

**Exhibit E**  
**Integrated Managed Care**  
**Health Homes**

**1. Health Homes Definitions**

- 1.1. "Aging and Long-Term Support Administration (ALTSA)" means the administration within the Department of Social and Health Services responsible for providing long-term services and supports to individuals who are functionally and financially eligible to receive such services.
- 1.2. "Allied or Affiliated Staff" means community health workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services outreach and engagement to the Enrollee under the direction and supervision of the Health Home Care Coordinator.
- 1.3. "Area Agency on Aging (AAA)" means a network of state and local programs that help older people to plan and care for their life long needs.
- 1.4. "Authorizing Entity" means an organization contracted by the state to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Behavioral Health Administrative Service Organizations, and Home and Community-based or Area Agency on Aging service entities.
- 1.5. "Behavioral Health Administrative Services Organization (BH-ASO)" means an entity selected by HCA to administer Behavioral Health services and programs, including Crisis and Ombuds Services for individuals in a defined Regional Service Area. The BH-ASO administers Crisis and Ombuds Services for all individuals in its defined service area, regardless of ability to pay, including Medicaid eligible members.
- 1.6. "Behavioral Health Services" means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.
- 1.7. "Behavioral Health Services Only (BHSO)" means those Enrollees who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.
- 1.8. "Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering Health Home services.
- 1.9. "Caregiver Activation Measure® (CAM®)" means an assessment that gauges the knowledge, skills and confidence essential to a caregiver providing care for a person with chronic conditions.
- 1.10. "Comprehensive Assessment Report and Evaluation (CARE)" means a person centered tool used by case managers to document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care, as defined in chapter 388-106 WAC.
- 1.11. "Coverage Area(s)" means pre-determined geographical areas composed of specific counties.

- 1.12. "Department of Social and Health Services (DSHS)" means the Washington State Department of Social and Health Services.
- 1.13. "Designated Staff" means either the Contractor's employee(s) or employee of any Subcontractor or employees of any Health Home Provider with whom the Contractor has a MOA to provide Health Home Services to the Contractor's Enrollees and whom have been authorized by their employer to access data.
- 1.14. "Developmental Disabilities Administration (DDA)" means the administration within the Department of Social and Health Services that provides services to individuals with developmental disabilities who are functionally and financially eligible to receive such services.
- 1.15. "Engagement" means the Enrollee's agreement to participate in Health Homes as demonstrated by the completion of the Enrollee's Health Action Plan.
- 1.16. "Fee-For-Service (FFS)" means the Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted Provider. Providers are paid on a per service basis.
- 1.17. "Full Dual Eligible" means a Medicare Beneficiary who is also eligible for the full scope of Medicaid covered benefits.
- 1.18. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the Enrollee's health or health outcomes.
- 1.19. "Health Action Plan (HAP)" means an Enrollee-prioritized plan identifying what the Enrollee plans to do to improve his or her health and well-being.
- 1.20. "Health Home Care Coordinator" means an individual employed by the Contractor or a CCO who provides Health Home Services.
- 1.21. "Health Home Participation Authorization and Information Sharing Consent Form" means a release form signed by the Enrollee to confirm the Enrollee's consent to participate in the health home program and to authorize the release of information to facilitate the sharing of the Enrollee's health information.
- 1.22. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six (6) Health Home Services are:
  - 1.22.1. Comprehensive Care Management
  - 1.22.2. Care Coordination and Health Promotion
  - 1.22.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up
  - 1.22.4. Individual and Family Support
  - 1.22.5. Referral to Community and Social Support Services
  - 1.22.6. The use of Health Information Technology to link services, as appropriate
- 1.23. "Involuntary Disenrollment" means the process to disenroll an Enrollee from the Health Home program when health or safety concerns are present, as defined in WAC 182-557-0500.
- 1.24. "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a

variety of care settings.

- 1.25. “Long Term Services and Supports (LTSS)” means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives.
- 1.26. “Memorandum of Agreement/Understanding (MOA or MOU)” means a business agreement for partnerships that do not involve a financial arrangement describing the roles and responsibilities of each party to the agreement.
- 1.27. “Parent Patient Activation Measure® (PPAM®)” means an assessment that gauges the knowledge, skills and confidence of the parent’s management of their child’s health.
- 1.28. “Patient Activation Measure® (PAM®)” means an assessment that gauges the knowledge, skills and confidence essential to managing one’s own health and health care.
- 1.29. “Patient Protection and Affordable Care Act” or “ACA” means Public Laws 111-148 and 111-152 (both enacted in March 2010).
- 1.30. “PRISM User Coordinator” means the employee appointed by the Contractor to be the point of contact for the HCA and DSHS’s PRISM Administration Team.
- 1.31. “Qualified Health Home” means an entity qualified by the state to administer the Health Home program to eligible beneficiaries.

## **2. Health Home Services for IMC Enrollees**

- 2.1. The Contractor shall provide Health Home services in addition to the Care Coordination Services described in Section 14 of the IMC Contract, to high cost, high needs Enrollees who meet Health Home eligibility criteria.
- 2.2. Health Home Services shall be community-based, integrated and coordinated across medical, Behavioral Health, and long-term services and supports to Enrollees based on the services described in Section 1945(h)(4) of the Social Security Act.
- 2.3. The Contractor shall ensure that the following are operational:
  - 2.3.1. Submission of completed and updated Health Action Plan (HAP) data through the *OneHealthPort* Health Information Exchange using the OneHealthPort Implementation Guide located at: [https://www.hca.wa.gov/assets/billers-and-providers/HAP\\_CanonicalGuide.pdf](https://www.hca.wa.gov/assets/billers-and-providers/HAP_CanonicalGuide.pdf). The HAP data will be stored in a Medicaid data base for evaluation purposes;
    - 2.3.1.1. Each HAP shall be submitted within sixty (60) calendar days of the HAP completion date.
  - 2.3.2. A system to track and share Enrollee information and care needs among Providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the Enrollee’s preferences and identified needs;
  - 2.3.3. A system to track Health Home Services through claims paid or services rendered and report the encounter data in accordance with HCA Encounter Data Reporting Guide;
  - 2.3.4. Enrollee access to a toll-free line and customer service representative to

answer questions, 8:00 a.m. to 5:00 p.m. from Monday through Friday regarding Health Home enrollment, disenrollment, and how to access services or request a change to another CCO;

- 2.3.5. A system for emergency consultation and general information available 24/7;
- 2.3.6. Lead Entities must have executed a MOU or MOA with organizations that authorize Medicaid services such as DSHS Home and Community Services (HCS), BH-ASOs, DDA, and Area Agencies on Aging (AAAs) to ensure continuity of care. MOU/MOAs must contain information related to Enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
- 2.3.7. The Contractor shall submit encounter data according to the three tier process listed below:
  - 2.3.7.1. Tier One: Outreach, Engagement, and Health Action Plan Development includes:
    - 2.3.7.1.1. Outreach by mail; phone; or other methods, continues until the eligible Enrollee agrees to participate or declines participation in the Health Home program. Contractor must document all attempts to contact Enrollee.
    - 2.3.7.1.2. Engagement occurs when the Enrollee agrees to a face-to-face visit between the Enrollee and the Health Home Care Coordinator in a location of the Enrollee's choosing, such as their home or Provider's office.
    - 2.3.7.1.3. Health Action Plan Development includes face-to-face visits to complete the initial Health Action Plan, the Health Home Participation Authorization and Information Sharing Consent form, and coaching to assist the Enrollee in identifying short and long-term goals and associated action steps.
  - 2.3.7.2. Tier Two: Intensive Health Home Care Coordination is the highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services and includes evidence that the Care Coordinator, the Enrollee, and the Enrollee's caregivers are:
    - 2.3.7.2.1. Actively engaged in achieving health action goals;
    - 2.3.7.2.2. Participating in activities that support improved health and well-being; and
    - 2.3.7.2.3. Have value for the Enrollee and caregivers, supporting an active level of care coordination through delivery of Health Home Services.
    - 2.3.7.2.4. Typically Intensive Health Home Care Coordination includes one face-to-face visit with the Enrollee every month in which a qualified Health Home Service is provided. Exceptions to the monthly face-to-face visit may be approved by the Contractor as long as the Health Home

Services provided during the month achieve one or more of the following:

- 2.3.7.2.4.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;
  - 2.3.7.2.4.2. Continuity and coordination of care through in-person visits, and the ability to accompany Beneficiaries to Health Care Provider appointments, as needed;
  - 2.3.7.2.4.3. Enrollee assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;
  - 2.3.7.2.4.4. Fostering communication between the providers of care, including the treating Primary Care Provider, medical specialists, personal care Providers and others, and entities authorizing Behavioral Health and long-term services and supports;
  - 2.3.7.2.4.5. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
  - 2.3.7.2.4.6. Health education and coaching designed to assist Beneficiaries to increase self-management skills and improve health outcomes; and
  - 2.3.7.2.4.7. Use of peer supports, support groups, and self-care programs to increase the Enrollee's knowledge about their health care conditions and improve adherence to prescribed treatment.
- 2.3.7.3. Tier Three: Low-Level Health Home Care Coordination occurs when the Enrollee and Health Home Care Coordinator identify that the Enrollee has achieved a sustainable level of progress toward meeting self-directed goals, or upon the Enrollee's request.
- 2.3.7.3.1. Low-Level Health Home Care Coordination includes monitoring the Enrollee's health care needs and progress toward meeting self-directed goals using one (1) or more of the six defined Health Home Services.
  - 2.3.7.3.2. At least one (1) qualified Health Home Service must be delivered during the month through face-to-face visits or

telephone calls.

- 2.3.7.4. The Tier will not change from month to month between Tier Two and Tier Three unless:
  - 2.3.7.4.1. The Enrollee and/or their caregivers consistently demonstrate an intensive or low-level Health Home need;  
or
  - 2.3.7.4.2. The Enrollee requests to change Tiers.
- 2.3.8. The Contractor's PRISM Coordinator shall identify all Designated Staff who have a business need to access PRISM.
  - 2.3.8.1. The Contractor shall ensure that Designated Staff complete and submit to the DSHS PRISM Administration Team all the necessary forms required by CMS and DSHS for data authorization and PRISM access, including:
    - 2.3.8.1.1. The PRISM Registration form; and
    - 2.3.8.1.2. The DSHS provided spreadsheet.
  - 2.3.8.2. The Contractor shall promptly notify the DSHS PRISM Administration Team to remove established Designated Staff user accounts due to employment termination, job reassignment, or other changes in circumstances.
- 2.3.9. Policies and Procedures: The Contractor shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated Contractor-specific policies and procedures that address the following:
  - 2.3.9.1. The requirement to maintain frequent, contact between the Health Home Enrollee and the Health Home Care Coordinator when delivering Health Home services;
  - 2.3.9.2. Ongoing availability of support staff to complement the work, collaborate, receive direction and report to the Health Home Care Coordinator;
  - 2.3.9.3. Support screening, referral and co-management of individuals with both Behavioral Health and physical health conditions;
  - 2.3.9.4. The Contractor's and subcontractor's roles and responsibilities for Enrollee engagement;
  - 2.3.9.5. Ensuring an appointment reminder system is in place for Enrollees.
  - 2.3.9.6. Tracking of Enrollee assignment to Care Coordination Organizations;
  - 2.3.9.7. Referrals to HCA for eligibility review of any potential Enrollee who seeks or needs Health Home services;
  - 2.3.9.8. Transitional care services for Enrollees transferring to or from a hospital, other inpatient setting, or emergency departments;
  - 2.3.9.9. A policy and procedure to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA; and

- 2.3.9.10. Due diligence for contacting the Enrollee for affirmation of participation.
- 2.3.9.11. Identify and address Enrollee gaps in care through:
  - 2.3.9.11.1. Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the Enrollee's age and underlying chronic conditions;
  - 2.3.9.11.2. Evaluation of Enrollee perception of gaps in care;
  - 2.3.9.11.3. Documentation of gaps in care in the Enrollee case file;
  - 2.3.9.11.4. Documentation of interventions in HAP and progress notes;
  - 2.3.9.11.5. Findings from the Enrollee's response to interventions; and
  - 2.3.9.11.6. Documentation of follow-up actions, and the person or organization responsible for follow-up.

### **3. Health Home Care Coordinator Qualification and Training Requirements**

The Contractor shall ensure that:

- 3.1. Health Home Coordinators must possess one of the following licenses or credentials:
  - 3.1.1. Current license as registered nurses, advanced registered nurse practitioners, licensed practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists or certified chemical dependency professionals, or;
  - 3.1.2. Master's or Bachelor's in social work, psychology, social services, human services, behavioral sciences, or;
  - 3.1.3. Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR).
- 3.2. The Contractor may request an exception for candidates who do not meet the qualifications in 3.1.
- 3.3. Health Home Care Coordinators and affiliated staff complete Enrollee confidentiality, data security, and mandatory reporting training upon hire and annually thereafter.
- 3.4. Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to completing the HAP with the Enrollee.
- 3.5. Health Home Care Coordinators complete the following training modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.
  - 3.5.1. Outreach and Engagement Strategies;
  - 3.5.2. Navigating the LTSS System;
  - 3.5.3. Cultural and Disability Considerations;

- 3.5.4. Assessment Screening Tools; and
- 3.5.5. Coaching and Engaging Clients with Mental Health Needs.
- 3.6. Health Home Care Coordinators and affiliated personnel comply with continued training requirements as necessary.
- 3.7. Evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.
- 3.8. The Contractor has a Health Home Care Coordinator trainer on staff to participate in training related activities and to provide the Health Home Care Coordinator training.
  - 3.8.1. The Contractor may subcontract for Health Home Care Coordinator training services with another contracted Qualified Health Home Lead Entity.
  - 3.8.2. The trainer shall be qualified by DSHS prior to providing Health Home Care Coordinator training.
  - 3.8.3. Trainer Qualification includes:
    - 3.8.3.1. Completion of the Health Home Care Coordinator training course;
    - 3.8.3.2. Completion of a State-sponsored trainer's preparation course;
    - 3.8.3.3. Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS; and
    - 3.8.3.4. Receipt of a State-issued letter authorizing the individual to provide training to Health Home Care Coordinators.
  - 3.8.4. The Contractor shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.
- 3.9. The Health Home Care Coordinator training must be delivered using only DSHS approved materials. Training should not include any additional curriculum or materials.
- 3.10. The trainer shall not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials or include unauthorized topics, curriculum, or material in the Health Home Care Coordinator Training.

#### **4. Eligibility and Enrollment**

HCA shall determine eligibility and identify Enrollees who are eligible for the Contractor's Health Home program.

- 4.1. Those determined eligible for Health Home services must have at least one chronic condition and be at risk of a second as determined by a minimum PRISM score of 1.5 (as determined by a PRISM score under WAC 182-557-0200). The chronic conditions are:
  - 4.1.1. Mental health conditions;
  - 4.1.2. Substance use disorders;
  - 4.1.3. Asthma;
  - 4.1.4. Diabetes;

- 4.1.5. Heart disease;
  - 4.1.6. Cancer;
  - 4.1.7. Cerebrovascular disease;
  - 4.1.8. Coronary artery disease;
  - 4.1.9. Dementia or Alzheimer's disease;
  - 4.1.10. Intellectual disability or disease;
  - 4.1.11. HIV/AIDS;
  - 4.1.12. Renal failure;
  - 4.1.13. Chronic respiratory conditions;
  - 4.1.14. Neurological disease;
  - 4.1.15. Gastrointestinal disease;
  - 4.1.16. Hematological conditions; and
  - 4.1.17. Musculoskeletal conditions.
- 4.2. HCA shall include a Health Home Clinical Indicator in the monthly enrollment file of IMC and BHSO Enrollees that meet Health Home criteria.
- 4.2.1. The Contractor shall ensure eligible IMC Health Home Enrollees are offered Health Home services through a contracted Qualified Health Home or a CCO until they agree to participate or decline to participate in the Health Home program.
  - 4.2.2. The Contractor must document in the client record why an eligible Enrollee declines to participate, unless the Enrollee does not want to explain his or her decision.
  - 4.2.3. When an Enrollee's PRISM risk score falls below 1.0 for six (6) consecutive months and the Enrollee has not been engaged in Health Home services, the Enrollee may be temporarily disenrolled at the Contractor's request via a Health Home Eligibility Update Project report initiated by HCA. If the Enrollee meets Health Home eligibility criteria, they must be re-enrolled with the Contractor.
- 4.3. The Contractor shall ensure Health Home eligible Enrollees are assigned a Health Home Care Coordinator through a Qualified Health Home.
- 4.4. Enrollees who have agreed to participate may disenroll from the Health Home program at any time. The Contractor shall maintain a record of all Enrollees who choose to disenroll from the Health Home program and the reason why.
- 4.5. Enrollees may be reenrolled in the Health Home program at any time if they meet the eligibility criteria at the time of the reenrollment request.
- 4.6. The Contractor shall use a standardized tool provided by the State to determine initial eligibility for Health Home services if the Enrollee has less than fifteen (15) months of claims history or is referred by a Provider. The Contractor shall notify HCA when the

Enrollee has been screened. When HCA determines the Enrollee qualifies, the Contractor shall ensure the Enrollee receives Health Home services unless the Enrollee declines to participate in the program.

- 4.7. The Contractor shall accept referrals for Health Home services from any health care Provider, whether or not the Provider is contracted with the Contractor.

## **5. Assignment**

- 5.1. The Contractor shall use a smart assignment process that takes into account the Enrollee's current Health Care Provider(s) when assigning Health Home Enrollees to community based subcontracted CCOs. The Contractor will:
  - 5.1.1. Use PRISM or other data systems to match the Enrollee to a CCO that provides most of the Enrollee's services; or
  - 5.1.2. Allow Enrollee choice of CCOs.
- 5.2. Subcontracted community based CCOs will receive a priority in the assignment of the total Health Home eligible Enrollees.
- 5.3. The Contractor shall ensure the Health Home eligible Enrollee is assigned to a Health Home CCO or internal Health Home Care Coordinator within thirty (30) calendar days of initial date of Health Home identification and enrollment.
- 5.4. The Contractor shall achieve and maintain the managed care Health Home eligible Enrollee engagement rate of at least 15 percent based on HCA's monthly Health Home Enrollment and Encounter Summary.
- 5.5. The Health Home Care Coordinator or affiliated staff shall:
  - 5.5.1. Arrange an in-person visit in the Enrollee's choice of location;
  - 5.5.2. Describe the program to the Enrollee including a description of Health Home services and care coordination;
  - 5.5.3. Arrange an appointment with the Health Home Care Coordination to complete the HAP;

## **6. Health Action Plan**

- 6.1. The Contractor shall ensure initial HAPs are completed within ninety (90) calendar days from the date of notification of the Enrollee's Health Home eligibility. A complete HAP must include documentation of agreement by the Enrollee to participate in the Health Home program.
  - 6.1.1. An Enrollee reentering the Health Home program, after disenrolling, will have a new opt in date generated upon agreeing to participate in the program. An initial Tier One HAP will not be completed for those Enrollees who have completed one previously. A HAP will be completed appropriate for their Care Coordination Tier.
- 6.2. The Contractor shall ensure the Health Home Care Coordinator uses the following resources to develop Enrollee HAPs:

- 6.2.1. The Enrollee's medical record, if available;
  - 6.2.2. PRISM data;
  - 6.2.3. Treatment plans, CARE assessments, and results of previous screens and assessments, if available;
  - 6.2.4. Information from the Contractor's authorization and service utilization systems; and
  - 6.2.5. Input from the Enrollee and his or her family and/or caregivers.
- 6.3. The Health Home Care Coordinator shall meet with the Enrollee in person to complete the initial HAP including the following:
- 6.3.1. The Health Home Care Coordinator meets with each Enrollee at the Enrollee's choice of location;
  - 6.3.2. The Health Home Participation Authorization and Information Sharing Consent form is completed;
  - 6.3.3. The Care Coordinator evaluate the Enrollee's support system;
  - 6.3.4. The Care Coordinator explains, develops, and completes the HAP with input from the Enrollee and/or the Enrollee's caregiver(s);
  - 6.3.5. The HAP documents the Enrollee's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;
  - 6.3.6. The HAP includes the required BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores;
  - 6.3.7. The HAP includes the required Patient Activation Measure (PAM®), or Patient Parent Activation Measure (PPAM®), or Caregiver Activation Measure (CAM®) activation level and screening score;
  - 6.3.8. The Health Home Care Coordinator also documents in the HAP all other screenings administered when medically indicated; and
    - 6.3.8.1. Additional screenings shall be completed, in alignment with state training, at the professional discretion of the Care Coordinator, or when indicated:
      - 6.3.8.1.1. By the assessment;
      - 6.3.8.1.2. By a diagnosis; or
      - 6.3.8.1.3. When the beneficiary identifies a concern related to pain, substance use disorder, falls, or anxiety.
  - 6.3.9. The HAP includes the reason the Enrollee declined assessment or screening tools.
  - 6.3.10. HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:
    - 6.3.10.1. After every four (4) month activity period to update the PAM®, PPAM®, or CAM®; BMI; Katz ADL; and PSC-17 or PHQ-9 screening

scores and reassess the Enrollee's progress towards meeting self-identified health action goals, add new goals or change in current goals; and

- 6.3.10.2. Whenever there is a change in the enrollee's health status or a change in the Enrollee's needs or preferences.
- 6.3.11. A completed and updated HAP with the Enrollee's goals and action steps must be provided to the Enrollee and with the Enrollee's consent shared with the Enrollee's caregiver and family in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.
- 6.3.12. Additional information not included in the State-developed HAP form must be included as an addendum.
- 6.3.13. Written information in the HAP must use language that is understandable to the Enrollee and/or the Enrollee's caregiver(s).
- 6.3.14. With Enrollee's consent, completed and updated HAPs must be shared with other individuals identified and authorized by the Enrollee on the signed Health Home Participation Authorization and Information Sharing Consent form.
- 6.3.15. The Health Home Care Coordinator shall meet with the Enrollee in person to complete the initial HAP. HAP updates or renewals may be done face-to-face, which can include the use of HIPAA-compliant telehealth. The HAP must include the following:
  - 6.3.15.1. Explain the HAP and the development process to the Enrollee;
  - 6.3.15.2. Complete a Health Home Participation Authorization and Information Sharing Consent form;
  - 6.3.15.3. Evaluate the Enrollee's support system; and
  - 6.3.15.4. Administer and score either the PAM®, PPAM® or CAM®.
- 6.3.16. The Health Home Care Coordinator uses the PAM®, PPAM®, or CAM® to:
  - 6.3.16.1. Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with Providers, maintain function, prevent declines and access appropriate and high quality health care;
  - 6.3.16.2. Target tools and resources commensurate with the Enrollee's level of activation;
  - 6.3.16.3. Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;
  - 6.3.16.4. Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the Enrollee; and
  - 6.3.16.5. As indicated by clinical judgment, complete HCA-approved screening tools for Behavioral Health conditions, if not already obtained from other sources.
- 6.3.17. Completed and updated HAP Data shall be submitted to HCA through the OneHealthPort (OHP) Health Information Exchange using the published OHP Implementation Guide and shall be preserved in the Contractor's local records

for evaluation purposes.

## **7. Care Coordinator Responsibilities**

- 7.1. The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, Behavioral Health, functional impairment, cultural and environmental factors affecting Enrollee's health and health care choices available to Health Home Enrollees.
- 7.2. The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally and linguistically appropriate manner and address health disparities by:
  - 7.2.1. Interacting directly with the Enrollee and his or her family in the Enrollee's primary language and recognizing cultural differences when developing the HAP;
  - 7.2.2. Understanding the dynamics of substance use disorder without judgment; and
  - 7.2.3. Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the Enrollee and his or her caregivers in addressing the obstacles.
- 7.3. The Health Home Care Coordinator shall:
  - 7.3.1. Discuss changes in Enrollee circumstances or condition with the treating/authorizing entities who serve the Enrollee;
  - 7.3.2. Document changes in the Enrollee's circumstances or conditions in the HAP in a timely manner;
  - 7.3.3. With the Enrollee's permission, include paid or unpaid caregivers who have a role in supporting the Enrollee to achieve health action goals and access health care and other services;
  - 7.3.4. Collaborate with Health Care Professionals such as Primary Care Providers, Mental Health Professionals, substance use disorder treatment Providers, social workers, and direct care Providers;
  - 7.3.5. Have access to Providers from the local community who authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), substance use disorder and medical services. This group may include BH-ASOs, DSHS-Home and Community Services (HCS), Community Mental Health Agencies (CMHA's), Area Agencies on Aging (AAAs), substance use disorder Providers, and community supports that assist with housing; and
  - 7.3.6. Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialists, family members, and housing or employment representatives or others to support the Enrollee's HAP.
  - 7.3.7. Review the information sharing consent of the Participation Authorization form with the Enrollee at a minimum of once per year.

## **8. Health Home Key Services**

### **8.1. Comprehensive Care Management Services**

- 8.1.1. The Contractor shall ensure the Health Home Care Coordinator:
  - 8.1.1.1. Documents interactions with the Health Home Enrollee including periodic follow-up, both face-to-face and telephonically;
  - 8.1.1.2. Assesses Enrollee's readiness for self-management and promotion of self-management skills;
  - 8.1.1.3. Reassesses the HAP and Health Home Enrollee's progress in meeting goals;
  - 8.1.1.4. Manages barriers to achieving health action goals;
  - 8.1.1.5. Facilitates communication between the Health Home Enrollee and service Providers to address barriers and achieve health action goals;
  - 8.1.1.6. Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
  - 8.1.1.7. Reassesses patient activation at minimum every four (4) month activity period, or more frequently if changes warrant reassessment using the PAM®; PPAM® or CAM® and documents the results in the HAP; and
  - 8.1.1.8. Ensures communication, coordination, and care management functions are not duplicated between the Health Home Care Coordinator and Medicaid case managers involved in the Enrollee's care, including DSHS and AAA case managers.

### **8.2. Care coordination and health promotion**

- 8.2.1. The Contractor shall ensure the Health Home Care Coordinator:
  - 8.2.1.1. Develops and executes cross-system care coordination to assist Enrollees to access and navigate needed services;
  - 8.2.1.2. Fosters communication between the care Providers, including the treating Primary Care Provider, medical specialists, Behavioral Health Providers and entities authorizing Behavioral Health and long-term services and supports;
  - 8.2.1.3. Maintains a caseload that ensures timely intervention;
  - 8.2.1.4. Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services;
  - 8.2.1.5. Provides interventions that recognize and are tailored for the medical, social, economic, Behavioral Health, functional impairment, cultural and environmental factors that affect an Enrollee's health and health care choices; and
  - 8.2.1.6. Provides educational materials that promote the following:
    - 8.2.1.6.1. Improved clinical outcomes;

- 8.2.1.6.2. Enrollee participation in his or her care;
  - 8.2.1.6.3. Continuity of care;
  - 8.2.1.6.4. Increased self-management skills; and
  - 8.2.1.6.5. Use of peer supports to increase the Enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.
- 8.2.2. Shares the HAP with individuals identified by the Enrollee, with the Enrollee's written consent. These individuals may include, but are not limited to: family, caregivers, Primary Care Providers, mental health treatment Providers, and authorizers of long term services and supports and/or substance use disorder treatment Providers.
- 8.2.2.1. The HAP shall provide written evidence of:
    - 8.2.2.1.1. The Enrollee's chronic conditions, severity factors and gaps in care, activation level, and opportunities to prevent avoidable emergency room, inpatient hospital and institutional use;
    - 8.2.2.1.2. Enrollee self-identified goals;
    - 8.2.2.1.3. Needed interventions and desired outcomes;
    - 8.2.2.1.4. Transitional care planning, including assessment and deployment of needed supports; and
    - 8.2.2.1.5. Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and paid or unpaid caregivers.
  - 8.2.2.2. The Health Home Care Coordinator shall assess the Enrollee's patient activation scores and level to determine the appropriate coaching methods and a teaching and support plan that includes:
    - 8.2.2.2.1. Introduction of customized educational materials based on the Enrollee's readiness for change;
    - 8.2.2.2.2. Progression of customized educational materials in combination with the Enrollee's level of confidence and self-management abilities;
    - 8.2.2.2.3. Documentation of opportunities for mentoring and modeling communication with health care Providers provided through joint office visits and communications with Health Care Providers by the Enrollee and the Health Home Care Coordinator;
    - 8.2.2.2.4. Documentation of wellness and prevention education specific to the Enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;
    - 8.2.2.2.5. Support for improved social connections to community networks, and links the Enrollee with resources that

support a health promoting lifestyle; and

8.2.2.2.6. Links to resources for, but not limited to: smoking cessation, substance use disorder prevention, nutritional counseling, obesity reduction, increasing physical activity, disease-specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.

8.2.3. Accompanies the Enrollee to critical health care and social service appointments when necessary to assist the Enrollee in achieving his or her health action goals.

8.2.4. Ensures treating Providers and authorizing entities coordinate and mobilize to reinforce and support the Enrollee's health action goals.

### **8.3. Transitional Care**

8.3.1. The Contractor shall provide and document the comprehensive transitional care for Health Home Enrollees to prevent avoidable readmission after discharge from an inpatient facility and to ensure proper and timely follow-up care.

8.3.2. In addition to services described in Transitional Care provisions of this Contract, the Contractor's transitional care planning process must include:

8.3.2.1. Participation by the Health Home Care Coordinator in appropriate phases of care transitions, including discharge planning; visits during hospitalizations or nursing home stays; home visits; post hospital/institutional stays; and follow-up telephone calls;

8.3.2.2. A notification system between the Contractor and facilities that provides prompt notification of an Enrollee's admission or discharge from an emergency department or inpatient setting;

8.3.2.3. Progress notes or a case file that documents the notification;

8.3.2.4. Transition planning details such as medication reconciliation, follow-up with Providers and monitoring documented in the HAP;

8.3.2.5. The Contractor may employ staff that have been trained specifically to provide transitional services, as long as the Health Home Care Coordinator is an active participant in the transitional planning process; and

8.3.2.6. Established frequency of communicating hallmark events to the assigned Health Home Care Coordinator.

### **8.4. Individual and family support**

8.4.1. The Contractor shall use peer supports, support groups, and self-management programs as needed, to increase the Enrollee's and caregiver's knowledge of the Enrollee's chronic conditions, promote the Enrollee's capabilities and engagement in self-management, and help the Enrollee improve adherence to prescribed treatment.

8.4.2. The Contractor shall ensure the Health Home Care Coordinator, with the

Enrollee's participation:

- 8.4.2.1. Identifies the role that the Enrollee's family, informal supports and paid caregivers provide to help the Enrollee achieve self-management and optimal levels of physical and cognitive function;
- 8.4.2.2. Educates and supports self-management; self-help recovery and other resources necessary for the Enrollee, his or her family and caregivers to support the Enrollee's individual health action goals;
- 8.4.2.3. Documents discussion of advance care planning with the Enrollee within the first year of the Enrollee's agreement to participate in the Health Home program; and
- 8.4.2.4. Communicates and shares information with the Enrollee's family and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

### **8.5. Referral to community and social support services**

8.5.1. The Health Home Care Coordinator shall ensure that:

- 8.5.1.1. Available community resources are identified and accessible to the Health Home Enrollee.
- 8.5.1.2. Referrals:
  - 8.5.1.2.1. Are overseen by the Health Home Care Coordinator;
  - 8.5.1.2.2. Support the Enrollee's health action goals;
  - 8.5.1.2.3. Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
  - 8.5.1.2.4. Are documented in the Enrollee's progress notes and HAP.
- 8.5.1.3. Assistance is provided to the Enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.
- 8.5.1.4. Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations.

## **9. Quarterly Quality Reports**

- 9.1. The Contractor shall submit quarterly quality reports via HCA's Managed File Transfer (MFT) site every three months in the current report format provided by HCA in accordance with the following reporting periods:
  - 9.1.1. January through March due May 1;
  - 9.1.2. April through June due August 1;
  - 9.1.3. July through September due November 1; and

9.1.4. October through December due February 1.

9.2. Reports using the incorrect report template will be returned to the Contractor to resubmit within two (2) business days.