

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | WA2020MS00020 | WA-20-0031 | Washington State Health Home Program

Package Header

Package ID	WA2020MS00020	SPA ID	WA-20-0031
Submission Type	Official	Initial Submission Date	9/30/2020
Approval Date	11/20/2020	Effective Date	7/1/2020
Superseded SPA ID	WA-18-0028		
	User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Washington State Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Washington's original Health Homes SPAs were WA 13-0008 (approved June 28, 2013) and WA 13-17 (approved December 11, 2013). WA 15-0011 (approved June 11, 2015) superseded both of these SPAs. SPA 16-006 (approved March 31, 2017) superseded 15-0011, added a 20% performance incentive payment to increase beneficiary engagement rates, and expanded the Health Home program statewide, adding King and Snohomish counties. SPA WA 18-0028 supersedes WA 16-0026, adds a 20% rate increase, and reduces the performance incentive payment to 5%. SPA WA 20-0031 supersedes WA 18-0028: This SPA adds updated payment methodology based on actuarial analysis completed in June 2020 and will end the incentive payment December 31, 2020. These changes are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions. The state will work with CMS to revert back to the rate methodology used prior to the national public health emergency as circumstances allow. Washington State requests an effective date of July 1, 2020, for these changes. The termination date for the rate methodology will be determined by the end of the emergency declaration, including any potential extensions, while the incentive payment will expire on December 31, 2020 (before the end of the national public health emergency).

Under Washington's approach, Health Homes are the bridge to integrate care within existing delivery systems for both managed care and Fee-for-Service beneficiaries. Washington's Medicaid delivery systems are undergoing a great deal of change as the Health Care Authority (HCA) integrates physical and behavioral health services through its managed care program. As HCA phases in statewide integration, Washington's Health Home program will become more managed care focused while continuing to serve beneficiaries who remain in the Fee-for-Service delivery system, such as full-dual eligibles and American Indian/Alaska Natives.

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

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their assigned beneficiaries. Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and at risk for a 2nd chronic condition using a tool that identifies those clients expected to have high costs in the future due to all their chronic conditions.

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

Lead Entities are qualified by HCA and DSHS through both a contracting process and

General Assurances

The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

Medicaid State Plan Print View

- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Payment Methodologies

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Payment Methodology

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

<input type="checkbox"/> Fee for Service	<input type="checkbox"/> Individual Rates Per Service	<input type="checkbox"/> Fee for Service Rates based on	<input type="checkbox"/> Severity of each individual's chronic conditions
	<input type="checkbox"/> Per Member, Per Month Rates		<input type="checkbox"/> Capabilities of the team of health care professionals, designated provider, or health team
			<input type="checkbox"/> Other
			Describe below
			The Managed Fee-for-Service (MFFS) system provides HH services via community-based HH Lead organizations which pay subcontracted Care Coordination Organizations & report their claims payments to as encounter data before receiving the monthly payment.
<input type="checkbox"/> Comprehensive Methodology Included in the Plan	<input type="checkbox"/> Incentive Payment Reimbursement	<input type="checkbox"/> Fee for Service Rates based on	<input type="checkbox"/> Severity of each individual's chronic conditions
			<input type="checkbox"/> Capabilities of the team of health care professionals, designated provider, or health team
			<input type="checkbox"/> Other
			Describe below
			The Washington state legislature approved a second rate increase for the Health Home program in 2020. Through analysis rates were developed based on actual costs of the program. Based on the actuarial analysis, a 26% aggregate rate increase is required to adequately fund the continuation of the Health Home program. The increase included two components: <ul style="list-style-type: none"> • 20% increase required to

align the rates with CY 2019 expenditures.

• 3.5% annual unit cost trend used to trend rates 1.5 years from CY 2019 to SFY 2021 based on a review of inflation indicators, historical and projected Medicare trends, and trends per capita GDP.

Rates were redistributed among the tiers to realign payment rates with estimated cost allocations. The complete report on cost data and assumptions used is available online at

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

As a result, the state implemented new rates for each tier effective July 1, 2020.

These rates are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions.

The 5% incentive payment established in August 2018 will continue through December 31, 2020. Lead Organizations will continue to be eligible to receive the incentive payment through December 2020 for meeting an engagement standard.

To receive the incentive payment each quarter, HCA produces a report of the total number of enrolled beneficiaries (denominator) with the total number of accepted encounters (numerator) to determine the engagement rate of the Health Home Leads. In order to receive the 5% incentive payment in addition to the regular encounter payments, Leads must meet the engagement rate.

To receive the incentive payment each quarter, HCA produces a report of the total number of enrolled beneficiaries (denominator) with the total number of accepted encounters (numerator) to determine the engagement rate of the Health Home Leads. In order to receive the 5% incentive payment in addition to the regular encounter payments, Leads must meet the engagement rate.

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

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

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

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

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

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

CCM (description included in Service Delivery section)

Risk Based Managed Care (description included in Service Delivery section)

Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Tiered Rates based on

Severity of each individual's chronic conditions

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

Other

Describe below

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

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

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

- Tier 1 (G9148) - initial engagement and action planning
- Tier 2 (G9149) - intensive level of care coordination
- Tier 3 (G9150) - low level of care coordination

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

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

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

The Tier Level of the client is intended to reflect the overall level of:
 1. Engagement and activation level of the client and/or their caregivers

2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home Services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

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

Qualifying Health Home Services Include:

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

Examples:

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

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

Examples:

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

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

Examples:

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

- o Review and verify medication reconciliation post discharge is completed

- Individual and Family Supports: Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.
Examples:
 - o Provide education and support of self-advocacy including referral to Peer Support specialists
 - o Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
 - o Educate client, family or caregivers of advance directives, client rights, and health care issues
 - o Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences

- Referral to Community and Social Supports: The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.
Examples:
 - o Identify, refer and facilitate access to relevant community and social services that support the client's HAP
 - o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
 - o Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services

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

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

Tier One:
* Minimum Contact:
>Contact is made with the client to arrange a face to face meeting to confirm the client's desire to participate in the Health Home Program.
>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.
* Activity Examples:
>Review PRISM and other available client records.
>Administer required screenings.
Administer optional screenings as needed.
>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).
>Establish a follow up plan with the client.
>Submit Tier One Claim for payment with date of service when the HAP has been completed.

Tier Two - Intensive Health Home care coordination:
* Minimum Contact:
>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.
>Exceptions can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.
>Exceptions can be approved to monthly care coordinator's face-to-

face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.

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

* Activity Examples:

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

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

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

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

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

>Medication reconciliation as part of care transitioning.

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

Tier Three - Low level Health Home care coordination:

* Minimum Contact:

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

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

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

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

* Activity Examples:

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

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

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

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Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2020

Website where rates are displayed

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

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description 1. The Washington state legislature approved a second rate increase for the Health Home program in 2020. Through analysis rates were developed based on actual costs of the program. Based on the actuarial analysis, a 26% aggregate rate increase is required to adequately fund the continuation of the Health Home program. The increase included two components:

- 20% increase required to align the rates with CY 2019 expenditures.
- 3.5% annual unit cost trend used to trend rates 1.5 years from CY 2019 to SFY 2021 based on a review of inflation indicators, historical and projected Medicare trends, and trends per capita GDP.

Rates were redistributed among the tiers to realign payment rates with estimated cost allocations. The complete report on cost data and assumptions used is available online at <https://hca.wa.gov/assets/billers-and-providers/HH-CareCoordinationRates.pdf>.

As a result, the state implemented new rates for each tier effective July 1, 2020. These rates are being requested during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof). The revised rate methodology is different than what is otherwise applied under the Medicaid state plan for use during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) and is time limited to no later than the termination of the national public health emergency, including any extensions. The 5% incentive payment established in August 2018 will continue through December 31, 2020. Lead Organizations will continue to be eligible to receive the incentive payment through December 2020 for meeting an engagement standard.

To receive the incentive payment each quarter, HCA produces a report of the total number of enrolled beneficiaries (denominator) with the total number of accepted encounters (numerator) to determine the engagement rate of the Health Home Leads. In order to receive the 5% incentive payment in addition to the regular encounter payments, Leads must meet the engagement rate.

Washington State has three payment tiers with specific HCPCS procedure codes defining the level of Health Home care coordination service provided. All three tiers have a combination of clinical and non-clinical staffing elements. The procedure code submitted for payment reflects the overall level of the beneficiary's engagement and activation level; activity in the Health Action Plan; provision of at least one of the six defined Health Home services; and frequency of contacts.

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

Tier Two (G9149) is for on-going, face-to-face and telephonic visits by exception with the beneficiary to provide one or more of the six Health Home services.

Tier Three (G9150) is low level care coordination for beneficiaries who request less contact or fewer face-to-face visits or have achieved a level of self-management their chronic conditions where intensive care coordination is no longer needed.

Tier One is paid once in a beneficiary's lifetime in the program and is submitted once the initial Health Action Plan is completed. Tiers Two and Three are submitted subsequent months after the Tier One and only one encounter (tier) is accepted per beneficiary per month.

2. Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. HAPs are reviewed against Tier One encounters to ensure payment has been made for a completed HAP. HAPs are updated every activity period, which consists of four months or more frequently if there has been a change in circumstances. HAPs are also updated when short and long-term goals have been completed and the beneficiary sets new goals.

Washington requires all Health Home providers to document the Health Home services provided in their

subcontracts with Care Coordination Organizations (CCOs). Annually, during contract compliance reviews, the state audits HAPs, care management records, and notes.

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

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Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

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

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

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

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

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

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

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created
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No items available