about the program. This booklet explains that once someone is found eligible, a care coordinator will be assigned to contact them.

Behind the scenes, the HCA assigns eligible community members to the appropriate Health Home lead providing oversight of this program. The lead then assigns people to one of their contracted care coordination organizations (CCO); at this point, the client is considered enrolled. Care coordination organizations are responsible for reaching out to "find" and engage clients.

What entities serve as leads and care coordination organizations?

You can view Health Home service providers (both leads and CCOs) using Washington State's Health Home dashboard.

https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes#health-home-dashboard

How do community partners check if their clients are eligible for the Health Home program?

At this time, there is no simple way for community partners to determine whether one of their existing clients is eligible for Health Home. Only select entities have access to the state's PRISM information. Clinical partners with access to ProviderOne (Washington State's federally certified Medicaid Management Information System) may be able to identify Health Home eligibility.

Can a community agency refer someone to Health Home?

There currently are no referral forms or processes for community partners to refer someone to a Health Home program in their region.

Do Health Home care coordinators have to have specific qualifications?

Health Home care coordinators may be Registered Nurses (RNs), ARNPs, licensed practical nurses, psychiatric nurses, psychiatrists, physician's assistants, clinical psychologists, licensed mental health counselors, agency affiliated certified mental health counselors, licensed marriage and family therapists, MSW, BSW or related Bachelor's prepared social workers, and certified chemical dependency professionals.

Community health workers or community health representatives may work with the care coordinator and client as "affiliated staff."

Does this program exist outside of Washington State?

Yes. As of April 2020, 20 states and the District of Columbia had a total of 35 approved Medicaid health home models. The target population and program delivery varies from state to state, but generally, all Health Home clients have complex needs that drive up the cost of their care.