

Exhibit C - Health Home Provider Qualification and Standards

The Health Home program is the central point for directing person-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency department visits; providing timely post discharge follow-up, and improving Beneficiary outcomes by addressing primary medical, specialist, behavioral health, and long-term services and supports (LTSS) through direct provision and contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes the following services that must be provided by designated Health Home providers:

1. Comprehensive care management
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of Health Information Technology (HIT) to link services, as feasible and appropriate.

Health Home Care Coordinators qualified to provide the Health Home Services -must complete a two-day training class before working with Beneficiaries to complete Health Action Plans. "Health Home Care Coordinator" means an individual employed by the Contractor or a Care Coordination Organization who provides or oversees Health Home Services. Services must be provided through face to face, telephonic and electronic contact delivered or overseen by trained and qualified professional staff.

I. General Qualifications

1. Health Home must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements.
2. Lead Entities, will be accountable for administration of the Health Home program. The lead entity must have a NPI on file in the ProviderOne payment system. If the lead entity also wishes to serve as a Care Coordination Organization (CCO) by using employed Health Home Care Coordinators, the CCO must also have a NPI with a Taxonomy code of 251B00000X.
3. Have the ability to collect and submit service encounters, disburse payments, subcontract with CCOs, monitor CCO performance, and report data to HCA.
4. Provide access to multidisciplinary teams of health care professionals that can address the full breadth of clinical and social service expertise for Beneficiaries who require assistance due to complex chronic conditions, mental health and substance use disorder issues, and long-term services and supports (LTSS). Additional members of the multidisciplinary teams may be primary care providers, mental health professionals, chemical dependency treatment providers, and social workers. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.
5. Provide care coordination and integration of health care services to all Health Home Beneficiaries through an assigned Care Coordinator who has access to a multidisciplinary team when necessary for care integration.
6. Subcontracts are in place with Health Home CCOs prior to the first request for reimbursement when partnerships involve a financial arrangement.
7. Remain responsible for all Health Home program requirements, including services performed by any subcontractor.
8. Health Home interventions must be targeted to eligible Beneficiaries and supported through assignment of a Health Home Care Coordinator who demonstrates the ability to:
 - a. Actively engage the Beneficiary in developing a Health Action Plan (HAP) provided in-person and at the Beneficiary's home, unless the Beneficiary requests another location;

- b. Reinforce and support the Beneficiary's HAP;
 - c. Coordinate with authorizing and prescribing providers as necessary to reinforce and support the Beneficiary's health goals;
 - d. Advocate, educate, and support the Beneficiary to attain and improve self-management skills;
 - e. Support Beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and
 - f. Accompany the Beneficiary to appointments when needed.
9. The Beneficiary's HAP is under the direction of a Health Home Care Coordinator who is accountable for facilitating access to medical, behavioral health care, LTSS and community social supports, and coordinating with entities that authorize these services as necessary to support the achievement of individualized health action goals.
 10. Assure hospitals have procedures in place for transitioning care and referring Beneficiaries who seek or need treatment in a hospital emergency department to the Beneficiary's Qualified Health Home.
 11. Have a notification system in place with hospitals, nursing homes, and residential/rehabilitation facilities in their network to provide 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.

II. Comprehensive or Intensive Care Management

Policies, procedures and data collection systems must be in place to create, document, execute and update an individualized, person-centered HAP for each Beneficiary.

Most comprehensive care management services should be delivered in-person with periodic follow-up by phone. This includes the ability to accompany Beneficiaries to health care provider appointments, as needed.

Health Home Care Coordinators assess Beneficiary readiness for self-management, promote self-management skills so the Beneficiary is better able to engage with health and service providers, and support the achievement of individualized health goals designed to attain recovery, improve function or health status or prevent or slow declines in functioning.

The Health Home Care Coordinator will help the Beneficiary develop a HAP which will be accessible to the Beneficiary, all Health Home team members, the Beneficiary's providers, and family/caregivers, with a consent to release form signed and in place.

The Beneficiary's HAP or care management case file shall provide evidence of:

1. A comprehensive and culturally appropriate HAP completed within 90 days of enrollment in the Health Home program. The HAP includes the Beneficiary's chronic conditions, gaps in care, activation level¹, and opportunities for potentially avoidable emergency department, inpatient hospital, and institutional use.
2. Recorded scores for mandatory and, when applicable, optional screenings that are appropriate to the age and health of the Beneficiary and referral to services.
3. The Beneficiary's activation level using the Patient Activation Measure (PAM ®) tool or when appropriate the Caregiver Activation Measure or Parent Patient Activation Measure; the Beneficiary shall be reassessed every four (4) month cycle while receiving Health Home services.
4. Active engagement of the Beneficiary in goal setting, defining interventions and establishing the timeframes for goal achievement identified in the Beneficiary's HAP. Beneficiaries and their designees play a central and active role in the development, implementation and monitoring of their HAP. An individualized HAP shall reflect Beneficiary and family preferences, education and support for self-management and other resources as appropriate.

5. Interventions that are evidence-based and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices.
6. Use of peer supports, support groups and self-care programs to increase the Beneficiary's knowledge about their health conditions and improve adherence to prescribed treatment.
7. Routine and periodic health reassessment, at minimum, in four (4) month cycles to include a reassessment of the level of Health Home services required to help the Beneficiary meet clinical and person-centered health action goals. Changes are made to the HAP based upon changes in Beneficiary need or preferences.
8. Access to and retention of needed health care and community services and resources.

III. Care Coordination and Health Promotion

The Health Home Care Coordinator shall play a central and active role in the development and execution of a multidisciplinary HAP of care including assisting the Beneficiary to access needed services. The Health Home Care Coordinator shall assure communication is fostered between the providers of care including the multidisciplinary team, the treating primary care provider, medical specialists and entities authorizing behavioral health services and LTSS.

The Beneficiary HAP or care management case file shall provide evidence of:

1. Outreach and engagement activities that support the Beneficiary's participation in their care and promote continuity of care.
2. Health education and coaching designed to assist Beneficiaries to increase self-management skills and improve health outcomes.
3. Communication between the Health Home Care Coordinator and the treating/authorizing entities and assurance that the Health Home Care Coordinator can discuss with these entities on an as needed basis, changes in Beneficiary circumstances, condition, or HAP that may necessitate changes in treatment or service need.
4. Care coordination and collaboration through case review meetings as needed, including members of Beneficiary's identified multidisciplinary team.
5. Assistance to secure appointments for Health Home Beneficiaries to medical, behavioral health, and LTSS providers to avoid unnecessary, inappropriate utilization of emergency department, inpatient hospital and institutional services.
6. Wellness and prevention education specific to the Beneficiary's chronic conditions, HAP, including 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 prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services based on individual needs and preferences.
7. Policies, procedures, and accountabilities (contractual or memos of understanding/agreements) to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, LTSS, and community based organizations.

IV. Comprehensive Transitional Care

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 HAP or care management case file shall provide evidence of:

1. Release of information to allow sharing of information that facilitates coordination of and transitions in care, as agreed to by the Beneficiary.
2. The use of a Health Home Care Coordinator as an active participant in all appropriate phases of care transition, including discharge planning, visits during hospitalizations or nursing home stays, post hospital/institutional stay home visits and telephone calls.
3. Beneficiary education that supports discharge care needs for medication management, follow-up appointments and self-management of chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers when requested by the Beneficiary.
4. Documentation of timely access to follow-up care post discharge, and to identify and re-engage Beneficiaries that do not receive post discharge care.

V. Individual and Family Support Services (including authorized representatives and identified decision makers)

The Health Home Lead Entity and 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 Lead Entities and care coordinators 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 Beneficiary's HAP or care management case file shall:

1. Identify and refer to resources that support the Beneficiary in attaining the highest level of health and functioning in the community, including transportation to medically necessary services and housing when needed.
2. Identify the roles of formal and informal supports, including direct care providers of LTSS, whom the Beneficiary has given consent to assist them in achieving health action goals.
3. Reflect and incorporate the preferences, education about and support for self-management and other resources necessary for the Beneficiary, their family and their caregiver to support the Beneficiary's individualized health action goals.
4. Identify the role that families, informal supports and caregivers provide to achieve self-management and optimal levels of physical and cognitive function.
5. Demonstrate a discussion of advance directives with Beneficiaries and their families.
6. Demonstrate communication and information sharing with Beneficiaries, their families, and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

VI. Referral to Community and Social Support Services

The Health Home Lead Entity and 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. Community and social support services may include LTSS, mental health, substance use disorder, and other community and social services accessed by the Beneficiary.

The Beneficiary's HAP and care management case file shall:

1. Identify available community-based resources discussed with the Beneficiary and actively manage appropriate referrals, advocates for access to care and services, provides coaching to Beneficiaries to engage in self-care, and follow-up with required services.
2. Provide 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.
3. Have policies, procedures, and accountabilities (through contractual or memos of understanding/agreements) to support effective collaboration with community based resources, which clearly define roles and responsibilities.
4. Provide documentation of referrals to and access by the Beneficiary of community based and other social support services as well as health care services that contribute to achieving the Beneficiary's health action goals.

VII. Use of Health Information Technology to Link Services

Health Home Lead Entities and CCOs will make use of available health information technology (HIT) and access data through the Predictive Risk Intelligence System (PRISM), Apple Health managed care organizations or fee-for-service systems, and other processes as feasible as the state develops Electronic Medical Record standards for Medicaid providers.

The Health Home infrastructure shall:

1. Use HIT to identify and support management of high risk Beneficiaries receiving Health Home services.
2. Use conferencing tools to support case conferences/team based care, including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).
3. Use a system to track and share Beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address Beneficiary need and preferences.
4. Use web-based HIT registries and referral tracking systems.
5. Develop a system with hospitals, nursing homes, and residential/rehabilitation facilities to provide the Health Home prompt notification of a Beneficiary's admission and/or discharge from an emergency department or inpatient stay.
6. Develop the systems required to support HIPAA compliant electronic transactions to accept enrollment and submit encounter data to the state's ProviderOne Medicaid Management Information System.
7. Obtain a standard contract with OneHealthPort to submit and process Health Action Plan data for each Beneficiary.

VIII. Quality Measures Reporting to State

Health Homes Lead Entities must demonstrate the ability to provide project management and oversight through their data, data sources, and management systems when monitoring the Health Home delivery system. Lead Entities must demonstrate the ability to collect, report, and share data with other providers, including HCA and DSHS for quality reporting purposes.

IX. Health Home Provider Functional Requirements (SMD 10-024)

Health Home providers must demonstrate their ability to perform each of the following federally-required functions, including documentation of the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted Health Home service interventions that will

be provided to promote patient engagement, participation in their plan of care and that ensure patients appropriate access to the continuum of physical and behavioral health care and social service needs.

1. Provide quality-driven, cost-effective, person and family centered Health Home services with cultural humility.
2. Coordinate and provide access to high-quality health care services using 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 healthcare 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.