

# Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b> WA2023MS00040	<b>SPA ID</b> WA-23-0027
<b>Submission Type</b> Official	<b>Initial Submission Date</b> 9/8/2023
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## SPA ID and Effective Date

**SPA ID** WA-23-0027

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2023	20-0031
Health Homes Geographic Limitations	7/1/2023	20-0031
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# Health Homes Intro

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## 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

Washington State Health Home Program

## 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

Under Washington's approach, the Health Home program is the bridge to integrate care within existing delivery systems for both managed care and fee-for-service beneficiaries. Washington's Medicaid delivery system integrates physical and behavioral health services statewide through its managed care program. Washington's Health Home program now serves managed care beneficiaries and beneficiaries who remain in the fee-for-service delivery system, such as a full-dual eligibles and American Indian/Alaska Native population.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) building care coordination capacity in all areas of the state; 2) improve the beneficiary's self-management abilities; and 3) reduce future cost trends or at the very least, attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their beneficiaries.

Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and are at risk for a second chronic condition using a tool that identifies clients expected to have high future costs due to all their chronic conditions.

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Home beneficiaries to HCA. Then HCA enrolls them into a Managed Fee-For-Service Health Home Lead Entity (designated provider) or notifies the Managed Care Organization (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to serve as a Care Coordination Organization (CCO) and must also subcontract with a wide-range of community-based Care Coordination Organizations to effectively manage the full breadth of beneficiary needs, increasing Washington's capacity to provide statewide Health Home services, especially in rural areas of the state.

There are six defined Health Home services, with each individual service fully defined by embedded activities to make up the composition of the service.

Washington's previous Health Home SPAs were WA-13-0008, approved June 28, 2013, and WA-13-0017, approved December 11, 2013. SPA WA-15-0011, approved June 11, 2015, superseded previous SPA versions. SPA WA-16-0026, approved March 31, 2017, superseded previous versions; it added a 20% performance incentive payment to increase beneficiary engagement rates and expand the Health Home program statewide. SPA WA-18-0028 superseded previous SPAs; it added a 20% rate increase and reduced the performance incentive payment to 5%. SPA WA-20-0031 supersedes previous SPAs; it updated payment methodology and added a 26% rate increase across all tiers.

SPA WA-23-0027 supersedes previous Health Home SPA versions. The following updates were made to SPA WA-23-0027:

- 1) The payment methodology was updated. The administrative rate increased from 8.5% to 10% and Health Home rates were updated based on legislature approval and Lead Entity (designated provider) feedback.
- 2) SPA language was updated to align with current definitions of face-to-face (includes both in person and telemedicine) and clarified areas that required an in person visit, like Tier 1 visits (initial HAP).
- 3) Based on CMS technical assistance, we removed Designated Providers prepopulated in MACPro and added Community-Based Organizations in the other designated provider section. Community-Based Organizations are defined in this section. The functions of a designated provider remain unchanged.
- 4) Based on CMS technical assistance, we removed prepopulated Provider Types and added Care Coordination Organization (CCO) to the "other" section. The CCO is responsible for providing Health Home services and the state Health Home program will determine guidance and protocols, using the expertise of clinical staff (physical a

## General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- 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.
- 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.

- 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 will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

# Health Homes Geographic Limitations

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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

# Health Homes Population and Enrollment Criteria

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## Categories of Individuals and Populations Provided Health Home Services

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

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

# Health Homes Population and Enrollment Criteria

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## Population Criteria

The state elects to offer Health Homes services to individuals with:

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

Specify the conditions included:

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

Name	Description
hematological	As defined by UC San Diego CDPS and Medicaid RX disease categories.
musculoskeletal	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cancer	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cerebrovascular disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
coronary artery disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
HIV/AIDS	As defined by UC San Diego CDPS and Medicaid RX disease categories.
renal failure	As defined by UC San Diego CDPS and Medicaid RX disease categories.
chronic respiratory conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
neurological disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
dementia or Alzheimer's disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Name	Description
intellectual disability or disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
gastrointestinal	As defined by UC San Diego CDPS and Medicaid RX disease categories.

**Specify the criteria for at risk of developing another chronic condition:**

At-risk for a second condition is a minimum predictive risk score of 1.5, which means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group (the Washington SSI-disabled population). The Washington risk score is based on the Chronic Illness & Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California-San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age and gender indicated in a beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) produce a risk score, with chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies, N=does not qualify) is loaded into Washington's Medicaid Management System (MMIS).

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool is on the Health Home website and distributed to the Lead Entities. Once a provider has determined a potentially beneficiary is eligible by manually calculating their risk, that information is sent to HCA for further analysis. If the beneficiary is eligible and not receiving other Medicaid care coordination services, they will be enrolled into a Health Home.

One serious and persistent mental health condition

# Health Homes Population and Enrollment Criteria

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## 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:

The state identifies Fee-for-Service beneficiaries who are eligible for the Health Home program based on their chronic condition and risk score, then enrolls them into a Managed Fee-for-Service Lead Entity/Designated Provider. Enrollment is based on zip code, amount of available beneficiaries within each zip code, and capacity to provide Health Home services. The Lead Entity assigns Health Home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, assigns the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt out of the assigned Health Home or change enrollment to another Health Home provider within the Health Home network. Eligible beneficiaries who opt out of participation and retain their 1.5 or higher risk score have the option of re-enrolling the Health Home program at any time by contacting HCA's customer service line.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO beneficiaries who are eligible for Health Homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs that are qualified to be Lead Entities, assign their Health Home beneficiaries to one of their network-affiliated Care Coordination Organizations (CCOs), who, in turn, assign the beneficiary to a Care Coordinator. MCOs that are not qualified as a Lead Entity/designated provider must delegate Health Home services to a qualified Lead Entity and assign their eligible/identified beneficiaries to their delegated Lead Entity. The delegated Lead Entity, in turn, will assign the beneficiary to one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the Health Home or change enrollment to another MCO or subcontracted Health Home CCO within the Health Home program.

Beneficiaries lose Health Home eligibility when their risk score drops below 1.0 for at least six continual months and they have not participated or engaged in the program during those months. Beneficiaries who actively participate and are engaged do not lose eligibility if their risk scores drops below 1.0.

- 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	
<a href="#">Health Homes Client Notice Letter-2018</a>	8/21/2018 4:56 PM EDT	
<a href="#">Your WA State HH Booklet 22-851</a>	8/21/2018 4:56 PM EDT	



# Health Homes Providers

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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
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Provider Type	Description
Managed Care Organizations	<ol style="list-style-type: none"><li>1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA</li><li>2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims</li><li>3. Experience operating broad-based regional provider networks</li><li>4. Contracts directly with the state as a Qualified Health Home</li><li>5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network</li><li>6. Subcontracts with community based CCOs to provide Health Home services</li><li>7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.</li><li>8. Maintains a list of CCOs and their assigned Health Home population</li><li>9. Monitors CCOs to ensure fidelity to the Health Home model</li><li>10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the</li></ol>

**Provider Type**

**Description**

Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.

11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA
14. Maintains an adequate network of Care Coordination Organizations
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find

**Tribal Clinics**

1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims
3. Experience operating broad-based regional provider networks
4. Contracts directly with the state as a Qualified Health Home
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network
6. Subcontracts with community based CCOs to provide Health Home services
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice
8. Maintains a list of CCOs and their assigned Health Home population
9. Monitors CCOs to ensure fidelity to the Health Home model
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.
11. Ensures person-centered and integrated Health Action Planning

Provider Type	Description
Community-Based Organizations (i.e., Area Agencies on Aging, FQHCs, Hospitals, Social Service Organizations, and Behavioral Health Agencies)	<p>which includes providing high touch care management</p> <p>12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator</p> <p>13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA</p> <p>14. Maintains an adequate network of Care Coordination Organizations</p> <p>15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find</p> <p>1. HIPAA-compliant data systems for enrollment, collecting and reporting encounters to HCA</p> <p>2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims</p> <p>3. Experience operating broad-based regional provider networks</p> <p>4. Contracts directly with the state as a Qualified Health Home</p> <p>5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network</p> <p>6. Subcontracts with community based CCOs to provide Health Home services</p> <p>7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary or optimizes beneficiary choice.</p> <p>8. Maintains a list of CCOs and their assigned Health Home population</p> <p>9. Monitors CCOs to ensure fidelity to the Health Home model</p> <p>10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols.</p> <p>11. Ensures person-centered and integrated Health Action Planning which includes providing high-touch care management</p> <p>12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator</p> <p>13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA</p> <p>14. Maintains an adequate network of Care Coordination</p>

Provider Type	Description
	Organizations 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

# Health Homes Providers

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Teams of Health Care Professionals

**Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards**

- Physicians
- Nurse Practitioners
- Nurse Care Coordinators
- Nutritionists
- Social Workers
- Behavioral Health Professionals
- Other (Specify)

Provider Type	Description
Care Coordination Organization	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team (i.e., Care Coordinator or Affiliated Staff), but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).

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Health Teams

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## Provider Infrastructure

### Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's Health Home service model is based on a multidisciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home Lead Entities (Designated Providers) ensures managed care organizations (MCOs): community-based organizations such as hospitals, FQHCs, Behavioral Health Agencies, Area Agencies on Aging, social service organizations; and tribal clinics, who may apply have the necessary skills and infrastructure to provide Health Home services.

Qualified Lead Entities, through their respective networks, provide intensive Health Home care coordination services to Medicaid and Medicaid/Medicare beneficiaries with chronic conditions to ensure that services delivered are integrated and coordinated across medical, mental health, substance use disorder, and long-term care services and supports. Beneficiaries who are eligible for Health Homes may receive direct services from both HCA and DSHS, but the Health Home contracts are based in HCA.

The Health Homes structure is built on the following hierarchy:

1. Designated Provider/Qualified Health Home Lead Entity - Healthcare systems, providers, and authorizing entities with experience developing community-based service provider network relationships, such as managed care organizations (MCOs), community-based organizations (i.e., hospitals, federally qualified health centers or FQHCs, Area Agencies on Aging, Behavioral Health Agencies, and social service organizations), and Tribal Clinics. The Lead Entities contract directly with the state and are responsible for service delivery model and administration of the Health Home. Lead Entities assign Health Home eligible beneficiaries into Care Coordination Organizations (CCOs), collect and submit encounters, disburse payment to network affiliated CCOs through the collection and submission of encounters, monitor quality, subcontract, collect, analyze, and report financial and health status to objectively determine progress towards meeting overall Health Home goals. Some Lead Entities also verify address and phone information and engage beneficiaries through telephonic contact to determine willingness to participate. Some Lead Entities may also serve as internal CCOs as a means of reaching rural areas of the state that may not have enough non-Lead CCOs to support capacity.
2. Network Affiliated Care Coordination Organizations (CCO) - Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. CCOs are responsible for implementing systematic processes and protocols to assure service delivery and beneficiary access to Care Coordinators and affiliated staff. CCOs may be managed care organizations, community-based organizations (i.e., hospitals, FQHCs, Area Agencies on Aging, Behavioral Health Agencies, Behavioral Health Agencies, and social service organizations), and Tribal Clinics.
3. Care Coordinators - Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits by actively engaging the beneficiary in developing a Health Action Plan (HAP); reinforcing the HAP and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating, and supporting the beneficiary to attain and improve self-management skills; ensuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they coordinate services with authorizing entities, for which the beneficiary is receiving service assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides to ensure services are provided in-person whenever needs, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible beneficiaries in the setting of their choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.
4. Affiliated Health Care Staff, such as community health workers, peer counselors, or other non-clinical personnel administrative support for the Health Home Care Coordinator, that includes mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator. Some affiliated staff may provide more direct care coordination functions under the supervision of a Care Coordinator.
5. Additional network providers who have agreed to participate in the Health Home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a Lead Entity, through the use of an operational agreement.

## 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 foundation of the Health Home program is the community-based Care Coordination Organization (CCO) network, subcontracted to Lead Entities. CCOs are a wide variety of medical, behavioral health and social service providers who provide Health Home services through contracted Care Coordinators. Because many Health Home beneficiaries have existing relationships with one or more providers, broad-based CCO networks enable a smart assignment process. For example, the clinic where the beneficiary has their primary care provider may be their CCO, or an Area Agency on Aging who supports the beneficiary with their long-term services and supports may be their CCO.

Each activity defined under the six Health Home services is built into Lead Entity contracts, ensuring that coordination of services, access to services, and person-centered care is delivered to the Health Home beneficiary. For example, the beneficiary is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the beneficiary during development and as they are updated, usually on a four-month cycle. Beneficiaries may include their families and caregivers as part of their support team and may authorize the release of the HAP to their family members, caregivers and providers. The HAP is both an electronic form and a paper form.

HCA and DSHS jointly sponsor training for Health Home service. Nursing staff developed core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole-person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or collaborative learning efforts continue to foster shared learning, information sharing and problem solving.

The state provides access to PRISM, a secure web-based clinical support tool showing the beneficiary's medical risk factors, demographics, eligibility, managed care status, housing, utilization of Medicaid and Medicare health services (including inpatient services, outpatient services, emergency department visits, filled prescriptions, mental health services, long term care services and supports, filled lab orders, and dental services), provider contact information, and long term care case manager assessments. This resource complements existing clinic-specific Electronic Health Records and provides the foundation for a continuous quality improvement program.

## **Other Health Homes Provider Standards**

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

Qualified Health Home Lead Entities and their networks are developed to meet the needs of the populations they serve. Care coordination is necessary across numerous service domains and therefore may include many different disciplines. The state qualifies each Lead Entity, who is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan, through contractual/operational arrangements with appropriate providers. A Care Coordinator is the central point of contact working with the managed care or Fee-for-Service beneficiary to direct person-centered health action planning and implementation, and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable Emergency Department visits; providing timely post discharge follow-up, and improving beneficiary outcomes by addressing health care needs.

For the first two phases of implementation, Washington issues an RFA (Request for Application) and qualified eight Lead Entities to provide Health Home services through their network of Care Coordination. Now the program is statewide, new organizations interested in being a Lead Entity will go through a contracting process after the state team determines need, provider readiness, and viability of the potential Lead Entity before approved to provide Health Home services.

The following minimum requirements to become a Qualified Health Home Lead Entity:

1. Applicant is a Medicaid provider in good standing, has the ability to serve at least 300 Health Home beneficiaries, has experience operating broad-based networks, agrees to serve the entire coverage area, assures a referral system is in place, documents beneficiary consent, subcontracts with CCOs, has the ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access and interpretation capabilities, can provide links to acute and outpatient medical, mental health and substance use services, and community-based social services.
2. Provider networks must include a wide variety of community-based CCOs.
3. Organizational infrastructure includes the ability to provide administrative functions, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face Health Home care coordination activities, ability to track Health Home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account movement between payment levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial and health status. Ability to ensure hospitals have procedures in place for referring Health Home eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room.
4. Core Health Home requirements must be met, showing the ability to provide six Health Home care coordination functions and a guarantee of non-duplication of efforts that includes: engagement and outreach; health action planning; self-management of chronic conditions; setting short and long-term goals; cultural competency; motivational interviewing; identification of services and gaps in services; evidence-based interventions; information sharing with beneficiary's treating/authorizing entities; establishment of multidisciplinary teams; accompanying beneficiary to visits when requested; arranging for priority appointments; notification systems for transitional care; follow-up on medications upon discharge and follow-up with pharmacy to get prescriptions filled; helping the beneficiary access follow-up care and referrals; optimizing social supports and family; and use of health information technology.

Before contracts are awarded, HCA and DSHS will conduct desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered only after the readiness reviews and after any identified deficiencies are mitigated through a corrective action plan. Before contracts are awarded to previously Qualified Lead Entities, HCA and DSHS will determine if their networks are adequate to provide Health Home services. MCOs who apply to become Lead Entities must also maintain an integrated managed care (IMC) contract with HCA.

The Health Home program will be audited during annual contract compliance audits. Based upon results of the audit, the Lead Entity may be put on corrective action or have their qualification status terminated.



Name	Date Created	
No items available		

# Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b>	WA2023MS00040	<b>SPA ID</b>	WA-23-0027
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	9/8/2023
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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care

**The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals**

- Yes
- No

**Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services**

Managed care contracts contain language to support the Health Home benefit for eligible beneficiaries. An MCO has two paths to choose from when providing those benefits. They may either become a qualified Health Home Lead Entity through the Request for Application process or they may provide their Health Home benefits through a delegation agreement with another qualified Health Home Lead Entity.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology
2. The use of clinical and non-clinical Care Coordinators and allied staff
3. Contracts, memorandums of agreement or operational agreements with hospitals for emergency department and hospitalization notification, including a referral process to refer beneficiaries to HCA for Health Home enrollment
4. Data security requirements
5. Standardized screening and assessments
6. Development of a Health Action Plan (HAP) through an in-person visit to promote self-management through the identification of the beneficiary's short and long-term goals
7. Encounter data reporting and documentation of delivered services to support encounters
8. The use of multidisciplinary care teams, that include the Care Coordinator, the beneficiary, and any other identified providers
9. Training requirements
10. Program Integrity
11. Grievances and Appeals processes
12. Access to the PRISM clinical decision support tool;
13. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for beneficiary outreach and education regarding medication use, lapses in pharmaceutical payments; and emergency department use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

The Apple Health MCO and IMC contracts are located online at <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home-resources>.

- The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created
No items available	

**The State intends to include the Health Home payments in the Health Plan capitation rate**

Yes

No

**Assurances**  The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

Other Service Delivery System

**Describe if the providers in this other delivery system will be a designated provider or part of the Team of health care professionals and how payment will be delivered to these providers**

In addition to the Managed Care Health Home delivery system, Washington also uses a Managed Fee-for-Service (MFFS) delivery system, which provides Health Home services through community-based Qualified Health Home Lead organizations. This service delivery system requires the Health Home Lead organization to pay for services to their subcontracted Care Coordination Organizations (CCOs) and report their claims payments to the state in the form of encounter data before receiving the monthly per member per month payment only for services rendered.

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

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## Payment Methodology

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

Fee for Service

Individual Rates Per Service

Per Member, Per Month Rates

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

Other

### Describe below

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations which pay subcontracted Care Coordination Organizations & report their claims payments to as encounter data before receiving the monthly payment.

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 Home (HH) rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. HH Lead entities pay for only one procedure code or service level encounter per beneficiary per month, regardless of the number of services the Health Home Care Coordinator provided to the beneficiary during the month. The procedure codes used to claim payment for the HH service level tiers are:

- Tier One - G9148
- Tier Two - G9149
- Tier Three - G9150

The three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high-touch interactions with the beneficiary and/or caregiver. The initial care coordination (CC) stage (Tier One) encompasses three primary responsibilities: health screening and assessments, development of a person-centered health action plan for care management, and assessing the beneficiary for self-management and promoting self-management skills to improve functional or health status or prevent or slow declines in functioning. Tier One of the HH rate is a one-time payment and indicates the beneficiary is engaged in the program.

The second service level, Tier Two, is for providing Intensive, high-touch HH services. Once a month, the Care Coordination Organization (CCO) submits a claim for payment of the Tier Two procedure code or service level encounter. This rate includes face to face meetings with the beneficiary, pays for and signifies the documentation and intensive CC provided for the beneficiary, delivering at least one of the six defined health home services.

The third service level, Tier Three, is for Low-Level HH services to maintain the beneficiary's self-management skills and continued assessment of needs. Once per month, the CCO submits a claim for payment of the Tier Three procedure code or service level encounter. Payment for this service level includes documentation that HH services were provided to beneficiary either face to face or by phone.

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)

Tiered Rates based on

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team

Other

**Describe below**

The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations who pay subcontracted Care Coordination Organizations & report their claims payments to HCA as encounter data before receiving the monthly payment.

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

Variations in payment is based on the level of care coordination provided, as noted in the tiers.

Tier 1 (G9148) - initial engagement and action planning  
Tier 2 (G9149) - intensive level of care coordination  
Tier 3 (G9159) - low level of care coordination

**Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.**

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and action planning = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home Services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically, the Tier will not change from month to month, between Tier Two and Tier Three but does change when the client and/or their caregivers consistently demonstrate an intensive or low level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home Services include:

- Comprehensive Care Management: The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- o Conduct outreach and engagement activities
- o Develop the HAP setting client centered goals and action steps to achieve the goals
- o Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
- o Prepare crisis intervention and resiliency plans
- o Support the client to live in the setting of their choice
- o Identify possible gaps in services and secure needed supports

- Care Coordination and Health Promotion: Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.

Examples:

- o Support to implement the HAP

- o Encourage and monitor progress towards individualized short and long term goals
- o Coordinate with service providers, case managers, and health plans
- o Conduct or participate in interdisciplinary teams
- o Assist and support the client with scheduling health appointments and accompany if needed
- o Communicate and consult with all providers and the client
- o Provide individualized educational materials according to the needs and goals of the client
- o Promote participation in community educational and support groups

- Comprehensive Transitional Care: The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.

Examples:

- o Follow-up with hospitals/ED upon notification of admission or discharge
- o Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
- o Assist with access to needed services or equipment and ensure it is received
- o Provide education to the client and providers that are located at the setting from which the person is transitioning
- o Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
- o Ensure follow-up with Primary Care Provider (PCP)
- o Review and verify medication reconciliation post discharge is completed

- Individual and Family Supports: Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.

Examples:

- o Provide education and support of self-advocacy including referral to Peer Support specialists
- o Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
- o Educate client, family or caregivers of advance directives, client rights, and health care issues
- o Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences

- Referral to Community and Social Supports: The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.

Examples:

- o Identify, refer and facilitate access to relevant community and social services that support the client's HAP
- o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
- o Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services

- Use of Health Information Technology to link services: Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

Client movement between Tiers

Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher.

Tier One:

\* Minimum Contact:

>Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program.

>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.

\* Activity Examples:

>Review PRISM and other available client records.

>Administer required screenings.

Administer optional screenings as needed.

>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).

>Establish a follow up plan with the client.

>Submit Tier One Claim for payment with date of service when the HAP has

been completed.

Tier Two - Intensive Health Home care coordination:

\* Minimum Contact:

>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.

>Exceptions can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.

>Exceptions can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.

>At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.

\* Activity Examples:

>Administration and follow up on clinical, functional, and resource use screenings.

>Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed.

>Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

>Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.

>Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs.

>Medication reconciliation as part of care transitioning.

>Education and coaching of caregivers, family members, and other supports.

Tier Three - Low level Health Home care coordination:

\* Minimum Contact:

>Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.

>The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.

>Contact may not occur every month depending on the HAP and the needs of the client.

>At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.

\* Activity Examples:

>Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. >Monthly call to check in on HAP progress and to identify new or changing goals.

>At Tier Three, the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

The Health Care Authority publishes the Encounter Data Reporting Guide (EDRG) for MCOs, Health Home Lead Entities, and Behavioral Health Organizations. The EDRG describes the frequency of required encounter data submissions and includes the Health Home Managed Fee-for-Services (MFFS) payment process. The EDRG is available on-line at: <https://www.hca.wa.gov/assets/billers-and-providers/encounter-data-reporting-guide.pdf>.

# Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b>	WA2023MS00040	<b>SPA ID</b>	WA-23-0027
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<b>Superseded SPA ID</b>	20-0031		
	User-Entered		

## 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

### Effective Date

7/1/2023

### Website where rates are displayed

<https://www.hca.wa.gov/assets/billers-and-providers/HHCareCoordinationRates.pdf>



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## 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** 1. The Washington State Legislature approved a rate increase for the FFS Health Home population. The fee-for-service (FFS) Health Home Leads made a request to the Legislature for an amount that would enable the FFS Health Home Lead Entities to be made whole financially. An additional rate increase was approved for the state fiscal year 2025. FFS Health Home Lead Entities requested an increase to the administrative rate: from 8.5% to 10% for each tier and the remaining proviso funds were used to increase the Tier 2 rate. In fiscal year 2024, the Tier 2 rate increased by 23% and an additional 5% rate increase will be added to the Tier 2 rate in fiscal year 2025.

2. Washington State has three payment tiers with specific HCPCS procedure codes that define the level of Health Home care coordination services provided. All three tiers have a mix of clinical and non-clinical staffing elements. The procedure code submitted for payment reflects the overall level of the beneficiary's engagement and activation level; activity in the Health Action Plan; provision of at least one of the six defined Health Home services; and frequency of contacts (face to face visits, phone calls, referrals, or care coordination).

3. 2.3. Tier One (G9148) is for initial engagement and health action planning. This is a one-time payment to initiate participation in the Health Home, conduct a face-to-face home visit, and complete the Health Action Plan (HAP). Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Tier Two (G9149) is for on-going, face-to-face and telephonic visits with the beneficiary to provide one or more of the six Health Home services. Tier Two is paid once per month, per beneficiary. The minimum level for reimbursement is at least one face-to-face contact with the beneficiary during the month.

Tier Three (G9150) is low-level care coordination for beneficiaries who request less contact or face-to-face visits or have achieved a level of self-management for their chronic conditions and no longer need the intensive care coordination. Tier Three is paid once per month, per beneficiary only for months in which a Health Home service was provided.

4. 3.4. Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. The HAPs are reviewed against the Tier One claims to ensure that a payment has been made for a completed HAP. HAPs are updated every activity period, which consists of four months, or more frequently if there has been a change in circumstances, such as a hospital or Emergency Department visit. HAPs are also updated when short and long-term goals have been finalized and the beneficiary sets new goals. Washington requires all Health Home providers to document the Health Home services provided in their subcontracts with Care Coordination Organizations (CCOs). Annually, during the contract compliance reviews the state audits care management records and notes.

5. Reviewing and rebasing the rates for future updates will happen every three years or more frequently if cost trends warrant a more frequent adjustment. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

# Health Homes Payment Methodologies

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## 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**

Case management provided under the state's 1915(c) waivers are non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, service planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for both individuals receiving long-term services and supports and individuals receiving developmental disabilities services will continue to be necessary for individuals served under waivers, and the Health Home program will not duplicate the functions provided by state and Area Agency on Aging (AAA) staff who perform these functions.

Health Homes will be responsible for review of claims and social service use history, health screening (e.g., screening for common mental health conditions associated with chronic illness such as depression, patient activation assessments), examination of current clinical conditions and treatment, and PRISM information. This assessment is used to identify care gaps, utilization patterns, where chronic care condition education and coaching may be most helpful and to assist the beneficiary in development and implementation of their Health Action Plan, including identification of self-care goals.

The Health Home will also be responsible for transitions, assessing beneficiaries at higher risk for re-institutionalization, assisting the beneficiary and their support network in gaining an understanding of discharge instructions and information, ensuring appropriate follow-up primary and specialty care and that medication reconciliation occurs, and assisting with referrals for additional services the beneficiary may need.

For Tribal PCCMs, the state will not allow an eligible Health Home enrollee to be enrolled in a Tribal PCCM and a Tribal Health Home at the same time. A Tribal member, if enrolled in a PCCM, must choose which method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll themselves from their Tribal PCCM.

Health Home enrollment is managed by the state and the ProviderOne enrollment and payment system which does not allow a tribal member to be enrolled in a Health Home and a PCCM at the same time.

The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

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).

## Optional Supporting Material Upload

Name	Date Created
No items available	

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS0004O | WA-23-0027 | Washington State Health Home Program

## Package Header

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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

Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include screening to assess gaps in care or establish baseline results, in-person visits to the beneficiary's home or location of their choice, and accompanying beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) to document a beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary, and is updated periodically on a four-month cycle, as well as when there are changes in beneficiary circumstances such as hospitalization or emergency department visits. The results of screenings and assessments are documented in the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting their short and long-term goals through active Health Home participation.

State approved clinical and functional screens identify depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens support referrals to services when needed, e.g., referral for assessment of need for substance use disorder treatment, specialty care or long term services and supports. Other assessments that may supplement comprehensive care management are mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans, including assessment results.

Care Coordinators may conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes. This may also be done by allied or affiliated staff under the direction of the Care Coordinator.

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

All Health Home Lead Entities will have access to the Medicaid Management Information System called ProviderOne (P1) and the DSHS Predictive Risk Intelligence System (PRISM). Authorizers and providers of long-term services and supports have access to DSHS's Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Most elements of CARE are also contained in PRISM. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to PRISM and reporting loss of eligibility on a monthly basis.
2. ProviderOne contains Medicaid eligibility, loss of eligibility, MCO and Health Home enrollment, disenrollment, claims, per member per month (PMPM) payment to MCOs, MFFS payment for Health Home services made to community-based Health Home Lead organizations and the collection and reporting of encounter data.
3. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA-compliant and can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with a facility's current Electronic Medical Record (EMR), when high-utilizing patients enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation.
4. PreManage is the information exchange system that alerts Health Home providers when their beneficiary is admitted for inpatient hospital services.

#### Scope of service

#### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners

- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Care Coordination Organization	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Indian Health Services (IHS)-Certified Community Health Representatives	The IHS-certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.
Exception to Rule	<p>Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization.</p> <p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"> <li>• Resume</li> <li>• Letters of recommendation</li> <li>• Educational transcripts</li> <li>• Documentation of courses, classes and trainings</li> <li>• Certifications</li> <li>• Licenses</li> </ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Experience</li> <li>• Skills/Knowledge</li> <li>• Letters of Recommendation</li> </ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p>
Allied or Affiliated Staff	<p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or affiliated staff may:</p> <ol style="list-style-type: none"> <li>1. Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit.</li> <li>2. Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.</li> </ol>

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b>	WA2023MS00040	<b>SPA ID</b>	WA-23-0027
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	9/8/2023
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## Care Coordination

### Definition

The dedicated Health Home Care Coordinator and affiliated staff play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator assures communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required Health Home services, including interventions. Allied staff, such as community health workers, peer counselors or other non-clinical staff, may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination provides informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators and affiliated staff promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

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

PRISM is an information technology resource that supports the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared, with beneficiary consent, via secure email or hard copy. The HAP includes:

1. Required and optional health screenings and assessments;
2. Beneficiary and Care Coordinator prioritized action items;
3. Beneficiary identified goals (short and long term);
4. Action steps for the beneficiary, the Health Home Care Coordinator and/or other direct service and medical providers; and
5. If the beneficiary has a personal care worker, action steps for them to support identified health action goals identified by the beneficiary.

The Health Home Care Coordinator updates and modifies the HAP on a four month cycle. The HAP is also updated and modified as needed to reflect:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

### Scope of service

#### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Care Coordination Organizations	<p>Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).</p>
Exception to Rule	<p>Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills, knowledge, and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and be eligible for professional liability insurance as required by the hiring organization.</p> <p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (e.g., any special skills or knowledge such as bicultural or bilingual), employee background and experience, and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"> <li>• Resume</li> <li>• Letters of recommendation</li> <li>• Educational transcripts</li> <li>• Documentation of courses, classes and trainings</li> <li>• Certifications</li> <li>• Licenses</li> </ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Experience</li> <li>• Skills/Knowledge</li> <li>• Letters of Recommendation</li> </ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p>
Indian Health Services (IHS) Certified Community Health Representatives	<p>The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence</p>
Allied or Affiliated Staff	<p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or Affiliated staff may:</p> <ol style="list-style-type: none"> <li>1. Communicate with service providers and health plans as appropriate to secure necessary care and supports;</li> <li>2. Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management.</li> <li>3. Advocate for services and assist with scheduling of needed services.</li> <li>4. Assist and support client with scheduling medical and applicable appointments.</li> </ol>

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

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## Health Promotion

### Definition

Health promotion begins for Health Home beneficiaries with the commencement of the Health Action Plan (HAP). Each Health Home must demonstrate use of self-management, recovery and resiliency principles using beneficiary-identified supports including family members and caregivers that are paid or unpaid. The Health Home Care Coordinator will use the beneficiary's activation score and level to determine the coaching methodology appropriate for each beneficiary to be used when working with the beneficiary towards reaching their health goals. Educational materials are customized and introduced according to the beneficiary's readiness for change, progressing with the beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The Health Home provides wellness and prevention education specific to the beneficiary's chronic conditions, HAP, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and links to resources that support a healthier lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiary needs and preferences.

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

Insignia Health is an information technology resource which provides calculation of the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), Parent/Patient Activation Measure (PPAM) and the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Health Home visit or by phone.

The Health Home Care Coordinator is able to view the medical claims, behavioral health claims, prescription claims, and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) in PRISM so that education materials can be tailored to the individual's engagement and activation.

### Scope of service

#### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as

Provider Type	Description
Indian Health Services (IHS) Certified Community Health Representatives	<p>required by the hiring organization.</p> <p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"> <li>• Resume</li> <li>• Letters of recommendation</li> <li>• Educational transcripts</li> <li>• Documentation of courses, classes and trainings</li> <li>• Certifications</li> <li>• Licenses</li> </ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Experience</li> <li>• Skills/Knowledge</li> <li>• Letters of Recommendation</li> </ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p>
Allied or Affiliated Staff	<p>The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.</p> <p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or Affiliated staff may:</p> <ol style="list-style-type: none"> <li>1. Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate.</li> <li>2. Promote participation in community educational and support groups.</li> <li>3. Provide links to health care resources that support the client's goals.</li> <li>4. Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services.</li> <li>5. Distribute health education and other materials.</li> <li>6. Assist with follow up calls and provide appointment reminders.</li> </ol>
Care Coordination Organizations	<p>Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).</p>



# Health Homes Services

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## Package Header

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

#### Definition

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan (HAP) includes transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file documents the notification and the HAP should be updated with transition planning.
2. The use of a Health Home Care Coordinator as an active participant in all appropriate phases of care transition, including discharge planning visits during hospitalizations or nursing home stays following hospital/institutional discharge, conducted via home visits and telephone calls.
3. Beneficiary education addressing discharge care needs, including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of family and formal or informal caregivers are facilitated when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post-discharge care.

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

Emergency Department Information Exchange (EDIE) notifications provide Medicaid claims data to ED physicians. EDIE is HIPAA-compliant. EDIE can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with facility's current electronic medical record when high utilizing beneficiaries enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's overall medical situation.

PreManage is information exchange system alerts providers when their beneficiary is accessing inpatient hospital services.

Lead FFS Entities with access to EDIE and Pre-Manage can push real-time information on ED visits and inpatient hospital stays to their Care Coordination Organizations.

Managed care Lead Entities notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCO Lead Entities also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

#### Scope of service

##### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	<p>Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization.</p> <p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"><li>• Resume</li><li>• Letters of recommendation</li><li>• Educational transcripts</li><li>• Documentation of courses, classes and trainings</li><li>• Certifications</li><li>• Licenses</li></ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"><li>• Education</li><li>• Experience</li><li>• Skills/Knowledge</li><li>• Letters of Recommendation</li></ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p>
Allied or Affiliated Staff	<p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or Affiliated staff may:</p> <ol style="list-style-type: none"><li>1. Support client with connecting to community supports to ensure that needed services or equipment are received.</li></ol>
Indian Health Services (IHS) Certified Community Health Representatives	<p>The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.</p>

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### Individual and Family Support (which includes authorized representatives)

#### Definition

The Health Home Care Coordinator recognizes the unique roles the beneficiary may assign to family, identified decision makers and caregivers in assisting them with accessing and navigating health care and social service delivery systems, as well as support health action planning.

The Health Home Care Coordinator uses peer supports, support groups, and self-management programs to increase beneficiary and caregivers' knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator, affiliated staff, and the beneficiary:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management, self-help recovery, and other resources necessary for the beneficiary, their family, and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with beneficiaries and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

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

The PRISM software application includes the PRISM Health Report for all beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care providers identified by the beneficiary and authorized by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics
2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the beneficiary's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

#### Scope of service

##### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Care Coordination Organizations	<p>Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).</p>
Exception to Rule	<p>Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization.</p> <p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"> <li>• Resume</li> <li>• Letters of recommendation</li> <li>• Educational transcripts</li> <li>• Documentation of courses, classes and trainings</li> <li>• Certifications</li> <li>• Licenses</li> </ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Experience</li> <li>• Skills/Knowledge</li> <li>• Letters of Recommendation</li> </ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p>
Allied or Affiliated Staff	<p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or Affiliated staff may:</p> <ol style="list-style-type: none"> <li>1. Educate client, family, or caregiver advance directives, client rights, and health care issues, as needed.</li> <li>2. Meet with client and family, inviting any other providers to facilitate needed interpretation services.</li> <li>3. Refer client/family to peer supports, support groups, social services, entitlement programs as needed.</li> </ol>
Indian Health Services (IHS) Certified Community Health Representatives	<p>The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.</p>

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## Referral to Community and Social Support Services

### Definition

The Health Home Care Coordinator and affiliated staff identify available community based resources, actively manage referrals, assist the beneficiary in advocating for access to care, and engage with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not otherwise provided through other case management systems, the Health Home Care Coordinator provides assistance in obtaining and maintaining eligibility for health care services, disability benefits, housing, personal needs and legal services. These services will be coordinated with appropriate local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator documents referrals to and access by the beneficiary of community- based and other social support services.

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

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

### Scope of service

#### The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Care Coordination Organizations	Care coordination services are provided through Care Coordination Organizations. Services may be provided by any member of the Health Home team but are driven by administrative protocols and clinical guidelines developed by appropriate health care professionals (i.e., nurses, mental health professionals, substance use disorder professionals).
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy/rule. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization.

Provider Type	Description
Allied or Affiliated Staff	<p>The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request:</p> <ul style="list-style-type: none"> <li>• Resume</li> <li>• Letters of recommendation</li> <li>• Educational transcripts</li> <li>• Documentation of courses, classes and trainings</li> <li>• Certifications</li> <li>• Licenses</li> </ul> <p>The state will review and score each Exception to Rule letter of request and documentation in the following areas:</p> <ul style="list-style-type: none"> <li>• Education</li> <li>• Experience</li> <li>• Skills/Knowledge</li> <li>• Letters of Recommendation</li> </ul> <p>The potential candidate must receive a score of at least 80% to qualify under the Exception to Rule</p> <p>Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.</p> <p>Allied or Affiliated staff may:</p> <ol style="list-style-type: none"> <li>1. Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals.</li> <li>2. Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems.</li> <li>3. Provide general information about upcoming community events.</li> </ol>
Indian Health Services (IHS) Certified Community Health Representative	<p>The IHS certified Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs must demonstrate how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs come from the communities they serve and have tribal cultural competence.</p>

# Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS00040 | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b>	WA2023MS00040	<b>SPA ID</b>	WA-23-0027
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<b>Superseded SPA ID</b>	20-0031		
	User-Entered		

## 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**

Enrollment flow is dependent upon 1) whether the beneficiary is enrolled with a Managed Care Lead Entity, or 2) is not enrolled in managed care and is receiving their medical benefits in the FFS delivery system. Almost all Washington's Medicaid Health Home beneficiaries are enrolled in managed care. Those that remain in the FFS delivery system either reside in a voluntary managed care county, are a full-dual eligible, or have self-identified as American Indian/Alaska Native.

All Health Home beneficiaries, regardless of whether they receive their Medicaid benefits in managed care or in FFS, have the same eligibility criteria - one or more chronic conditions from the chronic condition list and meet the state's definition of "at risk for another."





Enrollment starts with the identification of eligibility and assignment of a clinical indicator (Y=qualifies). The indicator is loaded into ProviderOne.

1. FFS beneficiaries with "Y" clinical indicators are enrolled into one of the qualified FFS Health Home Lead Entities in the geographic region in which they reside. Health Home outreach and education information is generated automatically and sent to the beneficiary by mail. The Health Home Lead Entity receives notification of the enrollment via HIPAA 834 files and assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).
2. Managed care organizations have their eligible Health Home beneficiaries identified with a "Y" clinical indicator and receive notification of eligibility via HIPAA 834 files. The MCO assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs). The MCO is responsible for making sure the enrollee is notified of their eligibility to receive Health Home services.
3. Any health care provider may refer beneficiaries to the Health Home program. An example is a local emergency room department who has agreed with the Health Home Lead Entity to refer potentially eligible participants to the program.

Engagement consists of the assigned CCO placing beneficiaries with a Care Coordinator, who contacts the beneficiary to offer Health Home services. Once the beneficiary has agreed to participate in a Health Home, the Care Coordinator prepopulates the Health Action Plan with PRISM claims utilization details and arranges for an in-person visit. PRISM provides episode information related to specific diagnoses or pharmacy utilization, inpatient and outpatient claims, emergency room visits, mental health claims, substance use disorder treatment claims, pharmacy claims, and long-term care assessment data.

During the home visit, the Care Coordinator:

1. Conducts the required and when needed optional brief screening;
2. Evaluates the beneficiary's support system;
3. Completes a Consent for Release of Information;
4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM) or Parent/Patient Activation Measure (PPAM); and
5. Develops the Health Action Plan (HAP) with the beneficiary, who will work with the CCO to identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	
<a href="#">HH Enrollment Procedure 22-09-01 E</a>	8/21/2018 5:02 PM EDT	
<a href="#">HH Beneficiary flow 06 0624</a>	8/21/2018 5:02 PM EDT	
<a href="#">Update 070117 HH CC Qualification Exception worksheet</a>	8/21/2018 5:02 PM EDT	
<a href="#">Guidelines-for-HH-staff</a>	8/21/2018 5:02 PM EDT	

# Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WA2023MS0004O | WA-23-0027 | Washington State Health Home Program

## Package Header

<b>Package ID</b>	WA2023MS0004O	<b>SPA ID</b>	WA-23-0027
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<b>Superseded SPA ID</b>	20-0031		
	User-Entered		

## 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**

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligibles will be determined by CMS.

**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)**

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long-term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide Health Information Exchange (HIE). HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.



# Health Homes Monitoring, Quality Measurement and Evaluation

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## 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

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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