
Table of Contents

State/Territory Name: Washington

State Plan Amendment (SPA) #: 16-0026

This file contains the following documents in the order listed:

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

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



Division of Medicaid & Children's Health Operations

March 30, 2017

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 16-0026

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA), Transmittal Number 16-0026, Washington State Health Home Program. This SPA adds King and Snohomish Counties to Washington's Health Home Program, as authorized under Section 2703 of the Patient Protection and Affordable Care Act (1945 of the Social Security Act). Individuals eligible to receive health home services include Medicaid participants who have one chronic condition and are at risk of developing another. The chronic conditions are specified in the SPA and include:

- Mental Health Condition;
- Substance Abuse Disorder;
- 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; and
- Gastrointestinal, hematological, and musculoskeletal conditions.

This SPA is approved effective April 1, 2017. Enclosed is a copy of the approved pages for incorporation into the Washington State Plan.

In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers in King and Snohomish Counties under this amendment, during the first eight fiscal quarters that the SPA is in effect, April 1, 2017, through March 31, 2019, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate April 1, 2019. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures for enrollees with chronic conditions.

If there are additional questions please feel free to contact me, or your staff may contact Kendra Sippel-Theodore at kendra.sippel-theodore@cms.hhs.gov or (206) 615-2065.

Sincerely,

Digitally signed by David L.

A large black rectangular box redacting the signature of David L. Meacham.

David L. Meacham
Associate Regional Administrator

Enclosure

cc:

Ann Myers, HCA
Agnes Ericson, HCA
Alice Lind, HCA

Attachment 3.1-H

Submission - Summary

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name Washington

Medicaid Agency Name Health Care Authority

Submission Component

☒ State Plan Amendment

☒ Medicaid

☐ CHIP

Submission Type

☒ Official Submission Package

☐ Draft Submission Package

Allow this official package to be viewable by other states?

☒ Yes

☐ No

Key Contacts

Name	Title	Phone Number	Email Address
Robbins, Alison	Managed Care Section Manager		
Myers, Ann	Rules & Publications Section Manager		
McAninch-Dake, Becky	Grants & Program Development Supervisor		

SPA ID and Effective Date

SPA ID WA-16-0026

Reviewable Unit	Proposed Effective Date
Health Homes Intro	4/1/2017
Health Homes Population and Enrollment Criteria	4/1/2017
Health Homes Geographic Limitations	4/1/2017
Health Homes Services	4/1/2017
Health Homes Providers	4/1/2017

TN: WA-16-0026
Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

Reviewable Unit	Proposed Effective Date
Health Homes Service Delivery Systems	4/1/2017
Health Homes Payment Methodologies	4/1/2017
Health Homes Monitoring, Quality Measurement and Evaluation	4/1/2017

Executive Summary

Summary Description Including Goals and Objectives Under Washington's approach, Health Homes are the bridge to integrate care within existing care systems. A Health Home directs 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 mobilizing and coordinating services provided by primary care providers, specialists, behavioral health providers, and long-term services and support providers. Care Coordinators are embedded in community-based settings to effectively manage the full breadth of beneficiaries' needs. SPA WA 16-0026 adds King and Snohomish counties to the State's Health Home program.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

Disaster-Related Submission

This submission is related to a disaster

- ☐ Yes
☒ No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2017	\$621,373.00
Second	2018	\$2,613,041.00

Federal Statute / Regulation Citation
Affordable Care Act, Section 2703, Section 1945

Governor's Office Review

- ☐ No comment
☐ Comments received
☐ No response within 45 days
☒ Other

Describe Exempt

Authorized Submitter

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter

Title None

Phone number

Email address

Authorized Submitter's Signature

Attachment 3.1-H

☒ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Attachment 3.1-H

Submission - Medicaid State Plan

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	N/A
Superseded SPA ID	N/A		

Submission - Medicaid State Plan

The submission includes the following

☒ Benefits☒ Health Homes Program

- ☒ Create new Health Homes program
- ☐ Amend existing Health Homes program
- ☐ Terminate existing Health Homes program
- ☐ Copy from existing Health Homes program
- ☐ Create new program from blank form

Name of Health Homes Program Washington State Health Home Program

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Attachment 3.1-H

Submission - Public Comment

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID WA2016MH00010

SPA ID WA-16-0026

Submission Type Official - Review 2

Initial Submission Date 12/20/2016

Approval Date 3/30/2017

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program Washington State Health Home Program

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

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

Indicate how the public notice was issued and public comment was solicited

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting
- ☒ Other method

Name of method	Date	Description
Publication in Washington State Register per 42 CFR 442.205(d)(1)	9/21/2016	Contracted Health Home services providers will be paid a monthly encounter rate for Fee-for-Service participating beneficiaries. Payment for eligible managed care beneficiaries is built into the Apple Health managed care organizations' capitation rate and no additional payment is made for their contractually required Health Homes.

Upload copies of public notices and other documents used

Name	Date Created	Type
16-0026 Health Homes Public Notice (2)	8/24/2016 4:38 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access

TN: WA-16-0026

Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Attachment 3.1-H

Submission - Tribal Input

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	N/A
Superseded SPA ID	N/A		
Name of Health Homes Program Washington State Health Home Program			

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

☒ Yes ☐ No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

☒ Yes ☐ No

☒ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

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

Tribal consultation was conducted in the following manner

☒ Indian Health Programs

Name of Program	Date of consultation:	Method/Location of consultation:
All Indian Health Programs	6/20/2016	Tribes did not request tribal consultation

☒ Urban Indian Organizations

Name of Organization	Date of consultation:	Method/Location of consultation:
All Urban Indian Organizations	6/20/2016	Tribes did not request tribal consultation

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☒ Indian Tribes

Name of Tribe	Date of consultation:	Method/Location of consultation:
All Indian Tribes	6/20/2016	Tribes did not request tribal consultation

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	Type
	6/24/2016 12:14 PM EDT	

TN: WA-16-0026
Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

Name	Date Created	Type
16-0026_HealthHomesExpansionTribalLetter		

Indicate the key issues raised (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Attachment 3.1-H

Submission - SAMHSA Consultation

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	N/A
Superseded SPA ID	N/A		
Name of Health Homes Program	Washington State Health Home Program		

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

Date of consultation

7/6/2012

11/8/2012

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Attachment 3.1-H

Health Homes Intro

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

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Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

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). SPA WA 15-0011 (approved June 11, 2015) superseded both of these SPAs; this SPA 16-0026 supersedes 15-0011.

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 Qualified Fee-for-Service Health Home Lead Entity (designated provider) or notifies the Qualified Managed Care Health Home Lead Entity (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 a Request for Application (RFA) process. Contracting is used if a Lead Entity has already been qualified through the RFA process and wants to broaden their Health Home service areas to other counties, while the RFA process is used to solicit new Lead Entities when adding counties that are not part of the Health Home program.

Health home services are composed of the six required Health Home services, with each individual service further defined by embedded activities which make up the composition of the service.

General Assurances

- ☒ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☒ The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☒ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☒ The state provides assurance that 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.

TN: WA-16-0026
Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

- ☒ 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.

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Attachment 3.1-H

Health Homes Population and Enrollment Criteria

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
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Categories of Individuals and Populations Provided Health Homes Services

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

- ☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- ☐ Medically Needy Eligibility Groups

Population Criteria

The state elects to offer Health Homes services to individuals with

- ☐ Two or more chronic conditions
- ☒ One chronic condition and the risk of developing another

Specify the conditions included

- ☒ Mental Health Condition
- ☒ Substance Use Disorder
- ☒ Asthma
- ☒ Diabetes
- ☒ Heart Disease
- ☐ BMI over 25
- ☒ Other (specify)

Name	Description
cancer	As defined by UC San Diego CDPS and Medicaid RX disease categories.
cerebrovascular disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
coronary artery disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
dementia or Alzheimer's disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
intellectual disability or disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
hematological and musculoskeletal conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
HIV/AIDS	As defined by UC San Diego CDPS and Medicaid RX disease categories.
renal failure	As defined by UC San Diego CDPS and Medicaid RX disease categories.

Attachment 3.1-H

Name	Description
chronic respiratory conditions	As defined by UC San Diego CDPS and Medicaid RX disease categories.
neurological disease	As defined by UC San Diego CDPS and Medicaid RX disease categories.
gastrointestinal	As defined by UC San Diego CDPS and Medicaid RX disease categories.

1-11 of 11

Specify the criteria for at risk of developing another chronic condition

At-risk for a second condition is a minimum predictive risk score of 1.5, meaning a beneficiary's expected future medical expenditures is expected to be 50% greater than the base reference group (the Washington SSI-disabled population). The Washington risk score is based on the Chronic Illness & Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California-San Diego, with risk weights normalized for the Washington Medicaid population. Diagnoses, prescriptions, age and gender indicated in a beneficiary's medical claims and eligibility history for the past 15 months (24 months for children) are produce a risk score, with chronic conditions checked across all categorically needy populations, and a clinical indicator (Y=qualifies, N=does not qualify) is loaded into Washington's Medicaid Management System (MMIS).

Potentially eligible beneficiaries with insufficient claims history may be referred to the program by contacting HCA. A tool has been developed to manually calculate risk. This tool is on the Health Home website and distributed to the Lead Entities. Once a provider has determined a potentially beneficiary is eligible by manually calculating their risk, that information is sent to HCA for further analysis. If the beneficiary is eligible, they will be enrolled into a Health Home.

☐ One serious and persistent mental health condition

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ☐ Opt-In to Health Homes provider
☒ Referral and assignment to Health Homes provider with opt-out
☐ Other (describe)

Describe the process used

The state identifies Fee-for-Service beneficiaries who are eligible for the Health Home program based on their chronic condition and risk score, then enrolls them into a Qualified Fee-for-Service Lead Entity/Designated Provider. Enrollment is based on zip code, amount of available beneficiaries within each zip code, and capacity to provide Health Home services. The Lead Entity assigns Health Home beneficiaries to one of their network affiliated Care Coordination Organizations (CCO), who, in turn, assigns the beneficiary to a Care Coordinator. Beneficiaries have the ability to opt out of the assigned Health Home or change enrollment to another Health Home provider within the Health Home network. Eligible beneficiaries who opt out of participation and retain their 1.5 or higher risk score have the option of re-enrolling the Health Home program at any time by contacting HCA's customer service line.

Managed care beneficiaries are auto-enrolled into a Medicaid managed care organization (MCO). The state identifies MCO beneficiaries who are eligible for Health Homes based upon their chronic condition and risk score and sends the information to their MCO. MCOs that are qualified to be Lead Entities, assign their Health Home beneficiaries to one of their network-affiliated Care Coordination Organizations (CCOs), who, in turn, assign the beneficiary to a Care Coordinator. MCOs that are not qualified as a Lead Entity/designated provider must delegate Health Home services to a qualified Lead Entity and assign their eligible/identified beneficiaries to their delegated Lead Entity. The delegated Lead Entity, in turn, will assign the beneficiary to one of their network affiliated CCOs and a Care Coordinator. Beneficiaries have the ability to opt-out of the Health Home or change enrollment to another MCO or subcontracted Health Home CCO within the Health Home program.

Beneficiaries lose Health Home eligibility when their risk score has dropped below 1.0 for six continual months and have not been participating or engaged in the program during those six months. Beneficiaries who are participating and engaged do not lose eligibility if their risk scores drops below 1.0.

☒ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
22-851 613	6/24/2016 12:49 PM EDT	

Attachment 3.1-H

Name	Date Created	Type
Final Beneficiary Letter Managed FFS - English	6/24/2016 12:50 PM EDT	

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Health Homes Geographic Limitations

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID WA2016MH00010

SPA ID WA-16-0026

Submission Type Official - Review 2

Initial Submission Date 12/20/2016

Approval Date 3/30/2017

Effective Date 4/1/2017

Superseded SPA ID N/A

- ☐ Health Homes services will be available statewide
- ☐ Health Homes services will be limited to the following geographic areas
- ☒ Health Homes services will be provided in a geographic phased-in approach

Phase 1

Title of phase

Phase 1

Implementation Date

7/1/2013

Phase-in will be done by the following geographic area

By county

Specify which counties

1. Asotin
2. Benton
3. Clark
4. Columbia
5. Cowlitz
6. Franklin
7. Garfield
8. Kittitas
9. Klickitat
10. Pierce
11. Skamania
12. Wahkiakum
13. Walla Walla
14. Yakima

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

Phase One: The first 14 counties were phased in beginning July 1, 2013 through two Requests for Application (RFA). HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and their responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	Type
No items available		

Phase 2

Title of phase

Phase 2

Implementation Date

10/1/2013

TN: WA-16-0026

Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

Phase-in will be done by the following geographic area

By county

Specify which counties

1. Adams
2. Chelan
3. Clallam
4. Douglas
5. Ferry
6. Grant
7. Grays Harbor
8. Island
9. Jefferson
10. Kitsap
11. Lewis
12. Lincoln
13. Mason
14. Okanogan
15. Pacific
16. Pend Oreille
17. San Juan
18. Skagit
19. Spokane
20. Stevens
21. Thurston
22. Whatcom
23. Whitman

Health Homes services are now available state-wide

No

Enter any additional narrative necessary to fully describe this phase

23 more counties were phased in beginning October 1, 2013 through an RFA. HCA and DSHS qualified Lead Entities according to which counties they were proposing to serve, their Care Coordination Organization network, and responses to RFA questions regarding their proposed processes to deliver Health Home services.

Name	Date Created	Type
No items available		

Phase 3**Title of phase**

Phase 3

Implementation Date

4/1/2017

Phase-in will be done by the following geographic area

By county

Specify which counties

1. King
2. Snohomish

Health Homes services are now available state-wide

Yes

Effective date of state-wide service implementation

4/1/2017

Enter any additional narrative necessary to fully describe this phase

King and Snohomish counties will be added in 4/1/2017 to make the Health Home program statewide. A combination RFA and contracting process will be used to qualify Lead Entities to provide Health Home services in King and Snohomish counties. Organizations that did not become Qualified Lead Entities during Phase One or Two will be required to become qualified through the third RFA. Lead Entities qualified in Phase One and Phase Two will be allowed to add King and Snohomish counties to their existing Health Home coverage areas through the contracting process by submitting their Care Coordination networks for analysis.

Note: Two RFAs were completed for the addition of King and Snohomish Counties. The first RFA 1862 did not have enough responses to support the implementation of the Health Home program in King County. A second RFA was done (RFA 1992) in December 2016 to see if other organizations were interested in becoming Qualified Lead Entities for King. As of the submittal of this SPA, the results have not been finalized yet.

Name	Date Created	Type
No items available		

Attachment 3.1-H

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Attachment 3.1-H

Health Homes Services

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

Service Definitions

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

Comprehensive Care Management

Definition

Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include screening to assess gaps in care or establish baseline results, in-person visits to the beneficiary's home or location of their choice, and accompanying beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals to attain recovery, improve functional or health status or prevent or slow declines in functioning. Comprehensive care management service delivery uses the Health Action Plan (HAP) to document a beneficiary directed care management plan. The HAP is created during a face-to-face initial visit with the beneficiary, and is updated periodically on a four month cycle, as well as when there are changes in beneficiary circumstances such as hospitalization or emergency department visits. The results of screenings and assessments are documented in the HAP and used to identify gaps in care and chart the beneficiary's progress towards meeting their short and long-term goals through active Health Home participation.

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

Care Coordinators may conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes. This may also be done by allied or affiliated staff under the direction of the Care Coordinator.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Home Lead Entities will have access to the Medicaid Management Information System called ProviderOne (P1) and the DSHS Predictive Risk Intelligence System (PRISM). Authorizers and providers of long-term services and supports have access to DSHS's Comprehensive Assessment and Reporting Evaluation (CARE) data either electronically or in paper form. Most elements of CARE are also contained in PRISM. Data sharing agreements and Release of Information consent forms will be maintained by all Health Home Lead Entities to facilitate sharing electronic health information with their Health Home network affiliates.

1. DSHS is responsible for maintenance and updates to PRISM and reporting loss of eligibility on a monthly basis.
2. ProviderOne contains Medicaid eligibility, loss of eligibility, MCO and Health Home enrollment, disenrollment, claims, per member per month (PMPM) payment to MCOs, FFS payment for Health Home services for FFS Lead Entities, and the collection and reporting of encounter data.
3. Emergency Department Information Exchange (EDIE) notification provides Medicaid claims data to ED physicians. EDIE is HIPAA compliant and can proactively alert care providers when high utilizing patients enter the ED through a variety of methods such as fax, phone, email, or integration with a facility's current EMR. Once notified, care providers can use EDIE to access care guidelines and crucial information on the patient from other participating facilities to better determine the patient's actual medical situation.
4. PreManage is information exchange system that alerts providers when their beneficiary is accessing inpatient hospital services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American

Attachment 3.1-H

Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.

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

d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

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

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCRSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

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

☒ Nurses

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

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☐ Medical Specialists

☐ Physicians

Attachment 3.1-H

☒ Physician's Assistants

Description

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

☐ Pharmacists

☒ Social Workers

Description

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

a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

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

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

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advanced registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation

Attachment 3.1-H

Provider Type	Description
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or affiliated staff may: 1. Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit. 2. Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.

Care Coordination

Definition

The dedicated Health Home Care Coordinator and affiliated staff play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator assures communication is fostered between the providers of care, including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical support such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required Health Home services, including interventions. Allied staff, such as community health workers, peer counselors or other non-clinical staff, may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination provides informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting a beneficiary's health and health care choices. Care Coordinators and affiliated staff promote:

1. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;
2. Outreach and engagement activities that support the beneficiary's participation in their care and promotes continuity of care;
3. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
4. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM is an information technology resource that supports the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

The Health Action Plan (HAP) may be shared, with beneficiary consent, via secure email or hard copy. The HAP includes:

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

The Health Home Care Coordinator updates and modifies the HAP on a four month cycle. The HAP is also updated and modified as needed to reflect:

1. A change in the beneficiary's condition;
2. New immediate goals to be addressed through the Health Home; and
3. Resolution of goals or action steps.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

- ☐ Nurse Practitioner

- ☒ Nurse Care Coordinators

Description

Attachment 3.1-H

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- b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.
- c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.
- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

☒ Nurses
Description

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☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants
Description

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

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- a. Licensed Independent Social Worker must graduate with a MA or PhD in social work and complete a minimum of 4000 hours of supervised experience of which 1000 hours must be direct client contact, over a three-year period

Attachment 3.1-H

supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

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- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Communicate with service providers and health plans as appropriate to secure necessary care and supports; 2. Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management. 3. Advocate for services and assist with scheduling of needed services. 4. Assist and support client with scheduling medical and applicable appointments.

Health Promotion

Definition

Health promotion begins for Health Home beneficiaries with the commencement of the Health Action Plan (HAP). Each Health Home must demonstrate use of self-management, recovery and resiliency principles using beneficiary-identified supports including family members and caregivers that are paid or unpaid. The Health Home Care Coordinator will use the beneficiary's activation score and level to determine the coaching methodology appropriate for each beneficiary to be used when working with the beneficiary towards reaching their health goals. Educational materials are customized and introduced according to the beneficiary's readiness for change, progressing with the beneficiary's level of confidence and self-management abilities. Opportunities for mentoring and modeling communication with health care providers are provided through joint office visits and communications with health care providers by the beneficiary and the Health Home Care Coordinator. The Health Home provides wellness and prevention education specific to the beneficiary's chronic conditions, HAP, including assessment of need and facilitation of receipt of routine preventive care, support for improving social connections to community networks, and links to resources that support a healthier lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiary needs and preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Insignia Health is an information technology resource which provides calculation of the Patient Activation Measure (PAM)/Caregiver Activation Measures (CAM), Parent/Patient Activation Measure (PPAM) and the Coaching for Activation website. This site provides educational materials linked to a beneficiary's level of activation and can be sent electronically to a beneficiary or printed for review at a Health Home visit or by phone.

Attachment 3.1-H

The Health Home Care Coordinator is able to view the medical claims, behavioral health claims, prescription claims, and LTC services utilization and selected CARE characteristics (for those beneficiaries with long-term services and supports) in PRISM so that education materials can be tailored to the individual's engagement and activation.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting of at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
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Attachment 3.1-H

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Description

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- ☐ Pharmacists
- ☒ Social Workers

Description

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

- a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.
- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
- e. Licensed social worker associate-advanced must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the

Attachment 3.1-H

Provider Type	Description
	potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate. 2. Promote participation in community educational and support groups. 3. Provide links to health care resources that support the client's goals. 4. Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services. 5. Distribute health education and other materials. 6. Assist with follow up calls and provide appointment reminders.
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Distribute health education and other materials. 2. Assist with follow up calls and provide appointment reminders.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)**Definition**

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility to ensure proper and timely follow-up care.

The beneficiary's Health Action Plan (HAP) includes transitional care planning. Transitional care planning includes:

1. A notification system with managed care plans, hospitals, nursing homes and residential/rehabilitation facilities to provide the Health Home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting. Progress notes or a case file documents the notification and the HAP should be updated with transition planning.
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 following hospital/institutional discharge, conducted via home visits and telephone calls.
3. Beneficiary education addressing discharge care needs, including medication management, encouragement and intervention to assure follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of family and formal or informal caregivers are facilitated when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post-discharge care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Emergency Department Information Exchange (EDIE) notifications provide Medicaid claims data to ED physicians. EDIE is HIPAA-compliant. EDIE can proactively alert care providers through a variety of methods such as fax, phone, email, or integration with facility's current electronic medical record when high utilizing beneficiaries enter the ED. Once notified, care providers can use EDIE to access care guidelines and crucial information on the beneficiary from other participating facilities to better determine the beneficiary's overall medical situation.

PreManage is information exchange system alerts providers when their beneficiary is accessing inpatient hospital services.

Lead FFS Entities with access to EDIE and Pre-Manage can push real-time information on ED visits and inpatient hospital stays to their Care Coordination Organizations.

Managed care Lead Entities notify Health Home Care Coordinators of beneficiary admission to hospital and tertiary care facilities to facilitate discharge planning and care transitions. MCO Lead Entities also inform the Health Home Care Coordinators of lapses in pharmacy refills for beneficiaries with chronic conditions requiring long-term use of medications. Health Home Care Coordinators are responsible for conducting outreach activities with the beneficiary to ensure medications have been picked up and are being used according to the clinical treatment plan.

Scope of service

The service can be provided by the following provider types

Attachment 3.1-H

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting of at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner☒ Nurse Care Coordinators

Description

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

☒ Nurses

Description

- a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.
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- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

Attachment 3.1-H

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

☐ Medical Specialists

☐ Physicians

☒ Physician's Assistants

Description

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

☐ Pharmacists

☒ Social Workers

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b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

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

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

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as:

Attachment 3.1-H

Provider Type	Description
	1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Support client with connecting to community supports to ensure that needed services or equipment are received.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Individual and Family Support (which includes authorized representatives)**Definition**

The Health Home Care Coordinator recognizes the unique roles the beneficiary may assign to family, identified decision makers and caregivers in assisting them with accessing and navigating health care and social service delivery systems, as well as support health action planning.

The Health Home Care Coordinator uses peer supports, support groups, and self-management programs to increase beneficiary and caregivers' knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Health Home Care Coordinator, affiliated staff and the beneficiary:

1. Identify the role that families, informal supports and paid caregivers provide to achieve self-management and optimal levels of physical and cognitive function;
2. Educate and support self-management, self-help recovery, and other resources necessary for the beneficiary, their family, and their caregivers to support the beneficiary's individualized health action goals;
3. Discuss advance directives with beneficiaries and their families; and
4. Communicate and share information with beneficiaries and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The PRISM software application includes the PRISM Health Report for all beneficiaries. The PRISM report is provided to the beneficiary's primary care provider and any other health care providers identified by the beneficiary and authorized by a signed release of information. This includes the Health Home Care Coordinator. The report includes:

1. Beneficiary demographics
2. Last dental appointment
3. Health conditions
4. Hospital stays
5. Emergency room visits
6. Office visits and procedures in the last 180 days, used by the Care Coordinator to assess sufficient clinical oversight of the beneficiary's chronic conditions
7. Prescriptions filled in the last 90 days
8. Prescriptions by drug class in last two years

Coaching for Activation educational materials are available electronically and are printed for beneficiary and family support.

Scope of service**The service can be provided by the following provider types**

- ☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with

Attachment 3.1-H

equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

- ☐ Nurse Practitioner
- ☒ Nurse Care Coordinators

Description

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

- ☒ Nurses

Description

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- d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.
- e. Psychiatric nurses are registered nurses with a Bachelor's degree from an accredited college or university, and have, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

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

Attachment 3.1-H

- ☐ Pharmacists
- ☒ Social Workers

Description

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- c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.
- d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and declare they are working toward full licensure.
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- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Educate client, family, or caregiver advance directives, client rights, and health care issues, as needed. 2. Meet with client and family, inviting any other providers to facilitate needed interpretation services. 3. Refer client/family to peer supports, support groups, social services, entitlement programs as needed.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Referral to Community and Social Support Services**Definition**

Attachment 3.1-H

The Health Home Care Coordinator and affiliated staff identify available community based resources, actively manage referrals, assist the beneficiary in advocating for access to care, and engage with community and social supports related to goal achievement documented in the Health Action Plan. When needed and not otherwise provided through other case management systems, the Health Home Care Coordinator provides assistance in obtaining and maintaining eligibility for health care services, disability benefits, housing, personal needs and legal services. These services will be coordinated with appropriate local, state and federal governments and community based organizations. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers needed to support the beneficiary in support of health action goals.

The Health Home Care Coordinator documents referrals to and access by the beneficiary of community-based and other social support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PRISM and Insignia Health are information technology sources supporting the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, transitional support needs, clinical protocols required and current utilization of case management, medical and behavioral health services.

Scope of service

The service can be provided by the following provider types

☒ Behavioral Health Professionals or Specialists

Description

- a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).
- b. Child psychiatrists must be licensed as physicians and surgeons, with graduate training in child psychiatry in a program approved by the American Medical Association or the American Osteopathic Association, and who is board-eligible or board-certified in child psychiatry.
- c. Licensed mental health counselors must graduate with a MA or PhD level educational program in mental health counseling or a related discipline, and complete 36 months of supervised full-time counseling or 3000 hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor. Licensed mental health counselors must pass an examination administered by the National Board of Certified Counselors. Licensed mental health counselors are not required to have supervised postgraduate experience prior to becoming an associate.
- d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☐ Nurse Practitioner

☒ Nurse Care Coordinators

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.
2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.
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4. Psychiatric advanced registered nurse practitioner means a person who is licensed as an advanced registered nurse practitioner, and who is board certified in advanced practice psychiatric and mental health nursing.
5. Psychiatric nurses are registered nurses with a bachelor's degree from an accredited college or university, and have, in addition, at least two years' experience in the direct treatment of mentally ill or emotionally disturbed persons, such experience gained under the supervision of a mental health professional.

☒ Nurses

Description

1. Licensed Practical Nurses (LPN) must successfully complete a commission approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice and pass the official National Council of State Boards of Practical Nurse Licensing Examination (NCLEX-

Attachment 3.1-H

PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington State before practicing.

2. Registered Nurses (RN) RNs must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington State before practicing.

3. Advanced registered Nurse Practitioners (ARNP) must have formal graduate education and achieve a national specialty certification for the nurse practitioner, nurse anesthetist or nurse midwife role. ARNPs must hold a registered nurse license in Washington State before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

4. Psychiatric advanced registered nurse practitioner means a person who is licensed as an advanced registered nurse practitioner, and who is board certified in advanced practice psychiatric and mental health nursing.

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

- ☐ Medical Specialists
- ☐ Physicians
- ☒ Physician's Assistants

Description

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

- ☐ Pharmacists
- ☒ Social Workers

Description

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

a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience of which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

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

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

- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dietitians
- ☐ Nutritionists
- ☒ Other (specify)

Attachment 3.1-H

Provider Type	Description
Exception to Rule	Health Home benefits and services must be provided by qualified care coordinators. On rare occasions, Health Home lead entities may request an exception to the policy. Consideration and approval may be given to those specific hires when the lead organization provides evidence that the education, skills and knowledge and experience of the individual are an acceptable substitution for care coordinator qualifications. The individual must meet Health Home employment standards such as criminal history background checks and eligible for professional liability insurance as required by the hiring organization. The lead entity will provide HCA a letter of request for approval to hire a specific candidate. The letter will include the rationale for the potential care coordinator (i.e. any special skills or knowledge such as bicultural or bilingual), employee background and experience and how the person will be supervised. The following are examples of supporting documentation the lead entity may include with the letter of request: • Resume • Letters of recommendation • Educational transcripts • Documentation of courses, classes and trainings • Certifications • Licenses Staff will review and rate each letter of request and documentation. Scores must be at least 80% in each section to qualify. Sections are identified as: 1. Education 2. Experience 3. Skills/Knowledge 4. Letters of Recommendation
Allied or Affiliated Staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator. Allied or Affiliated staff may: 1. Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals. 2. Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems. 3. Provide general information about upcoming community events.
Support Staff	Clerical or administrative staff who provide clerical supportive services under the direction of the Care Coordinator. Support staff may: 1. Provide general information about upcoming community events.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advanced registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Enrollment flow is dependent upon 1) whether the beneficiary is enrolled with a Managed Care Lead Entity, or 2) is not enrolled in managed care and is receiving their medical benefits in the FFS delivery system. Almost all Washington's Medicaid Health Home beneficiaries are enrolled in managed care. Those that remain in the FFS delivery system either reside in a voluntary managed care county, are a full-dual eligible, or have self-identified as American Indian/Alaska Native.

All Health Home beneficiaries, regardless of whether they receive their Medicaid benefits in managed care or in FFS, have the same eligibility criteria - one or more chronic conditions from the chronic condition list and meet the state's definition of "at risk for another."

Enrollment starts with the identification of eligibility and assignment of a clinical indicator (Y=qualifies). The indicator is loaded into ProviderOne.

1. FFS beneficiaries with "Y" clinical indicators are enrolled into one of the qualified FFS Health Home Lead Entities in the geographic region in which they reside. Health Home outreach and education information is generated automatically and sent to the beneficiary by mail. The Health Home Lead Entity receives notification of the enrollment via HIPAA 834 files and assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs).
2. Managed care organizations have their eligible Health Home beneficiaries identified with a "Y" clinical indicator and receive notification of eligibility via HIPAA 834 files. The MCO assigns the beneficiary to one of their local Health Home Care Coordination Organizations (CCOs). The MCO is responsible for making sure the enrollee is notified of their eligibility to receive Health Home services.
3. Any health care provider may refer beneficiaries to the Health Home program. An example is a local emergency room department who has agreed with the Health Home Lead Entity to refer potentially eligible participants to the program.

Engagement consists of the assigned CCO placing beneficiaries with a Care Coordinator, who contacts the beneficiary to offer Health Home services. Once the beneficiary has agreed to participate in a Health Home, the Care Coordinator prepopulates the Health Action Plan with PRISM claims utilization details and arranges for an in-person visit. PRISM provides episode information related to specific diagnoses or pharmacy utilization, inpatient and outpatient claims, emergency room visits, mental health claims, substance use disorder treatment claims, pharmacy claims, and long-term care assessment data.

During the home visit, the Care Coordinator:

1. Conducts the required and when needed optional brief screening;
 2. Evaluates the beneficiary's support system;
 3. Completes a Consent for Release of Information;
 4. Administers and scores the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM) or Parent/Patient Activation Measure (PPAM);
- and
5. Develops the Health Action Plan (HAP) with the beneficiary, who will work with the CCO to identify immediate and long-term goals, prioritize concerns and establish action steps.

Name	Date Created	Type
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Attachment 3.1-H

Name	Date Created	Type
No items available		

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Attachment 3.1-H

Health Homes Providers

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

Types of Health Homes Providers

☒ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians

☒ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

☒ Rural Health Clinics

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more

Attachment 3.1-H

beneficiaries within their Health Home network;

6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that

Attachment 3.1-H

complements the work of the Care Coordinator;

13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.
15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

☐ Home Health Agencies

☒ Case Management Agencies

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims;
3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA;
2. Disburses payment to Care Coordination Organizations (CCOs) based

Attachment 3.1-H

upon claims;

3. Experience operating broad-based regional provider networks;
4. Contracts directly with the state as a Qualified Health Home;
5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network;
6. Subcontracts with community based CCOs to provide Health Home services;
7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or
 - b. Optimizes beneficiary choice.
8. Maintains a list of CCOs and their assigned Health Home population;
9. Monitors CCOs to ensure fidelity to the Health Home model;
10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols;
11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management;
12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator;
13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA.
14. Maintains an adequate network of Care Coordination Organizations.

☒ Other (Specify)

Provider Type	Description
Behavioral Health Organizations	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Hospitals	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A

Attachment 3.1-H

Provider Type	Description
	smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
MCOs	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Substance Use Disorder Treatment providers	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs

Attachment 3.1-H

Provider Type	Description
	using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.
Tribal Clinics	1. HIPAA compliant data systems for enrollment, collecting and reporting encounters to HCA; 2. Disburses payment to Care Coordination Organizations (CCOs) based upon claims; 3. Experience operating broad-based regional provider networks; 4. Contracts directly with the state as a Qualified Health Home; 5. Has capacity to provide Health Home services to 300 to 500 or more beneficiaries within their Health Home network; 6. Subcontracts with community based CCOs to provide Health Home services; 7. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process: a. Uses data systems to match the beneficiary to the CCO that provides most of their services or has the expertise specific to serve the beneficiary; or b. Optimizes beneficiary choice. 8. Maintains a list of CCOs and their assigned Health Home population; 9. Monitors CCOs to ensure fidelity to the Health Home model; 10. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, and referral protocols; 11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; 12. Ensuring and documenting the availability of allied staff that complements the work of the Care Coordinator; 13. Collects, analyzes, and reports network adequacy and beneficiary driven Health Action Plans to HCA. 14. Maintains an adequate network of Care Coordination Organizations. 15. Employs Care Coordinators to supplement CCOs in areas where qualified Care Coordinators are hard to find.

☒ Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

☐ Physicians

☒ Nurse Practitioners

Describe the Provider Qualifications and Standards

a. Licensed Practical Nurses (LPN) must successfully complete a commission-approved nursing education program consisting of at least 60 hours of theory content and 120 hours of clinical practice, and must pass the official National Council of State Boards of Practical Nurse Licensing

Attachment 3.1-H

Examination (NCLEX-PN®) for their LPN nurse certificate. All LPNs must have an active status license in Washington before practicing.

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

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

☒ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

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

b. Registered Nurses (RN) must successfully complete a commission approved nursing education program consisting of a minimum of 40 hours of core course content, 40 hours of specialty content, and 160 hours of clinical practice in a specialty area. RNs must successfully pass the official National Council of the State Boards of Nursing Registered Nurse (NCSBN) or (NCLEX-RN). All RNs must have an active status license in Washington before practicing.

c. Advanced Registered Nurse Practitioners (ARNP) must have formal graduate education and obtain a national specialty certification as a nurse practitioner, nurse anesthetist or nurse midwife. ARNPs must hold a registered nurse license in Washington before taking an accredited nursing or nursing-related accrediting organization recognized by the US Department of Education or the Council of Higher Education Accreditation. Educational requirements include no less than 500 hours of clinical practice.

d. A psychiatric advanced registered nurse practitioner is a person who is licensed as an advanced registered nurse practitioner and is also board-certified in advanced practice psychiatric and mental health nursing.

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

☐ Nutritionists

☒ Social Workers

Describe the Provider Qualifications and Standards

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

a. Licensed Independent Social Worker must graduate with a MA or PhD social work and complete a minimum of 4000 hours of supervised experience or which 1000 hours must be direct client contact, over a three-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

b. Licensed Advanced Social Worker must graduate with a MA or PhD social work program and complete 3200 hours with supervision. At least 90 hours are direct supervision as specified by a licensed independent clinical social worker, a licensed advanced social worker, or an equally qualified licensed mental health professional. At least 40 hours must be in one-to-one supervision and 50 hours may be in one-to-one supervision or group supervision.

c. Licensed independent clinical social worker must graduate with a MA or PhD level social work program accredited by the Council on Social Work Education and successfully complete a supervised experience of at least 4000 hours of experience, of which 1000 hours must be direct client contact, over a 3-year period supervised by a licensed independent clinical social worker, with supervision of at least 130 hours by a licensed mental health practitioner.

d. Licensed social worker associate-independent clinical must graduate with a MA or PhD level social work program accredited by the Council on

Attachment 3.1-H

Social Work Education and declare they are working toward full licensure.

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

☒ Behavioral Health Professionals

Describe the Provider Qualifications and Standards

a. Psychologists must have a doctoral degree from a regionally-accredited institution, with at least 40 semester hours or 60 quarter hours of graduate courses, one full year of continuous residency, a practicum of at least 300 hours, and supervised experience consisting at least two years. Psychologists must take the National Examination of Professional Practice of Psychology (EPPP).

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

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

d. Licensed marriage and family therapists must have either an MA or PhD in marriage and family therapy or an MA or PhD in behavioral science with equivalent course work from an approved school. Licensed marriage and family therapists must complete a minimum of 2 years of supervised full-time marriage and family therapy. For full licensure, a licensed marriage and family therapists must take and pass the Association of Marital and Family Therapy Regulatory Boards examination. Licensed marriage and family therapist associate applicants are not required to have supervised postgraduate experience prior to becoming an associate.

☒ Other (Specify)

Provider Type	Description
Allied or Affiliated staff	Community health workers, peer counselors, wellness coaches or other non-clinical personnel who provide supportive services, outreach and engagement to the client under the direction and supervision of the Health Home Care Coordinator.
Physician Assistants	Physician Assistants (PA) must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent under the supervision of a physician. They must be academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. PAs must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the National Commission of Certification of Physician Assistants (NCCPA) examination. Physician assistants must have 4 clock hours of AID education and an active DEA registration.
Chemical Dependency Professionals	Chemical Dependency Professionals (CDPs) must pass the National Association of Alcoholism and Drug Abuse Counselor (NAADAC) National Certification Examination for Addiction Counselors or International Certification and Reciprocity Consortium (ICRC) Certified Addiction Counselor Level II or higher examination. CDPs must complete 1,000 to 2,500 hours of supervised experience, dependent upon the following, associate degree, baccalaureate degree, masters or doctoral degree, licensed as an advance registered nurse practitioner, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social worker or licensed as a psychologist, that include clinical evaluation and face-to-face counseling.

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The delivery of Washington's Health Home service model is based on an multidisciplinary array of medical care, behavioral health care, and community-based social services and supports for children and adults who meet Washington's defined chronic conditions and risk criteria. The integration of primary care, behavioral health services, and long-term care services and supports are critical when improving health outcomes and reducing costs.

Qualifying the Health Home Lead Entities/Designated Providers ensures managed care organizations (MCOs), hospitals, Federally Qualified Health Centers

Attachment 3.1-H

(FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment Providers, Specialty Care and Primary Care Providers, and Tribal Clinics who may apply have the necessary skills and infrastructure to provide Health Home services.

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

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

The Health Home structure is built on the following hierarchy:

1. Designated Provider/Qualified Health Home Lead Entities – Healthcare systems, providers and authorizing entities with experience developing community based service provider network relationships, such as managed care organizations (MCOs), hospitals, Federally Qualified Health Centers (FQHCs), Behavioral Health Organizations, Area Agencies on Aging (AAAs), Community Mental Health Agencies, Substance Use Disorder Treatment providers, Specialty Care, Primary Care Providers and tribal clinics. The Lead Entities contract directly with the state and are responsible for service delivery model and administration of the Health Home. Lead Entities assign Health Home eligible beneficiaries into Care Coordination Organizations (CCOs), collect and submit encounters; disburse payment to network affiliated CCOs through the collection and submission of encounters, monitor quality, sub-contract, collect, analyze and report financial, and health status to objectively determine progress towards meeting overall Health Home goals. Some Lead Entities also verify address and phone information, and engage participants through telephonic contact to determine willingness to participate. Some Lead Entities may also serve as internal CCOs as a means of reaching rural areas of the state that may not have enough non-Lead CCOs to support capacity.
2. Network Affiliated Care Coordination Organizations (CCO) – Accountable for Care Coordination staffing and oversight of direct delivery of the six Health Home services. CCOs are responsible for implementing systematic processes and protocols to assure service delivery and beneficiary access to Care Coordinators and affiliated staff. CCOs may be managed care organizations, hospitals, Federally Qualified Health Centers (FQHC), Behavioral Health Organizations, Area Agencies on Aging, Community Mental Health Agencies, Substance Use Disorder Treatment providers, Home Health, Specialty providers, such as AIDS or ESRD clinics, Specialty and Primary Care Providers, and Tribal Clinics.
3. Care Coordinators – Operate under the direction of the Care Coordination Organizations by directly interacting with participating beneficiaries. Care Coordinators provide the six defined Health Home care coordination benefits in-person by actively engaging the beneficiary in developing a Health Action Plan (HAP); reinforcing the HAP and supporting the beneficiary to attain short and long-term goals; coordinating with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals; advocating, educating and supporting the beneficiary to attain and improve self-management skills; ensuring the receipt of evidence-based care; supporting beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning; and accompanying the beneficiary to critical appointments when necessary. To better support beneficiary goals and ensure quality of care, they coordinate services with authorizing entities for which the beneficiary is receiving services assistance. A Health Home Care Coordinator must provide service in the community in which the beneficiary resides so services can be provided in-person whenever needed, unless the beneficiary requests to receive their services elsewhere. Health Home Care Coordinators serve eligible beneficiaries in the setting of their choice and may not establish policies that would restrict service because a beneficiary moves from one eligible setting to another.
4. Affiliated health care staff, such as community health workers, peer counselors or other non-clinical personnel provides administrative support for the Health Home Care Coordinator, such as mailing health promotion material, arranging for beneficiary transportation to appointments, and calling the beneficiary to facilitate face-to-face Health Home visits with the Care Coordinator. Some affiliated staff may provide more direct care coordination functions under the supervision of a Care Coordinator.
5. Additional network providers who have agreed to participate in the Health Home model through the use of memorandums of agreement, subcontracts, or operational agreements. For example, a clinic may agree to provide referrals to a Lead Entity, through the use of an operational agreement.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The foundation of the Health Home program is the community-based Care Coordination Organization (CCO) network, subcontracted to Lead Entities. CCOs are a wide variety of medical, behavioral health and social service providers who provide Health Home services through contracted Care Coordinators. Because many Health Home beneficiaries have existing relationships with one or more providers, broad-based CCO networks enable a smart assignment process. For example, the clinic where the beneficiary has their primary care provider may be their CCO, or an Area Agency on Aging who supports the beneficiary with their long-term services and supports may be their CCO.

Each activity defined under the six Health Home services is built into Lead Entity contracts, ensuring that coordination of services, access to services, and person-centered care is delivered to the Health Home beneficiary. For example, the beneficiary is involved in improving their health through the development of their Health Action Plan (HAP). HAPs are shared with the beneficiary during development and when they are updated on a four month cycle. Beneficiaries may include their families and caregivers as part of their support team and may authorize the release of the HAP to their family members, caregivers and providers.

Attachment 3.1-H

The HAP is both an electronic form and a paper form.

HCA and DSHS jointly sponsor training for Health Home service. Nursing staff developed core curriculum materials to support the provision of timely, comprehensive, high-quality services with a whole-person focus. DSHS offers technical assistance training for core skills relevant topics. Webinars, community network meetings and/or collaborative learning efforts continue to foster shared learning, information sharing and problem solving.

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

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Qualified Health Home Lead Entities and their networks are developed to meet the needs of the populations they serve. Care coordination is necessary across numerous service domains and therefore may include many different disciplines. The state qualifies each Lead Entity, who is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for persons with chronic illness across the lifespan, through contractual/operational arrangements with appropriate providers. A Care Coordinator is the central point of contact working with the managed care or Fee-for-Service beneficiary to direct person-centered health action planning and implementation, and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable Emergency Department visits; providing timely post discharge follow-up, and improving beneficiary outcomes by addressing health care needs.

Washington qualifies the designated providers as Lead Entities through both a Request for Application (RFA) process and a contracting process. For the first two phases of implementation, Washington issued an RFA and qualified eight Lead Entities to provide Health Home services through their network of Care Coordination Organizations. For the last implementation phase of the program, HCA will issue an RFA for any new organizations who wish to be Qualified Lead Entities in Coverage Area 2, which consists of Snohomish county with Island, San Juan, Skagit, and Whatcom counties and Coverage Area 3, which consists of King county. Previously Qualified Health Home Lead Entities may contract for Health Home services in Coverage Area 2 and 3 without responding to an RFA if they demonstrate network adequacy.

The following are minimum requirements to become a Qualified Health Home Lead Entity:

1. Applicant is a Medicaid provider in good standing, has the ability to serve at least 300 Health Home beneficiaries, has experience operating broad-based networks, agrees to serve the entire coverage area, assures a referral system is in place, documents beneficiary consent, subcontracts with CCOs, has the ability to coordinate care and services after critical events, such as emergency department use and hospital inpatient admission and discharge, language access and interpretation capabilities, can provide links to acute and outpatient medical, mental health and substance abuse services, and community-based social services;
2. Provider networks must include a wide-variety of CCOs, such as Community Mental Health Agencies (CMHAs), Substance Use Disorder treatment providers, long-term services and support providers, FQHCs, and Community Health Centers;
3. Organizational infrastructure – ability to provide administrative functions, customer service staff, policies on process and timelines for bringing in additional CCOs to preserve integrity of face-to-face Health Home care coordination activities, ability to track Health Home beneficiaries to CCO assignment, collecting and submitting claims and encounters, payment disbursement, taking into account movement between payment levels and/or movement between CCOs, quality monitoring, subcontracting, collecting, analyzing and reporting financial, and health status. Ability to ensure hospitals have procedures in place for referring Health Home-eligible beneficiaries for enrollment if they are seeking or need treatment in a hospital emergency room;
4. Core Health Home requirements must be met, showing the ability to provide six Health Home care coordination functions and a guarantee of non-duplication of efforts, engagement and outreach, health action planning, self-management of chronic conditions, setting short and long-term goals, cultural competency, motivational interviewing, identification of services and gaps in services, evidence-based interventions, information-sharing with beneficiary's treating/authorizing entities, establishment of multidisciplinary teams, accompanying beneficiary to visits when requested, arranging for priority appointments, notification systems for transitional care, follow-up on medication upon discharge and follow-up with pharmacy to get scripts filled, help the beneficiary access follow-up care, referrals, optimizing social supports and family, use of health information technology.

Before contracts are awarded through the RFA process, HCA and DSHS conducts desk audits and on-site readiness reviews to ascertain readiness to provide Health Home services. Contracts will be offered only after the readiness reviews and after any identified deficiencies are mitigated through a corrective action plan. Before contracts are awarded to previously Qualified Lead Entities, HCA and DSHS will determine if their networks are adequate to provide Health Home services.

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

As the Health Home program matures, HCA may allow other entities interested in applying to become a Qualified Health Home Lead Entity to submit a request to HCA, at which point the process for contracting will take effect.

Name	Date Created	Type
No items available		

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Attachment 3.1-H

Attachment 3.1-H

Health Homes Service Delivery Systems

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID WA2016MH00010

SPA ID WA-16-0026

Submission Type Official - Review 2

Initial Submission Date 12/20/2016

Approval Date 3/30/2017

Effective Date 4/1/2017

Superseded SPA ID N/A

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

☒ Fee for Service

☐ PCCM

☒ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

☒ Yes

☐ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

Managed care contracts contain language to support the Health Home benefit for eligible beneficiaries. An MCO has two paths to choose from when providing those benefits. They may either become a qualified Health Home Lead Entity through the Request for Application process or they may provide their Health Home benefits through a delegation agreement with another qualified Health Home Lead Entity.

Contract language will contain:

1. Standards for the six Health Home services - Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Individual and Family Support, Referrals to the Community and Use of Health Information Technology;
2. The use of clinical and non-clinical Care Coordinators and allied staff;
3. Contracts, memorandums of agreement or operational agreements with hospitals for emergency department and hospitalization notification, including a referral process to refer beneficiaries to HCA for Health Home enrollment;
4. Data security requirements;
5. Standardized screening and assessments;
6. Development of a Health Action Plan (HAP) through an in-person visit to promote self-management through the identification of the beneficiary's short and long-term goals;
7. Encounter data reporting and documentation of delivered services to support encounters;
8. The use of multidisciplinary care teams, that include the Care Coordinator, the beneficiary, and any other identified providers;
9. Training requirements;
10. Program Integrity;
11. Grievances and Appeals processes;
12. Access to the PRISM clinical decision support tool;
13. If the Health Home beneficiary is a Medicaid managed care enrollee, the MCO will share critical data with the Health Home Care Coordination Organization. Data may include institutional admissions and discharge readiness for transitional health care services management and facilitation, lapses in pharmaceutical payments that may indicate need for beneficiary outreach and education regarding medication use, lapses in pharmaceutical payments; and emergency department use that may suggest a need for a Care Coordinator visit or intervention to address the clinical and Health Action Plan goals.

☒ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	Type
No items available		

TN: WA-16-0026
Supersedes TN: WA-15-0011

Approved: 3/30/17

Effective Date: 4/1/17

04/10/2017

Attachment 3.1-H

Name	Date Created	Type

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

- ☒ Yes
☐ No

- Assurances**
- ☒ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following
 - Any program changes based on the inclusion of Health Homes services in the health plan benefits
 - Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
 - Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
 - Any risk adjustments made by plan that may be different than overall risk adjustments
 - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM
 - ☒ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services
 - ☒ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

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Attachment 3.1-H

Health Homes Payment Methodologies

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH0001O	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

Payment Methodology

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

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☒ Fee for Service 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

Completing the Health Action Plan and beginning work on individuals goals;
One-on-one, face-to-face home visits, high touch interactions; and
Low-level interactions to maintain progress.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

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

Rates were built for three levels of payment using a clinical and non-clinical staffing model combined with monthly service intensity. Health home services are provided by Registered Nurses and Social Workers, with some lower-level services provided by allied or affiliated staff.

Only one encounter per beneficiary is accepted per month regardless of how many services are provided to that beneficiary during the month.

Three levels of payment are dependent upon the intensity of the service, determined by one-on-one, high touch interactions. This first care coordination stage encompasses three primary responsibilities, in addition to the health home service: health screening and assessments, development of a health action plan for care management, and assess the beneficiary for self-management and promote self-management skills to improve functional or health status or prevent or slow declines in functioning. The encounter for the first care coordination stage is paid only once per lifetime of the benefit.

The second level is for Intensive Health Home Care Coordination. It is assumed that for each full-time employee (FTE), 50 beneficiaries can be supported. This rate is paid once per month, per beneficiary and is triggered by submittal of an encounter. An encounter is represented by documenting delivery of a health home service. This rate is used extensively for most of the care coordination services.

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

☐ PCCM (description included in Service Delivery section)

Attachment 3.1-H

- ☒ Risk Based Managed Care (description included in Service Delivery section)
- ☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

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

Apr 1, 2017

Website where rates are displayed

<http://www.hca.wa.gov/billers-providers/programs-and-services/resources-0#contracts-and-rate-information>

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

When the Health Home program was implemented in 2013, there was no cost data available for the program, except data from the Intensive Chronic Care Management (ICCM) model, which preceded the Health Home program. The ICCM population was aged, blind and disabled Medicaid-only beneficiaries, age 21 and older who were currently receiving home and community based long-term services and supports (LTSS) and Fee-for-Service medical benefits. Beneficiaries receiving LTSS were not enrolled in managed care. Care Coordination was provided by five mostly rural Area Agencies on Aging vendors. The purpose of the program was to provide locally based chronic care management to eligible Medicaid clients through care coordination activities provided by nurse care managers. The program was voluntary and incorporated outreach, care management, education, and assistance to enrollees in managing their disease, along with coordination of medical, mental health, substance use disorder and other community services based on the needs of the individual enrollee.

ICCM premiums, developed by Mercer, covered staffing and resources to provide care coordination services that were similar to the Health Home services. Mercer developed caseload assumptions which considered historical program experience as well as input from Mercer clinicians experienced with CCM programs. The state provided fully loaded annual compensation levels for care management staff which represented actual costs for the program. The number of Full Time Employees (FTEs) and the total annual compensation levels were combined to produce an average PMPM costs. Mercer added management and overhead costs for an administrative load, which was calculated to be 18% of fully-loaded employee salaries based on the program's operational expenditures.

Mercer gave the state an ICCM premium rate range from the lower bound of \$172.55, best estimate of \$181.63, and upper bound of \$190.71.

Because the two chronic care management programs were similar and there was no experience data for Health Homes benefits, the state asked Milliman to develop FFS rates for the Health Home program (for Fee-for-Service enrollees), using the Mercer analysis as their baseline. Salary data was used to develop average salaries, adjusted to be consistent with those reported in the Seattle/Bellevue/Everett region which was one of the highest salary regions in the state and included supervisors at nurse salary levels, plus \$10,000 because of their additional responsibilities.

The assumed average distribution of staff time to provide Health Home services varies by stage of care coordination and on an average staffing distribution of time by care coordinators. For intensive level of services, Milliman assumed most benefits are provided by Registered Nurses at 50%, Case Managers at 38%, Case Aides at 10% and supervision at 2%. Baseline salaries were loaded by 42% to account for other costs such as 24% for employee benefits, 15% for other staff expenses and 3% for administration.

Other cost assumptions include salary distribution, geographic distribution, and high-touch vs. low-touch intensity of services. Care Coordinators must provide at least one Health Home service to claim reimbursement, with the expectation that high touch means in-person, face-to-face care coordination and low-touch means a combination of face-to-face or telephonic contact.

Washington State has three payment tiers that define the level of care coordination services provided: The Tier Level of the beneficiary is intended to reflect the overall level of:

1. Engagement and activation level of the beneficiary and/or their caregivers;
2. Activity in the Health Action Plan;
3. Provision of at least one of the qualified Health Home services; and
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

All three tiers have a mix of clinical and non-clinical staffing elements.

Tier One is for initial engagement and health action planning. The reimbursable unit is \$252.93. 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.

Tier One includes:

- Contacting the beneficiary to introduce Health Home benefits, gain their approval to participate and schedule initial Care Coordinator face-to-face visit;
- Conducting a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs; and
- Completing Health Action Plan (HAP), with a face-to-face visit with the beneficiary to identify the beneficiary's short and long-term goals and action steps. Development of the HAP may include family members, caregivers, and other social supports as appropriate.

Attachment 3.1-H

Tier Two is for on-going, face-to-face and telephonic visits with the beneficiary to provide one or more of the six Health Home services. The reimbursement unit is \$172.61. Tier Two is paid once per month, per beneficiary. The minimum level of reimbursement is at least one face-to-face contact with the beneficiary during the month.

Tier Three is low-level care coordination for beneficiaries who either do not want frequent contact or face-to-face visits or have achieved a level self-management for their chronic conditions and no longer need high-level or intensive care coordination. The reimbursement unit is \$67.50 for the third tier. Tier 3 will be paid on a monthly basis and payment is made only for months in which an encounter occurred. An encounter is represented as either a phone call or home visit. Phone calls are assumed to last an average of 45 minutes. Home visits are assumed to take 2 hours and 15 minutes. For months in which an encounter occurs, 2/3 of the encounters will involve a phone call and 1/3 will involve a home visit.

Washington requires all Health Home Lead Entities to submit completed Health Action Plans (HAP) into a HAP database. The HAPs are reviewed against the Tier One encounters to ensure that a payment has been made for a completed HAP. HAPs are updated every four and eight months, or more frequently if there has been a change in circumstances, such as a hospital or Emergency Department visit. HAPs are updated when short and long-term goals have been finalized and new goals are set by the beneficiary.

Washington requires all Lead Entities to require documentation of the Health Home services provided by care coordinators in their contracts with Care Coordination Organizations. Case records and notes are audited annually during on-site contract compliance audits. Quarterly Quality reports are submitted to HCA by all the leads and must contain:

- Summary and overview of Health Home services:
 - o Activities;
 - o Strengths and best practices; and
 - o Barriers encountered during the reporting period.
- Updated list of the Contractor's Care Coordination network of providers;
- De-identified individual Health Home beneficiary success stories;

The 2013 FFS rates originally included a withhold portion for Tier Two and Three. HCA staff reviewed the FFS rates in late 2014 and determined the administrative portion of the rate payment was not enough to support infrastructure costs for Fee-for-Service Health Homes. The withhold portion of the rates was discontinued on January 1, 2015. The current FFS rates without the withholds are effective for services on or after January 1, 2015.

Reviewing and rebasing the rates for Health Home services was initially planned to happen every two years, but was curtailed due to legislative direction in April 2015 to discontinue the program by January 1, 2016 due to lack of funding. In November 2015, Washington was informed by CMS that it would receive Medicare shared savings attributable to the Duals Demonstration/Health Home program and that information prompted a renewed interest in keeping the program alive. Milliman was asked to review the current Health Home rate structure in May, 2016 in order to update them for January 1, 2017 and in August 2016, the draft rates were released to HCA and DSHS, with a caveat from Milliman that the data was not uniformly collected by the leads and their CCOs.

Reviewing and rebasing the rates for future updates will happen every three years or more frequently if cost trends warrant more frequent adjustments. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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 meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions
- ☒ 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)

Attachment 3.1-H

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Attachment 3.1-H

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - Washington State Health Home Program - WA - 2016

CMS-10434 OMB 0938-1188

Not Started

In Progress

Complete

Package Header

Package ID	WA2016MH00010	SPA ID	WA-16-0026
Submission Type	Official - Review 2	Initial Submission Date	12/20/2016
Approval Date	3/30/2017	Effective Date	4/1/2017
Superseded SPA ID	N/A		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligible will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide health information exchange. HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Quality Measurement and Evaluation

- ☒ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☒ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☒ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☒ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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