



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSR 14-08-039 ; or**
 Expedited Rule Making--Proposed notice was filed as WSR _____; or
 Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

- Original Notice**
 Supplemental Notice to WSR _____
 Continuance of WSR _____

Title of rule and other identifying information: (Describe Subject)

Chapter 182-557 WAC - Health Homes

Hearing location(s):

Health Care Authority
Cherry Street Plaza Building; Conf Rm
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:

http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: 360-725-1000

Date: May 5, 2015 Time: 10:00 a.m.

Date of intended adoption: Not sooner than May 6, 2015
(Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360)586-9727

by 5:00 p.m. on May 5, 2015

Assistance for persons with disabilities: Contact

Kelly Richters by April 27, 2015

TTY (800) 848-5429 or (360) 725-1307 or e-mail:
kelly.richters@hca.wa.gov

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

Revisions to this chapter are necessary to develop a grievance and appeal process for the Health Homes program and to add a clinical eligibility tool for those clients who do not have sufficient claims history to qualify for health homes.

Reasons supporting proposal: See purpose

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021

Is rule necessary because of a:

- | | | |
|-------------------------|------------------------------|--|
| Federal Law? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| Federal Court Decision? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| State Court Decision? | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
- If yes, CITATION:

DATE

March 27, 2015

NAME (type or print)

Jason R. P. Crabbe

SIGNATURE

TITLE

HCA Rules Coordinator

CODE REVISER USE ONLY

**OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED**

DATE: March 27, 2015

TIME: 10:45 AM

WSR 15-08-058

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: Health Care Authority

- Private
 Public
 Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Wendy Barcus	PO Box 42716, Olympia WA 98504-2716	(360) 725-1306
Implementation.... Agnes Ericson	PO Box 45530, Olympia WA 98504-5530	(360) 725-1115
Enforcement..... Agnes Ericson	PO Box 45530, Olympia WA 98504-5530	(360) 725-1115

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No. Explain why no statement was prepared.

The Agency has analyzed the proposed rules and concludes they do not impose more than minor costs for affected small businesses.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

WAC 182-557-0050 Health home—General. (1) The agency's health home program provides patient-centered care to ~~((beneficiaries))~~ participants who:

(a) Have ~~((a))~~ at least one chronic condition as defined in WAC 182-557-0100; and

(b) ~~((Be))~~ Are at risk of a second chronic condition ~~((with))~~ as evidenced by a minimum predictive risk score of 1.5~~((; and~~

~~((c) Are at risk for high health costs, avoidable admissions to institutional care settings, and poor health outcomes)).~~

(2) The health home~~((s))~~ program offers six care coordination activities to assist ~~((the beneficiary))~~ participants in self-managing ~~((his or her))~~ their conditions and navigating the health care system:

(a) Comprehensive or intensive care management including, but not limited to, assessing participant's readiness for self-management, promoting self-management skills, coordinating interventions tailored to meet the ~~((beneficiary's))~~ participant's needs, and facilitating improved outcomes and appropriate use of health care services;

(b) Care coordination and health promotion;

(c) Comprehensive transitional care between care settings including, but not limited to, after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting);

(d) Individual and family support services to provide health promotion, education, training and coordination of covered services for ~~((beneficiaries))~~ participants and their support network;

(e) Referrals to community and support services; and

(f) Use of health information technology (HIT) to link services between the health home and ~~((beneficiaries))~~ participants' providers.

(3) The agency's health home program does not:

(a) Change the scope of services for which a ~~((beneficiary))~~ participant is eligible under medicare or a Title XIX medicaid program;

(b) Interfere with the relationship between a ~~((beneficiary))~~ participant and his or her chosen agency-enrolled provider(s);

(c) Duplicate case management activities the ~~((beneficiary))~~ participant is receiving from other providers or programs; or

(d) Substitute for established activities that are available through other programs administered ~~((through))~~ by the agency or other state agencies.

(4) Qualified health home providers must:

(a) Contract with the agency to provide services under this chapter to eligible ~~((beneficiaries))~~ participants;

(b) Accept the terms and conditions in the agency's contract;

(c) Be able to meet the network and quality standards established by the agency;

(d) Accept the rates established by the agency; and

(e) Comply with all applicable state and federal requirements.

WAC 182-557-0100 Health home program—Definitions. The following terms and definitions apply to the health home program:

Action - For the purposes of this chapter, means one or more of the following:

(1) The denial of eligibility for health home services.

(2) The denial or limited authorization by the qualified health home of a requested health home service, including a type or level of health home service.

(3) The reduction, suspension, or termination by the qualified health home of a previously authorized health home service.

(4) The failure of a qualified health home to provide authorized health home services or provide health home services as quickly as the participant's condition requires.

Agency - See WAC 182-500-0010.

~~((Beneficiary — A person who is eligible for health home services. See WAC 182-557-0200.))~~

Chronic condition - Means a condition that, in combination with the ((beneficiary's)) client's health care expenditure risk score, determines eligibility for health home services. The chronic conditions ((covered)) are mental health conditions, substance use disorders, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability ((or disease)), HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions.

~~((Contractor — The entity providing covered services under contract with the agency.))~~

Client - For the purposes of this chapter, means a person who is eligible to receive health home services under this chapter.

Clinical eligibility tool - Means an electronic spreadsheet which uses manually entered demographic, diagnoses, and pharmacy information to calculate an individual's expected health care expenditure risk score.

Coverage area((s)) - ~~((Predetermined))~~ Means a geographical area((s)) composed of ((specific counties that will facilitate a phased in implementation of health homes.

~~**Covered services** — The medicare and medicaid covered services that will be coordinated as part of health home program activities.~~

~~**DSHS** — The department of social and health services.))~~ one or more counties within Washington state.

Fee-for-service (FFS) - See WAC 182-500-0035.

Full dual eligible - For the purpose of this chapter, means ((an individual)) a fee-for-service client who receives qualified medicare beneficiary coverage or specified low-income medicare beneficiary coverage and categorically needy health care coverage.

Grievance - Means an expression of a participant's dissatisfaction about any matter other than an action. Possible subjects for grievances include the quality of health home services provided and aspects of interpersonal relationships, such as rudeness.

~~**Health action plan** - ((A beneficiary prioritized plan identifying what the beneficiary plans to do to improve their health and/or self-management of health conditions.~~

~~Health home~~— An entity composed of community based providers, qualified and contracted by the agency to provide health home services to eligible beneficiaries.)) Means a plan that identifies the participant's goals to improve and self-manage their health conditions.

Health home care coordinator - Means staff employed by or subcontracted by the qualified health home to provide one or more of the six defined health home care coordination benefits listed in WAC 182-557-0050.

Health home services - Means services described in WAC 182-557-0050 (2)(a) through (f).

Medicaid - See WAC 182-500-0070.

~~((Participation~~— A beneficiary's agreement to a health action plan which constitutes an agreement by the beneficiary to participate in health home services.

~~Predictive modeling~~— Using historical medical claims data to predict future utilization of health care services.

~~PRISM or Predictive Risk Intelligence System~~— A DSHS secure web-based predictive modeling and clinical decision support tool. This tool provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a regular basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next twelve months based on the patient's disease profile and pharmacy utilization.

~~Risk score~~— A measure of expected cost risk in the next twelve months based on the beneficiary's disease profiles, medical care utilization, and pharmacy utilization.

~~Self-management~~— With guidance from a health home care coordinator or health home care team, the concept of the beneficiary being the driver of his or her own health through the process of:

- Identification of health care conditions;
- Health action planning;
- Education;
- Monitoring to ensure progress towards achievement of health action goals; and
- Active involvement of the beneficiary in the decision making process with the health home care coordinator or health home care team.)) Participant - Means a client who has agreed to receive health home services under the requirements of this chapter.

Qualified health home - Means an organization that contracts with the agency to provide health home services to participants in one or more coverage areas.

AMENDATORY SECTION (Amending WSR 13-12-002, filed 5/22/13, effective 7/1/13)

WAC 182-557-0200 Health home program—((Client)) Eligibility ((and participation)). (1) To ((participate in)) be eligible for the health home program, a ((beneficiary)) client must:

- (a) Be a recipient of categorically needy health care coverage((~~or~~
- (b) A full dual eligible; and
- (i)) through:
 - (i) Fee-for-service, including full dual eligible clients; or

(ii) An agency-contracted managed care organization.

(b) Have one or more chronic condition~~((s+))~~ as defined in WAC 182-557-0100; and

(c) Be at risk of developing another chronic condition as determined by a ((PRISM)) risk score of 1.5 or greater based on either:

(i) The risk score ~~((of 1.5 or greater; and))~~ from algorithms used to measure the expected health care expenditures for the next twelve months based on the client's demographic, diagnoses, and pharmacy history relative to a reference group. These algorithms are developed by the department of social and health services and are used to initiate an eligibility determination; or

(ii) A risk score from the agency's clinical eligibility tool located on the agency's web site and developed by the department of social and health services. This tool may be used by a health care provider to determine whether a client has a risk score of 1.5 or greater. See the agency's clinical eligibility tool at http://www.hca.wa.gov/Pages/health_homes.aspx; and

(d) Agree to participate in a health home program.

~~(2) A ((beneficiary participating in the health home program must not be:~~

~~(a) Eligible for)) client is ineligible to receive health home services when the client has third-party coverage that provides comparable health care ((management)) services or requires administrative controls that ((would duplicate or interfere with)) duplicates services provided by the agency's health home program((; or~~

~~(b) Receiving services through another health system that health home services would duplicate)).~~

~~(3) Using ((data)) information provided by the department of social and health services (DSHS), the agency identifies ((beneficiaries)) clients who are ((potential participants of)) eligible for health home services.~~

~~((a) Beneficiaries who are)) (4) When the agency determines a client is eligible for health home~~((s will be enrolled with a qualified health home; and~~~~

~~(b)) services, the agency enrolls the client with a qualified health home in the coverage area where the client lives.~~

~~(a) The client may decline ((enrollment)) health home services or change to a different ((plan if he or she chooses to.~~

~~(4) A beneficiary who meets the participation requirements in this section will:~~

~~(a) Receive services from a qualified health home that contracts with the agency to provide health home services in the coverage area in which the beneficiary resides;~~

~~(b) Work with a care coordinator employed by or contracting with a qualified health home provider to)) qualified health home or a different health home care coordinator.~~

~~(b) If the client accepts enrollment in the health home program, a health home care coordinator will:~~

~~(i) Work with the participant to develop a health action plan that ((details)) describes the ((beneficiary's)) participant's health goals and includes a plan for ((achievement of)) reaching those goals; and~~

~~((c) Receive additional)) (ii) Provide health home services at a level appropriate to the ((beneficiary's)) participant's needs.~~

~~(5) A participant who does not agree with a decision regarding health home services, including a decision regarding the ((beneficiary's)) client's eligibility to ((participate in)) receive health~~

home services, has the right to an administrative hearing as described in chapter 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-12-002, filed 5/22/13, effective 7/1/13)

WAC 182-557-0300 Health home services—Confidentiality and data sharing. (1) Qualified health homes (~~((contractors))~~) must comply with the confidentiality and data sharing requirements that apply to (~~((clients))~~) participants eligible under medicare and Title XIX medicaid programs and as specified in the health home contract.

(2) The agency and the department of social and health services (DSHS) share health care data with qualified health homes (~~((contractors))~~) under the provisions of RCW 70.02.050 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(3) The agency requires qualified health homes (~~((contractors))~~) to monitor and evaluate participant activities and report to the agency as required by the health home contract.

NEW SECTION

WAC 182-557-0350 Health home—Grievance and appeals. (1) Qualified health homes must have a grievance and appeals process in place that complies with the requirements of this section and must maintain records of all grievances and appeals.

(a) This section contains information about the grievance system for fee-for-service clients, including full dual eligible clients, for health home services. These participants must follow the process in chapter 182-526 WAC for appeals.

(b) Participants who are enrolled in an agency-contracted managed care organization must follow the process in WAC 182-538-110 to file a grievance or an appeal for health home services.

(2) Grievance process.

(a) Only a participant or the participant's authorized representative may file a grievance with the qualified health home orally or in writing. A health home care coordinator may not file a grievance for the participant unless the participant gives the health home care coordinator written consent to act on the participant's behalf.

(b) The qualified health home must:

(i) Accept, document, record, and process grievances that it receives from the participant, the participant's representative, or the agency;

(ii) Acknowledge receipt of each grievance, either orally or in writing, within two business days of receiving the grievance;

(iii) Assist the participant with all grievance processes;

(iv) Cooperate with any representative authorized in writing by the participant;

(v) Ensure that decision makers on grievances were not involved in previous levels of review or decision making for the grievance;

(vi) Consider all information submitted by the participant or the participant's authorized representative;

(vii) Investigate and resolve all grievances;

(viii) Complete the disposition of a grievance and notice to the affected parties as quickly as the participant's health condition requires, but no later than forty-five calendar days from receipt of the grievance;

(ix) Notify the participant, either orally or in writing, of the disposition of grievances within five business days of determination. Notification must be in writing if the grievance is related to a quality of care issue.

(3) **Appeal process.**

(a) The qualified health home must give the participant written notice of an action.

(b) The written notice must:

(i) State what action the qualified health home intends to take and the effective date of the action;

(ii) Explain the specific facts and reasons for the decision to take the intended action;

(iii) Explain the specific rule or rules that support the decision, or the specific change in federal or state law that requires the action;

(iv) Explain the participant's right to appeal the action according to chapter 182-526 WAC;

(v) State that the participant must request a hearing within ninety calendar days from the date that the notice of action is mailed.

(c) The qualified health home must send the written notice to the participant no later than ten days before the date of action. The written notice may be sent by the qualified health home no later than the date of the action it describes only if:

(i) The qualified health home has factual information confirming the death of a participant; or

(ii) The qualified health home receives a written statement signed by a participant that:

(A) The participant no longer wishes to receive health home services; or

(B) Provides information that requires termination or reduction of health home services and which indicates that the participant understands that supplying the information will result in health home services being ended or reduced.

(d) A health home care coordinator may not file an appeal for the participant.

(e) If the agency receives a request to appeal an action of the qualified health home, the agency will provide the qualified health home notice of the request.

(f) The agency will process the participant's appeal in accordance with chapter 182-526 WAC.

(g) Continued coverage. If a participant appeals an action by a qualified health home, the participant's health home services will continue consistent with WAC 182-504-0130.

(h) If the participant requests a hearing, the qualified health home must provide to the agency and the participant, upon request, and within three working days, all documentation related to the appeal.

(i) The qualified health home is an independent party and is responsible for its own representation in any administrative hearing, subsequent review process, and judicial proceedings.

(j) If a final order, as defined in WAC 182-526-0010, requires a qualified health home to provide the participant health home services that were not provided while the appeal was pending, the qualified health home must authorize or provide the participant those health home services promptly. A qualified health home cannot seek further review of a final order issued in a participant's administrative appeal of an action taken by the qualified health home.

AMENDATORY SECTION (Amending WSR 13-12-002, filed 5/22/13, effective 7/1/13)

WAC 182-557-0400 Health home—Payment. Only an agency-contracted qualified health home may bill and be paid for providing health home services described in this chapter. Billing requirements and payment methodology are described in the contract between the agency and the (~~contractor~~) qualified health home.