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## **Table of Contents**

**State/Territory Name:** Washington

**State Plan Amendment (SPA) #:** 15-0011

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600, MS/RX-200  
Seattle, WA 98104



**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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6/11/15

Dorothy Frost Teeter, Director  
MaryAnne Lindeblad, Medicaid Director  
Health Care Authority  
Post Office Box 45502  
Olympia, Washington 98504-5010

RE: WA 15-0011

Dear Ms. Frost Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS), Seattle Regional Office, has completed its review of Washington State Plan Amendment (SPA) Transmittal Number 15-0011 submitted on March 26, 2015. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The SPA was submitted to remove payment withholds and to make technical amendments. This SPA is approved with an effective date of January 1, 2015. Enclosed is a copy of the approved pages for incorporation into the Washington State plan.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this State Plan Amendment, please contact me, or have your staff contact Rick Dawson at [Rick.Dawson@cms.hhs.gov](mailto:Rick.Dawson@cms.hhs.gov) or (206) 615-2387.

Sincerely,

Digitally signed by David L. Meacham - S  
DN: c=US, o=U.S. Government, ou=HHS,  
ou=CMS, email=meacham@cms.hhs.gov

Date: 2015.06.11 13:44:54 -0700

David L. Meacham  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

cc: Christa Speicher, CMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**15-0011**

2. STATE  
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
January 1, 2015

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1945 of the Social Security Act; 42 USC 1396w-4

7. FEDERAL BUDGET IMPACT:  
a. FFY 2016 \$700,254  
b. FFY 2017 \$2,029,258

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Submitted via MMDL Attachment 3.1-H pages 1-64  
[REDACTED] P&I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable)

Attachment 3.1-H pages 1 – 53 (TN# 13-0008) and  
pages 54 – 107 (TN# 13-17)

10. SUBJECT OF AMENDMENT

Health Homes

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED: Exempt  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:  
MARYANNE LINDEBLAD

14. TITLE:  
MEDICAID DIRECTOR

15. DATE SUBMITTED:

3-26-15

16. RETURN TO:

Ann Myers  
Office of Rules and Publications  
Division of Legal Services  
Health Care Authority  
626 8<sup>th</sup> Ave SE MS: 42716  
Olympia, WA 98504-2716

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

3/26/15

18. DATE APPROVED:

6/11/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

01/01/2015

20. SIGNATURE OF [REDACTED]

Digitally signed by David L. Meacham -S  
DN: cn=US, ou=U.S. Government, ou=HHS

21. TYPED NAME:

David L. Meacham

22. TITLE: Associate Regional Administrator

Division of Medicaid and Children's Health

23. REMARKS:

6/11/15: the state authorizes a P&I change to the 179 box 8

# Health Home State Plan Amendment

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

## Submission Summary

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### Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

15-0011

### Supersedes Transmittal Number:

Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

WA 13-0008 and 13-17

- The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.

### Name of Health Homes Program:

WA HHS

### State Information

State/Territory name:

Washington

Medicaid agency:

Health Care Authority

### Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:

Ann Myers

Title:

Rules and Publication Manager

Telephone number:

(360) 725-1345

Email:

Ann.Myers@hca.wa.gov

The primary contact for this submission package.

Name:

Becky McAninch-Dake

Title:

Telephone number:

Email:

The secondary contact for this submission package.

Name:

Title:

Telephone number:

Email:

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

(mm/dd/yyyy)

### Executive Summary

Summary description including goals and objectives:

SPA 15-0011 supersedes WA 13-0008 and WA 13-17.

Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs.

Washington has four high level goals to assess the effectiveness of their health home program - 1) Improve the beneficiary's clinical outcomes and experience of care; 2) Improve the beneficiary's self-management abilities; 3) Improve health care quality and promote efficient and evidence-based health care service delivery; and 4) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

### Federal Budget Impact

Federal Fiscal Year	Amount
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First Year			

## Federal Statute/Regulation Citation

Affordable Care Act, Section 2703, Section 1945

## Governor's Office Review

- No comment.
- Comments received.

Describe:

- No response within 45 days.
- Other.

Describe:

## Submission - Public Notice

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Indicate whether public notice was solicited with respect to this submission.

- Public notice was not required and comment was not solicited
- Public notice was not required, but comment was solicited
- Public notice was required, and comment was solicited

Indicate how public notice was solicited:

- Newspaper Announcement

- Publication in State's administrative record, in accordance with the administrative procedures requirements.

Date of Publication:

03/04/2015 (mm/dd/yyyy)

- Email to Electronic Mailing List or Similar Mechanism.

Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

[Empty text area for description]

- Website Notice

Select the type of website:

- Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

(mm/dd/yyyy)

Website URL:

[Empty text field for website URL]

- Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

[Empty text field for website URL]

- Other

- Public Hearing or Meeting

- Other method

Indicate the key issues raised during the public notice period:(This information is optional)

- Access

Summarize Comments

[Empty text area for summarizing comments]

Summarize Response

[Empty text area for summarizing response]

- Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

 Service Delivery

Summarize Comments

Summarize Response

 Other Issue

## Submission - Tribal Input

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

 This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.

 The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

- Indian Tribes
- Indian Health Programs
- Urban Indian Organization

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service delivery

Summarize Comments

J. Miller of the Upper Skagit Indian Tribe requested a draft copy of the SPA. No comments other than to say this is "a fascinating new way to deliver primary health care."

Summarize Response

Thank you.

Other Issue

**Submission - SAMHSA Consultation**

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

Date of Consultation	
Date of consultation: 07/06/2012 (mm/dd/yyyy)	
Date of consultation: 11/08/2012 (mm/dd/yyyy)	

## Health Homes Population Criteria and Enrollment

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### Population Criteria

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

- Two or more chronic conditions

Specify the conditions included:

- Mental Health Condition
- Substance Abuse Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25

Other Chronic Conditions	
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- One chronic condition and the risk of developing another

Specify the conditions included:

- Mental Health Condition
- Substance Abuse Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25

Other Chronic Conditions	
cancer, cerebrovascular disease, coronary artery disease,	
dementia or Alzheimer's disease, intellectual disability or disease,	
hematological and musculoskeletal conditions.	
HIV/AIDS, renal failure, chronic respiratory conditions	
neurological disease, gastrointestinal,	

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

At risk of a second is a minimum predictive risk score of 1.5. The predictive risk score of 1.5 means a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group, the WA SSI disabled population. The WA risk score is based on the Chronic Illness & Disability Payment System 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 WA Medicaid population. Diagnoses, prescriptions, age and gender from the beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are analyzed, a risk score is calculated and chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies; N=does not qualify) is loaded into the WA 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 will be on the Health Home website and distributed to the Designated Providers. Once a provider has determined a beneficiary is eligible by manually calculating their risk, that information will be sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a health home.

- One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

- Health Homes services will be available statewide

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

- By county

Specify which counties:

Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima.

- By region

Specify which regions and the make-up of each region:

- By city/municipality

Specify which cities/municipalities:

- Other geographic area

Describe the area(s):

### 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

Describe the process used:

- Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

The state identifies Fee-for-Service beneficiaries who are eligible for health homes based upon their chronic condition and risk score, and enrolls them into a Fee-for-Service qualified health home designated provider. Enrollment will be based on zip codes, amount of available enrollees within those zip codes, and capacity to provide health home services. The designated provider will assign health home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt-out of the assigned health home or change enrollment to another designated provider or subcontracted Health Home CCO within the qualified provider network. Eligible beneficiaries who opt-out have the option of enrolling in a Health Home with a contracted designated provider at any time.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO enrollees who are eligible for health homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs who are qualified to be designated providers assign their eligible, identified health home enrollees to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, will assign the beneficiary to a Care Coordinator. MCOs who are not qualified as a designated provider must delegate health services to a qualified designated provider and assign their eligible/identified enrollees to their delegated designated provider. The designated provider, in turn, will assign the beneficiary to a 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 designated provider or subcontracted Health Home CCO within the qualified provider network.

- The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.

Other

Describe:

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The State 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 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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.
- The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

## 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

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
  - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or

- b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
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- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
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- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Rural Health Clinics

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
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  - b.Optimizes beneficiary choice.

- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
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- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Community Health Centers

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
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- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Community Mental Health Centers

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
  - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
  - b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.

- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Home Health Agencies

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
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- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:

Case Management Agencies

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
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- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
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- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards:

- 1.Experience operating broad-based regional provider network;
- 2.Contracts directly with the state as a Qualified Health Home;
- 3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;
- 4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);
- 5.Subcontracts with CCOs to directly provide the Health Home care coordination services;
- 6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
  - a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of

- their services; or
- b.Optimizes beneficiary choice.
- 7.Maintains a list of CCOs and their assigned Health Home population.
- 8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;
- 9.Collects and reports encounters to the HCA;
- 10.Disburses payment to CCOs based upon encounters;
- 11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;
- 12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Other (Specify)

Provider	
Name:	<input type="text"/>
Provider Qualifications and Standards:	<ul style="list-style-type: none"> <li>1.Experience operating broad-based regional provider network;</li> <li>2.Contracts directly with the state as a Qualified Health Home;</li> <li>3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;</li> <li>4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);</li> <li>5.Subcontracts with CCOs to directly provide the Health Home care coordination services;</li> <li>6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:                             <ul style="list-style-type: none"> <li>a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or</li> <li>b.Optimizes beneficiary choice.</li> </ul> </li> <li>7.Maintains a list of CCOs and their assigned Health Home population.</li> <li>8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;</li> <li>9.Collects and reports encounters to the HCA;</li> <li>10.Disburses payment to CCOs based upon encounters;</li> <li>11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;</li> <li>12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.</li> </ul>
Name:	<input type="text"/>
Provider Qualifications and Standards:	

Provider	
<p>1.Experience operating broad-based regional provider network;                  2.Contracts directly with the state as a Qualified Health Home;                  3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;                  4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);                  5.Subcontracts with CCOs to directly provide the Health Home care coordination services;                  6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:                  a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or                  b.Optimizes beneficiary choice.                  7.Maintains a list of CCOs and their assigned Health Home population.                  8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;                  9.Collects and reports encounters to the HCA;                  10.Disburses payment to CCOs based upon encounters;                  11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;                  12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.</p>	
<p>Name:                  Substance Use Disorder Treatment providers                  Provider Qualifications and Standards:                  1.Experience operating broad-based regional provider network;                  2.Contracts directly with the state as a Qualified Health Home;                  3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;                  4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);                  5.Subcontracts with CCOs to directly provide the Health Home care coordination services;                  6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:                  a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or                  b.Optimizes beneficiary choice.                  7.Maintains a list of CCOs and their assigned Health Home population.                  8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;</p>	

Provider	
<p>9.Collects and reports encounters to the HCA;                      10.Disburses payment to CCOs based upon encounters;                      11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;                      12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.</p>	
<p>Name:                      Tribal Clinics</p> <p>Provider Qualifications and Standards:</p> <ol style="list-style-type: none"> <li>1.Experience operating broad-based regional provider network;</li> <li>2.Contracts directly with the state as a Qualified Health Home;</li> <li>3.Has capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network;</li> <li>4.Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another Care Coordination Organization (CCO);</li> <li>5.Subcontracts with CCOs to directly provide the Health Home care coordination services;</li> <li>6.Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:                             <ol style="list-style-type: none"> <li>a.Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or</li> <li>b.Optimizes beneficiary choice.</li> </ol> </li> <li>7.Maintains a list of CCOs and their assigned Health Home population.</li> <li>8.Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider 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, referral protocols, and sharing of prior authorizations for hospital stays when applicable;</li> <li>9.Collects and reports encounters to the HCA;</li> <li>10.Disburses payment to CCOs based upon encounters;</li> <li>11.Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator;</li> <li>12.Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.</li> </ol>	

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

Describe the Provider Qualifications and Standards:

Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

Nutritionists

Describe the Provider Qualifications and Standards:

Social Workers

Describe the Provider Qualifications and Standards:

Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

Other (Specify)

Health Teams

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

Medical Specialists

Describe the Provider Qualifications and Standards:

Nurses

Describe the Provider Qualifications and Standards:

Pharmacists

Describe the Provider Qualifications and Standards:

Nutritionists

Describe the Provider Qualifications and Standards:

Dieticians

Describe the Provider Qualifications and Standards:

Social Workers

Describe the Provider Qualifications and Standards:

Behavioral Health Specialists

Describe the Provider Qualifications and Standards:

Doctors of Chiropractic

Describe the Provider Qualifications and Standards:

Licensed Complementary and Alternative Medicine Practitioners

Describe the Provider Qualifications and Standards:

Physicians' Assistants

Describe the Provider Qualifications and Standards:



### 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 health homes (HH) is the community network, which must be present to qualify as a designated provider to ensure partnerships between mental health and substance abuse providers, long-term care services and supports providers, and medical communities that support care coordination and access through HH services. The client is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the client during development and when they are updated. Clients may include their families and caregivers as part of their team.

Training for Health Home service delivery is sponsored by HCA and DSHS. Nursing staff develop 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 learning collaboratives foster shared learning, information sharing and problem solving.

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

HAP data is electronically submitted to the State and is kept in a secure Health Information Exchange. This allows the State to analyze metrics on quality of care and health outcomes. HAPs are electronically filed with the Designated Providers to inform them of a client's progress towards managing their chronic conditions.

### Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The delivery of Washington's health home service model is based on an inter-disciplinary 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 designated providers ensures that managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics have the necessary skills and infrastructure to provide health home services.

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

Additionally, multidisciplinary team members are recruited to support engagement and outreach, clinical decisions and evidenced-based care. Multidisciplinary team members may be composed of willing participants who provide direct service to the beneficiary and subject matter experts, such as primary care providers, mental health professionals, chemical dependency treatment providers, social workers, nutritionists/dieticians, direct care workers, pharmacists, peer specialists, community health navigators, family members or housing representatives.

The Health Home structure is built on the following hierarchy:

1. Qualified Designated Provider/Lead - Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care and Primary Care Providers. The Designated Provider contracts directly with the state and is responsible for service delivery model and administration of the Health Home. The designated providers collect and submit encounters; disburse payment to network affiliated Care Coordination Organizations through the collection and submission of encounters; monitor quality; sub-contract; collect, analyze and report financial, health status and performance and outcome measures to objectively determine progress towards meeting overall Health Home goals; and provide customer service, such as toll-free lines or nursing advise lines.
2. Network Affiliated Care Coordination Organizations – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. Care Coordination Organizations are responsible for implementing systematic processes and protocols to assure beneficiary access to Care Coordinators and care coordination functions. Care Coordination Organizations can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Regional Support Networks, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty Care and Primary Care Providers.
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 in-person by actively engaging the beneficiary in developing a Health Action Plan; reinforcing the Health Action Plan 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; assuring 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 will coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible individuals in the setting of the beneficiary's choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another. Care Coordinators must be clinical or non-clinical professionals, such as RNs, ARNPs, Psychiatric ARNPs, Social Workers, Mental Health Social Workers, Chemical Dependency Professionals, and Counselors.

4. Allied health care staff, such as community health workers, peer counselors or other non-clinical personnel provide administrative support for the Health Home Care Coordinator, such as 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.
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 designated provider, through the use of an operational agreement.

#### Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows: Health home designated providers and their networks are developed to meet the needs of the population. Care coordination should occur across service domains and therefore include many different disciplines. A designated provider is qualified by the State and 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. The 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 room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing health care needs.

Washington will qualify the designated provider through a contracting process for each phase of implementation. Qualifications include:

1. Applicant is a Medicaid provider in good standing, ability to serve 1,000 to 2,000 health home beneficiaries, experience operating broad-based networks, agrees to serve the entire coverage area, assures 24 hours/seven days a week information and referrals, documents beneficiary consent, subcontracts with CCOs, ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access/translation capability, links to acute and outpatient medical, mental health and substance abuse services, links to community-based social services, including housing;
2. Provider Networks – must include authorizing entities, such as the DSHS Functional and Financial Eligibility section, Regional Support Networks, Disability Determinations, and a wide-variety of Care Coordination organizations, such as CMHAs, Substance Abuse Treatment providers, long-term services and supports, FQHCs, and Community Health;
3. Organizational Infrastructure – ability to provide administrative functions, such as toll-free lines, 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 intensity levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, health status and performance and outcome measures. 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 – ability to provide six health home care coordination functions and guarantee of non-duplication of efforts, 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, sharing information with beneficiary's treating/authorizing entities, establishing multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology; and
5. Center for Medicare and Medicaid Services (CMS) Health Home Provider Functional Requirements – descriptions of process used to ensure 11 core health requirements are met.

HCA and DSHS will conduct desk audits and on-site readiness reviews before awarding Designated Provider status to ascertain readiness to provide Health Home services. Contracts will only be offered after the readiness

reviews and any identified deficiencies are mitigated through a corrective action plan.

The period of performance for FFS Health Home contract(s) is an initial two years. For managed care organizations who apply to become qualified designated providers, the period of performance will be based upon their managed care contract. The program will be audited during annual contract compliance audits. Based upon results of the audit, the designated provider may be put on corrective action or have their qualification status terminated.

Other entities interested in applying to become a designated provider may submit a request to the Health Care Authority, at which time, the process for contracting will take effect.

## Health Homes Service Delivery Systems

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

Fee for Service

PCCM

- PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.
- The PCCMs will be a designated provider or part of a team of health care professionals.

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.

If yes, describe how requirements will be different:

Tribal clinics are allowed to contract with HCA to become a designated provider and provide services under a Health Home contract if they meet all the contracting requirements, including systems capability to receive 834 HIPAA compliant enrollment notifications, ability to submit encounter data to the ProviderOne payment system and ability to submit Health Action Plans into the HCA secure

Medicaid database through HCA Health Information Exchange (HIE). If the clinic also has a PCCM contract with HCA, the tribal member may be enrolled in the PCCM or in the Health Home program, but are not allowed to be enrolled in both at the same time to avoid duplication of services. To enroll in the Tribal Health Home, tribal members must meet Health Home eligibility criteria, agree to participate in the Health Home and agree to disenroll from the PCCM. The tribal member, if eligible for Health Homes, has a choice between remaining in the PCCM program or agreeing to enroll in the Health Home program.

Risk Based Managed Care

- The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:

- The current capitation rate will be reduced.
- The State will impose additional contract requirements on the plans for Health Homes enrollees.

Provide a summary of the contract language for the additional requirements:

- Other

Describe:

- The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals. Provide a summary of the contract language that you intend to 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 enrollees. A MCO has two paths to choose from when providing those benefits. They may either become a qualified designated provider through the readiness review process or they may provide their health home benefits through a delegation agreement with another qualified designated provider.

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 support staff;
3. Contracts, memorandums of agreement or operational agreements with hospitals for ER notification and hospitalization, including a referral process to refer beneficiaries for health home services;
4. Standardized screening and assessments;
5. Development of a Health Action Plan through an in-person visit to promote self-management through the identification of the enrollee's short and long-term goals;

6. Process and outcome measures;
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. 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 client outreach and education regarding medication use and over-use patterns, such as emergency room use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

- 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.

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

- 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.

No

Indicate which payment methodology the State will use to pay its plans:

- Fee for Service
- Alternative Model of Payment (describe in Payment Methodology section)
- Other  
Description:

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:

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.

### Health Homes Payment Methodologies

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

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

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

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

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

Other: Describe below.

Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity.

Three levels of payment are dependent upon who is providing the services and the intensity of the service determined by in-person, one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. There is no withhold for this component of the rate.

This is a one-time only rate and is triggered by the submission of a Health Action Plan encounter and the documentation of a health home service.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full-time employee (FTE), 50 clients can be supported. This rate is paid once per month, per beneficiary and is triggered by documenting delivery of a health home service.

The third level of payment is for Low-Level Health Home Care Coordination. This rate is paid once per month with an encounter. Low-level payment will be paid on a monthly basis, and payment is made only for months in which an encounter occurred. An encounter is represented by documenting delivery of a health home service. It is assumed that for months in which an encounter occurs, 2/3 will involve a phone call and 1/3 involves a home visit.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

From July 1, 2013 to March 5, 2015, CMS regulations require that a health home service must be delivered before a payment can be made. Milliman adjusted the rates for the new set of Health Home care coordination activities and a new set of regulations by converted the staffing levels to a broader set of clinical and non-clinical staff, adjusting the percentages of time staff would be interacting with the beneficiary on a monthly basis, and averaging a defined set of in-person visits and telephonic contact. This methodology allowed for a more efficient calculation of the rates based upon the costs of a known model. A minimum level of activities was derived from averaging the amount of in-person visits and telephonic contact. The three rate levels derived from the analysis are:

1. The first PMPM for Health Homes, which includes Outreach, Engagement and Health Action Plan - \$252.93
2. Intensive Health Home Care Coordination - \$172.61
3. Low-level Health Home Care Coordination - \$67.50

A portion of the rates were also defined for administrative functions and withholds. The administrative functions and withholds are part of the total rate as documented above:

1. Outreach, Engagement and Health Action Plan - \$25.29, no withhold
2. Intensive Health Home Care Coordination - \$17.26, \$3.45

### 3. Low-level Health Home Care Coordination - \$6.75, \$1.35

On and after March 6, 2015, CMS regulations require that a health home service must be delivered before a payment can be made. Milliman adjusted the rates for the new set of Health Home care coordination activities and a new set of regulations by converted the staffing levels to a broader set of clinical and non-clinical staff, adjusting the percentages of time staff would be interacting with the beneficiary on a monthly basis, and averaging a defined set of in-person visits and telephonic contact. This methodology allowed for a more efficient calculation of the rates based upon the costs of a known model. A minimum level of activities was derived from averaging the amount of in-person visits and telephonic contact. The three rate levels derived from the analysis are:

1. The first PMPM for Health Homes, which includes Outreach, Engagement and Health Action Plan - \$252.93
2. Intensive Health Home Care Coordination - \$172.61
3. Low-level Health Home Care Coordination - \$67.50

A portion of the rates were also defined for administrative functions. The administrative functions are part of the total rate as documented above:

1. Outreach, Engagement and Health Action Plan - \$25.29,
2. Intensive Health Home Care Coordination - \$17.26,
3. Low-level Health Home Care Coordination - \$6.75,

This SPA does not make changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners.

#### Per Member, Per Month Rates

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

The state developed a three-tiered rating system for the health home service delivery. Health Home encounters are submitted per member/per month. The initial tier of \$252.93 is a once in a lifetime payment. Policy guiding the decisions for rate tiers was based on efficiency of an automated process to reduce human error, economy of only paying for a service when a service is delivered, and quality by building into the payment structure the ability to pay for Registered Nurses, Social Workers, and licensed or certified counselors as Care Coordinators.

The reimbursable units are \$252.93 for the first tier, \$172.61 for the 2nd tier and \$67.50 for the 3rd tier. Cost assumptions include salary distribution, geographic distribution, and high-touch vs. low touch intensity of services. Care Coordinators must provide at least one health home service to claim reimbursement, with the expectation that high touch means in-person, face-to-face care coordination and low-touch means a combination of face-to-face or telephonic touch. All three tiers have a mix of clinical and nonclinical staffing elements.

The state will review the rates every two years through an actuarial analysis based upon experience data.

The agency's rates were set as of July 1, 2013 and are effective for services on or after that date. All rates are published on [http://www.hca.wa.gov/medicaid/health\\_homes/Documents/HHCareCoordinationRates.pdf](http://www.hca.wa.gov/medicaid/health_homes/Documents/HHCareCoordinationRates.pdf). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

#### Incentive payment reimbursement

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

From July 1, 2013 to March 5, 2015, the state will pay the entire rate for the first year of the program. Policy directives on keeping the rates whole had three goals: 1) allow Health Homes to build their infrastructure and increase their capacity to provide health home services; 2) keep the withhold administratively simple; and 3) reward better performing health homes by reducing the withhold amount incrementally based upon performance measure results.

The state will apply a withhold penalty to the rates using the following structure. At the end of the 10th month of the first year of the program, the engagement rate for participation will be calculated using the following metrics:

Numerator – Number of beneficiaries assigned to the designated provider during the measurement period who had a paid encounter for “Outreach, Engagement and Health Action Plan,” regardless of who was paid for that encounter;

Denominator – Number of beneficiaries assigned to the designated provider during the measurement period.

The 2nd year withholds will be applied to the Intensive Health Home Care Coordination rate of \$172.61 per member/per month and the Low-level Health Home Care Coordination rate of \$67.50 per month/per month with an encounter.

1. 45% or higher participation rates will guarantee full payment of the rates for another year, with no withhold applied;
2. Under 45% to 40% participation, a portion of the total withhold will be removed from the health home rate;
3. Under 39% to 30, a higher portion of the withhold will be removed from the rate, and
4. Under 30% the entire withhold amount of \$3.45 will be removed from the Intensive Health Home of \$172.61, reducing the rate to \$169.16.

Low-Level Health Home Care Coordination

1. Same percents in 1 through 3 above, and
2. Under 30% the entire withhold amount of \$1.35 will be removed from the Low-Level Health Home rate of \$67.50 reducing the rate to \$66.15.

Health homes who improve their results during the 2nd year, will have their rates adjusted back up to the total, based upon their engagement percentages.

On and after March 6, 2015, the state will pay the entire rate with no withholds to allow Health Homes to build their infrastructure and increase their capacity to provide health home services;

1. The first PMPM for Health Homes, which includes Outreach, Engagement and Health Action Plan - \$252.93
2. Intensive Health Home Care Coordination - \$172.61
3. Low-level Health Home Care Coordination - \$67.50

A portion of the rates were also defined for administrative functions. The administrative functions are part of the total rate as documented above:

1. Outreach, Engagement and Health Action Plan - \$25.29,
2. Intensive Health Home Care Coordination - \$17.26,
3. Low-level Health Home Care Coordination - \$6.75.

PCCM Managed Care (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 PM/PM 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.

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

Rate only reimbursement

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.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

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 individuals receiving long term services and supports and developmental disabilities services will continue to be necessary for individuals served under waivers and health homes will not duplicate the functions provided by state and Area Agency on Aging staff that 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 application 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 individual in development and implementation of their health care plan, including identification of self-care goals.

The health home will also be responsible for transitions, assessing individuals at higher risk for re-institutionalization and assisting the individual and their support network in gaining an understanding of discharge instructions and information, ensure appropriate follow-up primary and specialty care and that medication reconciliation occurs, and to assist with referrals for additional services the client 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 make a choice about what method they wish to use for case management. If they decide to become enrolled in a Tribal Health Home, they must disenroll from their Tribal PCCM.

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

- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule
- The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.

Transmittal Number: 15-0011 Supersedes Transmittal Number: WA 13-0008 Proposed Effective Date: Jan 1, 2015 Approval Date:

Transmittal Number: 15-0011 Supersedes Transmittal Number: WA 13-0008 Proposed Effective Date: Jan 1, 2015 Approval Date:  
Attachment 3.1-H Page Number: 9

## Submission - Categories of Individuals and Populations Provided Health Homes Services

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

- Categorically Needy eligibility groups

### Health Homes Services (1 of 2)

Category of Individuals  
CN individuals

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 will deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany 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) as the beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary and updated periodically every 4, 6 and 8 months. It is also updated when there are any changes in beneficiary circumstances such as hospitalization or ER visits. The results of screenings and assessments are captured via the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting goals through active participation in comprehensive care management.

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

All Health Home designated providers/lead entities will have access to the Medicaid Management Information System - ProviderOne (P1), the DSHS Predictive Risk Intelligence System (PRISM) and Insignia Health information technology sources. Authorizers and providers of long-term services and supports have access to the DSHS Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. 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 the CARE and PRISM.

2. Insignia Health is responsible through a DSHS licensing agreement for maintenance and updates to the Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM) and administrative web site functions including Coaching for Activation.

3.HCA's P1 data system is responsible for Medicaid eligibility, enrollment, disenrollment, claims and per member per month (PMPM) payment to MCOs, payment of health homes, encounter data collection and reporting.

4.Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. 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. A care management module is being developed for the EDIE system to facilitate defined treatment plans for frequent ED users in Washington State.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

#### Description

1.Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

2.Child psychiatrists are licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board eligible or board certified in child psychiatry.

3.Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.

4. Licensed marriage and family therapists must graduate with a master's degree or doctoral degree educational program in marriage and family therapy or a behavioral science MA or PhD with equivalent course work from an approved school. The licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family

therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

Nurse Care Coordinators

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
4. Psychiatric advanced registered nurse practitioner" means a person who is licensed as an advanced registered nurse practitioner; and who is board certified in advanced practice psychiatric and mental health nursing.
5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

Nurses

Description

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treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

Pharmacists

Description

Social Workers

Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience or which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one

supervision or group supervision.

3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dietitians

Description

Nutritionists

Description

Other (specify):

Name

Chemical Dependency Professionals

Description

Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination

for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

## Care Coordination

### Definition:

The dedicated Health Home Care Coordinator shall 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 shall assure 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. 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 shall provide 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 will 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 and Insignia Health are information technology sources that support 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 via secure email or hard copy. The HAP includes:

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

The HAP is updated and modified by the Health Home Care Coordinator quarterly, and as needed to support care transition. The HAP is also updated and modified as needed according to:

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.

Future HIT development may include the addition of the HAP data elements to an electronic application, such as a web-based portal.

The Health Home will promote the use of web-based health information technology registries and referral tracking systems.

#### Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

##### Description

1. Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

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Medical Specialists

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Description

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4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

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Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

 Nutritionists

Description

 Other (specify):

Name

Description

Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

## Health Promotion

### Definition:

Health promotion begins for health home beneficiaries with the commencement of the Health Action Plan. Each Washington health home must demonstrate use of self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers. The Health Home Care Coordinator will use the beneficiary's activation score and level (1-4) to determine the coaching methodology for each beneficiary and develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progressed with a 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 will provide wellness and prevention education specific to the beneficiary's chronic conditions, Health Action Plan, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting 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 individual 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 source and provides, in connection with the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), 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 Home Visit or by phone.

PRISM contains the history of the PAM/CAM scores and responses for each survey administered to the beneficiary. The Health Home Care Coordinator is able to view the scores for each beneficiary alongside the medical, behavioral health claims and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) so that education materials can be tailored to the individual's engagement and activation.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

#### Description

1. Psychologists must have a doctoral degree from a regionally accredited institution, with at least 40 semester hours or sixty quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, supervised experience requirement of no fewer than two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

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Nurse Care Coordinators

#### Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.

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5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

Nurses

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Medical Specialists

Description

Physicians

## Description

 Physicians' Assistants

## Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

 Pharmacists

## Description

 Social Workers

## Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience of which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
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Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Chemical Dependency Professionals

Description

Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Services (2 of 2)

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Category of Individuals

## CN individuals

### Service Definitions

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

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

#### Definition:

Comprehensive transitional care shall be provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan shall include 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 room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification and the Health Action Plan should be updated with transition planning.
2. The use of a Health Home Care Coordinator as an active participant in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.
3. Beneficiary education that supports 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 formal or informal caregivers shall be 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) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant. EDIE can proactively alert care providers when high utilizing beneficiaries enter the ED through a variety of methods such as fax, phone, email, or integration with facility's current EMR. 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 actual medical situation.

Managed care organizations (MCOs) will notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCOs will 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.

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Behavioral Health Professionals or Specialists

Description

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 Pharmacists

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Doctors of Chiropractic

Description

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Individual and family support, which includes authorized representatives

**Definition:**

The Health Home Care Coordinator shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the Health Home Care Coordinator to increase beneficiary and caregiver's 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 and beneficiary shall:

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 individuals 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:

PRISM software applications include the PRISM Health Report for selected beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care provider

identified by the beneficiary and supported 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 client'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 benefit/service

- The benefit/service can only be provided by certain provider types.

- Behavioral Health Professionals or Specialists

##### Description

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Medical Specialists

Description

Physicians

Description

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 Doctors of Chiropractic

Description

[Empty text box]

- Licensed Complementary and Alternative Medicine Practitioners

Description

[Empty text box]

- Dieticians

Description

[Empty text box]

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Description

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Referral to community and social support services, if relevant

Definition:

The Health Home Care Coordinator identifies available community based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports related to goal achievement documented in the Health Action

Plan. When needed and not provided through other case management systems, the Health Home Care Coordinator provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of 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 shall document 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 benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

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 Physicians' Assistants

## Description

Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.

 Pharmacists

## Description


 Social Workers

## Description

All social workers listed below must pass either the American Association of State Social Work Board's advanced or clinical examination for licensure. The Associate social workers listed below are not required to have supervised postgraduate experience prior to becoming an associate.

1. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4,000 hours of supervised experience or which 1,000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

2. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3,200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

3. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4,000 hours of experience, of which 1,000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

4. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

5. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

Doctors of Chiropractic

Description

[Empty text box for description of Doctors of Chiropractic]

Licensed Complementary and Alternative Medicine Practitioners

Description

[Empty text box for description of Licensed Complementary and Alternative Medicine Practitioners]

Dietitians

Description

[Empty text box for description of Dietitians]

Nutritionists

Description

[Empty text box for description of Nutritionists]

Other (specify):

Name

Chemical Dependency Professionals

Description

Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

Enrollment - based on chronic conditions and meeting the state's definition of "at risk for another" a clinical indicator (Y=qualifies) will be loaded into the WA MMIS. Beneficiaries with clinical indicators of "Y" will be enrolled into one of the qualified health home networks in the geographic region in which they reside. Outreach and education information will be generated by enrollment and sent from the State to the beneficiary by mail. The Health Home will receive the enrollment on a HIPAA compliant 837 and assign the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).

Beneficiaries may be referred to Health Homes by any health care provider. An example is a referral from a local emergency room department who has agreed with the Health Home to refer potentially eligible participants to the program.

Engagement - the assigned CCO places the beneficiaries with a Care Coordinator. The beneficiary is contacted and offered health home services. Once the beneficiary has agreed to participate in a Health Home, the CC prepopulates the Health Action Plan with PRISM claims utilization and arranges for an in-person visit. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.

During the home visit, the CC:

1. Conducts a brief health screening including mental, physical and chemical dependency
2. Evaluates 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); and
5. Introduces the Health Action Plan (HAP) to the beneficiary. Together, the CCO and beneficiary identify immediate and long-term goals, prioritize concerns and establish action steps.

Medically Needy eligibility groups

- All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.
- Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.
  - All Medically Needy receive the same services.
  - There is more than one benefit structure for Medically Needy eligibility groups.

## Health Homes Monitoring, Quality Measurement and Evaluation

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### Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

There is no generally accepted methodology for determining “avoidable” readmissions. We will use the CMS - defined specifications of Plan All-Cause 30 Day Readmissions required for the duals demonstration grant, adjusted for the health home population, unless a different metric is required by CMS. The current specifications:

Risk-adjusted percentage of participating health home clients who were readmitted to a hospital within 30 days following discharge from the hospital for an index admission.

Numerator: Risk-adjusted readmissions among participating health home clients at a non-Federal, short-stay, acute-care or critical access hospital, within 30 days of discharge from the index admission included in the denominator, and excluding planned readmissions.

Denominator: All hospitalizations among participating health home clients not related to medical treatment of cancer, primary psychiatric disease or rehabilitation care, fitting of prostheses, and adjustment devices for beneficiaries at non-Federal, short-stay acute care or critical access hospitals, where the beneficiary was continuously enrolled in Medicaid and health homes for at least 1 month after discharge, was not discharged to another acute-care hospital, was not discharged against medical advice, and was alive upon discharge and for 30 days post-discharge.

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.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

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.

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, eligibility, and enrollment 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 will use the PRISM tools 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 will enable the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met. Use of these tools will allow the State to monitor cost and utilization data to ensure program goals are met.

The State has developed HIT through OneHealthPort, an entity contracted with HCA to consult on building a statewide health information exchange. HCA has developed 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 Database to refine or to correct identified data collection errors occur whenever a need is identified.

### Quality Measurement

- The State provides assurance that it will require 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.

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

- The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

<p><b>Measure:</b> 30 day All Cause Readmissions</p> <p><b>Measure Specification, including a description of the numerator and denominator.</b> We will use the CMS Health Home defined specifications of Plan All-Cause 30 Day Readmissions unless a different metric is required by CMS:</p> <p>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</p> <p><b>Numerator:</b> Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination;</p> <p><b>Denominator:</b> Count the number of Index Hospital Stays for each age, gender, and total combination.</p> <p><b>Data Sources:</b> ProviderOne (MMIS) claims and encounter data; Health Home enrollment data</p> <p><b>Frequency of Data Collection:</b></p> <p> <input type="radio"/> Monthly  <input type="radio"/> Quarterly  <input type="radio"/> Annually  <input type="radio"/> Continuously  <input checked="" type="radio"/> Other  <input type="text" value="Daily"/> </p>	
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Emergency Room Visits

<p><b>Measure:</b> Preventable/Avoidable or Treatable in a primary care setting ED visits</p> <p><b>Measure Specification, including a description of the numerator and denominator.</b> Focus on Preventable/avoidable or treatable in a primary care setting ED visits, consistent with the CMS-defined MFFS duals specifications:</p> <p>Based on lists of diagnoses developed by researchers at the New York University Center to Health and Public Service Research, this measure calculates the rate of ED use for conditions that are either preventable/avoidable, or treatable in a primary care setting</p> <p>( <a href="http://wagner.nyu.edu/chpsr/index.html?p=61">http://wagner.nyu.edu/chpsr/index.html?p=61</a> )</p>	
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<p>Numerator: Total number of ED visits with principal diagnoses defined in the NYU algorithm among demonstration-eligible enrollees;</p> <p>Denominator: Demonstration-eligible enrollees</p> <p>Data Sources: ProviderOne (MMIS) claims and encounter data; Health Home enrollment data</p> <p>Frequency of Data Collection:</p> <p><input type="radio"/> Monthly</p> <p><input type="radio"/> Quarterly</p> <p><input type="radio"/> Annually</p> <p><input type="radio"/> Continuously</p> <p><input checked="" type="radio"/> Other</p> <p>Daily</p>	
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### Skilled Nursing Facility Admissions

<p>Measure: Skilled nursing facility placements</p> <p>Measure Specification, including a description of the numerator and denominator. Focus on proportion of enrollees in skilled nursing facilities: Numerator: Number of demonstration-eligible enrollees who received institutional long term care services;</p> <p>Denominator: Number of demonstration-eligible enrollees.</p> <p>Data Sources: ProviderOne (MMIS) claims and encounter data; Health Home enrollment data</p> <p>Frequency of Data Collection:</p> <p><input type="radio"/> Monthly</p> <p><input type="radio"/> Quarterly</p> <p><input type="radio"/> Annually</p> <p><input type="radio"/> Continuously</p> <p><input checked="" type="radio"/> Other</p> <p>Daily</p>	
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Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

#### Hospital Admission Rates

Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under capitated managed care. Member month data collected from eligibility files.

#### Chronic Disease Management

Diagnosis/procedure codes, pharmacy and service utilization collected from claims data for those services provided under fee-for-service and encounter data for those services provided under capitated managed care based on disease specific evidence based protocols.

#### Coordination of Care for Individuals with Chronic Conditions

Chronic disease management data is collected through administration claims/encounter data, nurse care manager assessments, health home payment and health home encounter data verifying services received by clients (AOD treatment, mental health services, prescriptions, etc). This data is obtained through the State's MMIS payment system (ProviderOne). RN Care management notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring.

#### Assessment of Program Implementation

Indicators of program implementation are collected from enrollment data, claims/encounter data, client assessment data and interim progress reports.

#### Processes and Lessons Learned

The state has experience in implementation of opt-out and passive enrollment. The state will phase enrollment geographically to ensure ability to evaluate processes and apply lessons learned. Washington will use the HealthPath Washington Advisory Team (HAT) to collect input on implementation as well as to make recommendations on implementation strategies to ensure issues are addressed quickly and effectively. Process and lessons learned are collected through key informant interviews and interim progress reports.

#### Assessment of Quality Improvements and Clinical Outcomes

Quality improvement indicators are collected from enrollment data, claims/encounter data, and client assessment data. As detailed in the quality measures section, Washington has identified a list of quality and outcomes measures that apply lessons learned from previous care management pilots that served high cost/high risk individuals. The outcome measures are intended to measure both quality and cost outcomes. Quality will be measured at multiple levels.

#### Estimates of Cost Savings

The State will use the same method as that described in the Monitoring section.

If no, describe how cost-savings will be estimated.

Information on cost savings comes from administrative claims/encounter data.

#### PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 80 per response, 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.