Amerigroup RealSolutions in healthcare

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August 9, 2017

Karen Spoelman
King County Behavioral Health and Recovery Division
401 Fifth Ave Ste. 400
Seattle, WA 98104-2377

Dear Karen Spoelman:

Enclosed is a copy of the executed agreement between King County Behavioral Health and Recovery Division and Amerigroup Washington, Inc.

Please note: Providers attached to this agreement must be credentialed by Amerigroup before they can be reimbursed per the agreement to provide services to Amerigroup members (unless otherwise indicated by state regulations). All providers will be notified with a credentialing notification letter indicating their credentialing approval date.

We invite you to visit our provider self-service website at https://providers.amerigroup.com/WA for the latest tools designed to save you time and money. The website also gives you access to:

- Instructions and information on electronic data interchange (EDI) and electronic funds transfer (EFT)
- The Amerigroup provider manual
- Provider news bulletin (our state provider newsletter)
- Health plan and industry updates on policies and clinical developments
- Quick reference guide

Please contact your local Provider Relations representative or the Provider Services team at 1-800-454-3730 with any questions or concerns.

We look forward to working with you!

Sincerely,

Network Management

AGREEMENT

AMERIGROUP WASHINGTON, INC. ("Amerigroup") enter into this agreement with King County Behavioral Health and Recovery Division_ ("CCO") as of the effective date identified below.

I. ENGAGEMENT

(a) Definitions.
Capitalized words or phrases in this Agreement shall have the same meaning set forth in Attachment A, Definitions.

(b) Scope of Work.
CCO will perform the services described in Attachment B, Scope of Services and in Attachment D, Program Contract Requirements for Health Homes, in a manner that is equal to or exceeds industry standards.

(c) Fee.
CCO will be compensated according to the terms set forth in Attachment C, Compensation. CCO shall submit monthly Invoices, or 837 claim files, whichever is applicable, to Amerigroup, and all undisputed amounts are due within thirty (30) days after Amerigroup receives such Invoice or 837 claim file, as applicable. Notwithstanding the foregoing, Amerigroup will not remit any payment until CCO provides a taxpayer identification number ("TIN") to Amerigroup. CCO waives payment for Services and/or expenses for which Invoices or 837 claim files are submitted to Amerigroup later than one-hundred twenty (120) days after the date of Services and/or expenses for which the Invoice or 837 claim file is submitted.

(d) Records.
i. CCO shall ensure that information about Clients, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations. CCO shall maintain medical, financial and administrative records concerning services provided to Clients in accordance with industry standards and Regulatory Requirements, including without limitation applicable law regarding confidentiality of Client information. Such records shall be retained by CCO for the period of time required under Regulatory Requirements, but in no event less than ten (10) years from the date the service is rendered. CCO shall provide state and federal agencies access to review records related to services provided hereunder in accordance with Regulatory Requirements. CCO shall permit AMERIGROUP or its designated agent to review records directly related to services provided to Clients, either by providing such records to AMERIGROUP for off-site review, or on-site at CCO's facility, upon reasonable notice from AMERIGROUP and during regular business hours. CCO shall obtain all necessary releases, consents and authorizations from Clients with respect to their medical records to permit AMERIGROUP access to such records. CCO shall supply the records described above at no charge upon request. The rights and obligations of the parties under this section shall survive the termination of this Agreement. CCO will have the right to audit AMERIGROUP records relating to Covered Services rendered by CCO to Clients.

ii. CCO shall cooperate in the transfer of Clients' medical records to other Participating Providers when required, subject to Regulatory Requirements, and shall assume the cost associated therewith. Following a Client's request for record transfer, CCO shall transfer such Client's medical records in CCO's

custody within ten (10) days following the request, or such other time period required under applicable Regulatory Requirements.

II. TERM AND TERMINATION

(a) Term.
The term of this Agreement shall be effective on the date it is mutually executed, and shall renew automatically thereafter for a successive term or one year unless either party notifies the other party of its intent to exercise the termination clause in Section II of this agreement.

(b) Termination.

i. Either Party may terminate this Agreement on sixty (60) days' written notice.

ii. Termination without cause. Notwithstanding any other provision included in this Agreement, CCO and Amerigroup may terminate this Agreement at any time during its term by providing ninety (90) days prior written notice to the other party.

iii. Termination by either party for cause. Either party may terminate this Agreement for cause, defined as a material breach of this Agreement by the other party, hereto upon ninety (90) days written notice to the other party. The notice shall set forth the reasons for termination and provide the breaching party ninety (90) days to cure such material breach or the termination become effective.

iv. CCO shall immediately notify Amerigroup of any debarment, exclusion, suspension, or other event that makes CCO an Ineligible Person, as defined in the Excluded Party Section of this Agreement. This agreement will automatically and immediately terminate if CCO is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement to, any program under Titles XVIII, XIX or XX of the Social Security Act.

III. PROPPRIETARY INFORMATION/CONFIDENTIALITY

(a) The parties acknowledge and agree that all information pertaining to this Agreement, relating to Amerigroup's and CCO's quality assurance, utilization management, risk management and peer review programs, Amerigroup's and CCO's credentialing procedures, this Agreement, including the rates of compensation payable under this Agreement, Amerigroup's Provider Manual, and all other information related to Amerigroup programs, policies, protocols and procedures, is proprietary information. The parties agree not to use such proprietary information except for the purpose of carrying out their obligations under this Agreement. Neither party shall disclose any proprietary information to any person or entity without the other party's express written consent except to the extent such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information or unless required by law.

(b) CCO and Amerigroup shall each treat all information which is obtained through its respective performance under the Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations, including without limitation 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time, and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations and securing of its rights hereunder. CCO and Amerigroup shall each have a system in effect to protect all records and all

other documents deemed confidential by law which are maintained in connection with the respective activities of CCO or Amerigroup and performed in connection with this Agreement. Any disclosure or transfer of confidential information by CCO or Amerigroup will be in accordance with applicable law.

(c) CCO represents and warrants that it is a "covered entity" as defined in 42 C.F.R. Section 160.103 and that as such it is required to comply with requirements regarding protection of certain protected health information in accordance with 42 C.F.R. Parts 160 and 164 as amended from time to time. In the event that CCO is not a covered entity, as such term is defined in the HIPAA Regulations, the parties shall execute a separate business associate agreement prior to any disclosure or use of protected health information ("PHI") under this Agreement. CCO acknowledges that if it is not a covered entity, Amerigroup is unable to disclose to CCO any PHI regarding any Client until a separate business associate agreement is fully effective between the parties hereto.

IV. ADDITIONAL PROVISIONS

(a) Representations and Warranties of CCO.

CCO hereby represents and warrants that: (i) it is not currently, nor has it been at any time prior to the date of this Agreement, debarred, suspended, or otherwise excluded from participating in any state or federally funded healthcare program, or knowingly has a relationship with an individual as defined by 42 CFR 438.610, as amended; (ii) it is not party to any agreement, judgment, order, consent, or equitable relief, written or oral, which would limit or restrict it in any manner from providing the Services contemplated hereunder; (iii) it is in compliance with applicable immigration laws; (iv) all services contemplated herein shall be performed in the United States of America. It is understood and agreed that the foregoing representation and warranty has been included as a material inducement for Amerigroup to enter into this Agreement and that Amerigroup would not have entered into this agreement but for the foregoing representation and warranty. Breach, or anticipated breach, of the foregoing representation and warranty shall be a material breach of this agreement and, without limitation of remedies, shall be cause for immediate termination of this Agreement; (v) each of its employees, agents and subcontractors assigned to perform the Services are duly licensed or registered, as appropriate, to perform the Services and that the Services will be performed in a competent and professional manner, with the degree of skill and care that is required by current competent and professional procedures for services in this area; (vi) it shall secure and maintain while this Agreement is in effect sufficient resources and any licenses and/or permits required for the proper performance of its duties hereunder; and (vii) no payment received pursuant to this Agreement shall be made to or deposited into institutions or entities located outside of the United States.

(b) Insurance.

At all times during the term of this Agreement, CCO shall obtain and maintain in full force and effect Commercial General Liability, Workers' Compensation, Professional Liability/Errors & Omissions Liability, Automobile Liability, if appropriate, and any such other insurance coverage conforming to industry standards for the Services to be provided hereunder. CCO shall provide Amerigroup with evidence of such insurance coverage at the commencement of the Agreement and thereafter upon the request of Amerigroup.

(c) Dispute Resolution.

The Parties shall use their best, good faith efforts to cooperatively resolve disputes and problems that arise in connection with this Agreement, and to use informal methods to resolve those disputes whenever possible.

(d) Indemnification.
Amerigroup and CCO shall indemnify, defend and hold each other harmless from claims, demands and causes of action arising out of this Agreement and the performance of it and asserted against the indemnitee by any party, including, without limitation, CCO's and Amerigroup's respective employees for personal injury, death or loss of or damage to property resulting from the indemnitor's negligence or willful misconduct. Where personal injury, death, or loss of or damage to property is the result of joint negligence or willful misconduct of Amerigroup and CCO, the indemnitor's duty of indemnification shall be in proportion to its allocable share of such joint negligence or willful misconduct. If either party is strictly liable under applicable law, the other party's duty of indemnification shall be in the same proportion that its negligence or willful misconduct contributed to the personal injury, death, or loss of or damage to property for which a party is strictly liable. The term "negligence" in this Agreement shall include active or passive negligence

(e) Entire Agreement and Modification.
This Agreement embodies the entire agreement and understanding between the Parties with respect to the subject matter hereof, and supersedes all prior agreements, letters of intent and understandings between such Parties relating to the subject matter hereof and thereof. No amendment, modification, termination, or waiver of any provision of this Agreement shall be effective unless the same shall be set forth in a writing signed by a representative of each party, and then only to the extent specifically set forth therein.

(f) No Waiver.
Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Agreement. Only the individuals who are authorized to sign this Agreement or amendments to it have the authority to waive any term or condition of this Agreement.

(g) Survivability.
The terms and conditions contained in this Agreement which, by their sense and context, are intended to survive the expiration or termination of this Contract shall survive. Surviving terms include, but are not limited to: confidentiality, dispute resolution, indemnification, or limitations of liability shall survive termination or expiration of this Agreement. Moreover, any provisions of this Agreement that contemplate performance subsequent to any termination or expiration of this Agreement shall survive any termination or expiration of this Agreement and continue in full force and effect.

(f) No Third Party Rights.
This Agreement is entered into solely between Amerigroup and CCO and shall not be deemed to create any rights in any third parties or to create any obligations of either Party to any third party.

(g) Counterparts.
This Agreement may be executed in two or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument.

(h) Notice.
Whenever one Party is required to give notice to the other Party under this Agreement, it shall be deemed given if mailed by the United States Postal Services (USPS), as registered or certified mail, with a return receipt requested, postage prepaid and addressed as follows:

In the case of Amerigroup, notice shall be sent to the points of contact identified below:

Amerigroup Washington, Inc.
705 5th Avenue South, Suite 300
Seattle, Washington 98104
Attn: _____

Telephone: (206) 674-4463
Fax: (855) 270-9583
E-mail: _____

In the case of CCO, notice shall be sent to the points of contact identified below:

_King County Behavioral Health and Recovery Division_____
_401 Fifth Avenue, Suite 400_____
_Seattle, Washington 98104_____

Attn: Karen Spoelman
Telephone(206) 263-8982_____

Fax: (206) 296-0583_____
Email: Karen.spoelman@kingcounty.gov_____

Notice shall become effective on the date delivered as evidenced by the return receipt or the date returned to sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accordance with this Section, stating the change and setting forth the new address, which shall be effective on the tenth (10^{th}) day following the effective date of such notice unless a later day is specified in the notice. A courtesy copy of a notice may be emailed and/or faxed by one Party to the other Party, but that will not begin the clock for the notice period.

(i) Non-Discrimination.
Amerigroup is subject to the provisions of Executive Order 11246, as amended, and its implementing rules and regulations. As an "Equal Opportunity Employer", Amerigroup does not discriminate against any employee or qualified applicant for employment because of race, color, sex, religion, citizenship, national origin, veteran status, marital status, disability, age, or other legally protected status.

(j) Limitation on Use of Federal Funds.
CCO agrees, pursuant to 31 U.S.C. 1352 and 45 CFR Part 93, that no federal appropriated funds have been paid or will be paid to any person by or on behalf of CCO for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative contract.

(k) Limitation on Use of Non-federal Funds.
If any funds other than federal appropriated funds have been paid or will be paid by CCO to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract, and the contract exceeds $100,000, CCO shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions.

(l) Compliance.
CCO and its employees, agents, or subcontractors who provide Services hereunder shall at all times during the term of this Agreement comply with all applicable federal, state, and local laws, regulations ordinances and codes and shall (i) conduct business in conformance with sound ethical standards of integrity and honesty; (ii) conduct business in such a way as to not give the appearance of impropriety, even when the behavior or activity is in compliance with the law; and (iii) not achieve business results by illegal act or unethical conduct.

Amerigroup directs CCO to Amerigroup's Code of Business Conduct and Ethics ("Code"). The Code is located on the Amerigroup Corporation website at http://www.amerigroup.com/sites/amerigroup.com/files/files/Amerigroup_Code_of_Conduct.pdfAlso included on that site are Amerigroup's policies related to detecting, preventing and deterring fraud waste and abuse. To ensure that compliance is maintained, Amerigroup relies upon the help of its contractors in identifying and reporting potential compliance issues. If CCO becomes aware of a potential compliance issue, Amerigroup requests that a compliance report be filed with Amerigroup Corporation's Chief Compliance Officer, or on the anonymous external hotline at http://amerigroup.silentwhistle.com or www.silentwhistle.com.

(m) Compliance with Regulatory Requirements.
Amerigroup and CCO will each comply with all applicable Regulatory Requirements when performing their respective obligations under this Agreement, including but not limited to the requirements set forth on Attachment D, Program Contract Requirements for Health Homes.

IN WITNESS WHEREOF, Amerigroup and CCO have entered into this Agreement.

AMERIGROUP WASHINGTON, INC.

Signature: Erikka Smith

By: Erikka Smith
Title: Director - PDM
Date: August 25, 2017

King County Behavioral Health and Recovery Division
TIN: 91-6001327

Signature: Steve A.

By: Steve Andryszewski
Title: Chief Financial Officer
Date: 6-16-2017

ATTACHMENT A
DEFINITIONS

1.1 "Area Agency on Aging (AAA)" means a network of State and local programs that help older people to plan and care for their life long needs.

1.2 "Authorizing Entity" means an organization contracted by the State to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Behavioral Health Organizations, and Home and Community-based Services Providers.

1.3 "Behavioral Health Organization (BHO)" means a county authority, a group of county authorities, or other entity recognized by the secretary of the Department of Social and Health Services in a defined regional service area that provides both mental health and substance use disorder treatment services.

1.4 "Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering the six Health Home Services to the participating members.

1.5 "Care Coordination Services" means services that coordinate care across several domains. The purpose is to coordinate the full breadth of clinical and social service expertise for high cost/ high risk beneficiaries with complex Chronic Conditions, mental health, and substance use disorder issues and/or long-term service needs and supports.

1.6 "Caregiver Activation Measure (CAM)" means an assessment that gauges the knowledge, skills, and confidence essential to providing care for a person with Chronic Conditions.

1.7 "Chronic Condition(s)" means a physical or behavioral health condition that is persistent or otherwise long lasting in its effects.

1.8 "Client" means a person who is eligible for Care Coordination Services as defined by Amerigroup.

1.9 "Clinical" means Professional (licensed, or otherwise approved) personnel including, but not limited to, registered nurses, licensed practical nurses, Physician's Assistants, Chemical dependency Professionals, BSW or MSW prepared social workers.

1.10 "Comprehensive Assessment Report and Evaluation (CARE)" means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC.

1.11 "Covered Services" means the set of Medicaid Care Coordination services to be coordinated as part of this Health Home Care Coordination Model.

1.12 "Department of Social and Health Services (DSHS)" means the Washington State Department of Social and Health Services.

1.13 "Designated Staff" means either the Contractor's employee(s) or employee of any Subcontractor or employees of any Health Home provider with whom the Contractor has a MOA to provide Health Home Services to the Contractor's enrollees and whom have been authorized by their employer to access data.

1.14 "Developmental Disabilities Administration (DDA)" means the administration within the Department of Social and Health Services that provides services to individuals with disabilities who are functionally and financially determined to receive such services.

1.15 "Eligibility File" means a data file that is sent at least monthly, transmitted by Amerigroup to CCO reflecting eligibility information for all clients assigned to CCO.

1.16 "Engagement" means the member's agreement to participate in Health Homes as demonstrated by the completion of the member's Health Action Plan.

1.17 "Health Action Plan (HAP)" means the plan created with the Client and the Health Home Care Coordinator identifying the Beneficiary's plans to improve their health.

1.18 "Health Home Care Coordinator" means staff employed by CCO to provide Care Coordination Services. Services are delivered or overseen by registered nurses, licensed practical nurses, psychiatric nurses, psychiatrists, physician's assistants, clinical psychologists, licensed mental health counselors, agency affiliated certified mental health counselors, licensed marriage and family therapists, MSW, BSW or related professionally prepared social workers, and certified chemical dependency professionals. Services are delivered or overseen by registered nurses, licensed practical nurses, Physician's Assistants, Bachelors in Social Work or Masters in Social Work or related professionally prepared social workers and Chemical Dependency Professionals. Such Health Home Care Coordinators must meet the qualifications set forth on Attachment E.

1.19 "Health Home Information Sharing and Consent Form" means a release form signed by the member to authorize the release of information to facilitate the sharing of the member's health information.

1.20 "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six (6) Health Home Services are:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional care from inpatient to other settings including appropriate follow-up
- Individual and Family Support
- Referral to Community and Social Support Services
- The use of Health Information Technology to link services, as appropriate.

1.21 "Initial Health Screening" means a screening and interview process that will, at a minimum: screen and assess risk factors, health status, adherence to provider's treatment plan, knowledge of and adherence to prescribed medications, housing status, as well as the Beneficiary's specific needs, including limited English proficiency, health literacy, and the need for or use of supportive services and resources.

1.22 "Initial Health Assessment (IHA)" includes completion of an assessment tool such as PAM and/or CAM.

1.23 "Invoice" means a bill or statement for Care Coordination Services rendered to a Participant submitted in a format approved by Amerigroup and with all service and encounter information required by Amerigroup.

1.24 "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.

1.25 "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives.

1.26 "Memorandum of Agreement/Understanding (MOA or MOU)" means a business agreement for partnerships that do not involve a financial arrangement that describes the roles and responsibilities of each party to the agreement.

1.27 "Outreach, Engagement, and Health Action Plan Development" means the first tier in a three-tiered system and may include a variety of methods, such as mail, phone, or home/doctor visit. Outreach continues until the eligible Beneficiary either declines participation or agrees to participate in the program as a Participant. After the Beneficiary agrees to participate, a face-to-face visit will be scheduled between the Beneficiary and the Health Home Care Coordinator in a location of the Beneficiary's choosing, such as their home or provider's office. The reimbursement rate for Outreach, Engagement and Health Action Planning includes time for preparation and planning which consists of pre-populating the Health Action Plan (HAP) with relevant PRISM utilization data and noting utilization patterns and gaps in care. Execution is the face-to-face visit and the completion of the Health Action Plan, which may utilize the Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM), including Coaching for Activation to assist the Participant in identifying short and long-term goals. Amerigroup will not reimburse CCO for outreach and engagement activities that do not result in converting a Beneficiary to a Participant.

1.28 "Parent Patient Activation Measure (PPAM)" is an assessment that gauges the knowledge, skills and confidence of the parent's management of their child's health.

1.29 "Participant" means a person who is able to participate in Health Home services as demonstrated by the completion of a Health Action Plan.

1.30 "Patient Activation Measure (PAM)" means an assessment that gauges the knowledge, skills, and confidence essential to managing one's own health and healthcare.

1.31 "Predictive Risk Intelligence System (PRISM)" means the joint DSHS/HCA, DSHS Research and Data Analysis administered, web-based database used for predictive modeling and clinical decision support and is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are measure of expected costs in the next 12 months based on Beneficiary's disease profiles and pharmacy utilization.

1.32 "Qualified Health Home" means an entity composed of community-based providers, qualified by the state to provide Health Home Services to eligible enrollees.

1.33 "Rate Tiers" means a three-tier system of payment for Care Coordination Services that makes separate payments for 1) outreach, engagement, and Health Action Plan; 2) Intensive Care Coordination; and 3) Low Level Care Coordination. For each Participant, CCO will only be reimbursed for either Intensive Care Coordination or Low Level Care Coordination on a per month basis. Under no circumstances will CCO receive reimbursement for both Intensive Care Coordination and Low Level Care Coordination of a Participant in the same month. If no Care Coordination services are provided during the month for a particular Participant, then CCO will not be paid for that Participant.

1.34 "Regional Support Network (RSN)" means a county authority or group of county authorities or other entity recognized by the secretary of the DSHS to administer mental health services in a defined region.

1.35 "Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, a program contract, or otherwise imposed by an agency in connection with the operation of a program or the performance required by either party under this Agreement.

1.36 "Tier Two - Intensive Care Coordination" means the highest level of the face-to-face care coordination. At a minimum, Tier Two includes one face-to-face visit with the client every month. Additional services include:

(a) Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual and as deemed necessary by CCO.

(b) Continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed;
(c) Participant assessments (as selected by CCO) to determine readiness for self-management and promote self-management skills so the Participant is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning;

(d) Fostering communication 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;

(e) Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the Health Action Plan;

(f) Health education and coaching designed to assist Participants to increase self-management skills and improve health outcomes; and

(g) Use of peer supports, support groups, and self-care programs to increase the Participant's knowledge about their health care conditions and improve adherence to prescribed treatment.

1.37 "Tier 3 - Low Level Care Coordination" means maintenance of the Participant's self-management skills with periodic home visits and telephone calls to reassess health care needs.

1.38 "Transitions of Care" Means healthcare services including but not limited to: assessment for risk of readmission, appropriateness of discharge planning, timely provider follow up post discharge (within seven (7) days of discharge), and post Transitions support aimed at effective ongoing self-management.

1.39 "Work Day" means any day, Monday through Friday, except for a holiday recognized by the U.S. federal government.

ATTACHMENT B
SCOPE OF SERVICES

AMERIGROUP AND CCO GENERAL REQUIREMENTS

1. In addition to the requirements in this Attachment B, Amerigroup and CCO shall provide such services and comply with such Regulatory Requirements as set forth on Attachment D, Program Contract Requirements for Health Homes.

2. CCO will notify Amerigroup of any changes in a Participant's assignment within thirty (30) days of effective date of change.

3. Amerigroup and CCO acknowledge and agree that Participants have the right to request a new provider or to prospectively discontinue receiving Care Coordination Services from CCO at any time.

4. CCO will coordinate with Amerigroup to ensure referrals for Covered Services are directed to Amerigroup Participating Providers whenever possible. Whenever possible, Beneficiary relationships with current community based organizations will be maintained.

5. CCO will be responsible to verify ongoing eligibility of Participants. Amerigroup will send a daily Eligibility File to CCO. CCO acknowledges that Amerigroup will only pay for Care Coordination Services rendered to Participants who are currently eligible through Amerigroup.

6. Health Assessments, Health Action Plans and case notes will be distributed to Amerigroup staff for review and documentation.

7. CCO will send Amerigroup a monthly status report that includes assignment, date of assignment, status and any members who request to opt out.

8. CCO will document all care management activity in the care management platform designated by Amerigroup.

AMERIGROUP RESPONSIBILITIES

1. Amerigroup is responsible for the Initial Health Screening and assignment of Beneficiary to CCO.

2. Amerigroup will provide CCO with an eligibility file at least once weekly.

3. Amerigroup will pay CCO based on the negotiated rates and frequency detailed in Attachment C – Compensation. Amerigroup will not reimburse CCO for outreach and engagement activities that do not result in converting a client to a Participant as demonstrated by the completion of a HAP.

4. Amerigroup is responsible for utilization management (prior authorization and concurrent review) decisions. Care Coordination does not require prior authorization.

5. Amerigroup is responsible for complex case management activities.

6. Amerigroup is responsible for handling of Client and practitioner complaints related to Care Coordination activities

7. Amerigroup is responsible for assessment of Client satisfaction with Care Coordination Services.

8. Amerigroup is responsible for requiring a corrective action plan for any compliance issues identified and tracking it to completion.

9. Amerigroup is responsible for submitting encounter data to Health Care Authority.

10. Amerigroup will monitor and maintain the staff training (i.e. mandatory and elective training records) records and access requests for state systems such as Provider One and PRISM for submission to the HCA.

11. Amerigroup will assign a CCO for each Participant based upon the Participant's diagnosis/ses, service utilization history, and most frequently used health providers, age, and any unique characteristics or needs within five (5) Work Days of receipt of Participant Information from Amerigroup.

12. Simultaneously, Amerigroup will send a welcome letter to each Client outlining:

    12.1 A Health Home Care Coordinator or Wellness Coach will be contacting them soon.
    12.2 Description of CCO's responsibilities and available services.
    12.3 The toll-free CCO Customer Services number, toll-free Crisis Line, CCO website address, and the Amerigroup's 27/4 nurse advice line as sources of additional information as well as the HCA contact numbers.
    12.4 Any HCA contact names, numbers of other information requested by HCA.

CCO's RESPONSIBILITIES

1. **Assignment**

1.1 At least once a week CCO will receive an eligibility file from Amerigroup. Amerigroup will determine who meets eligibility requirements for this program.

1.2 CCO loads the information into Provider Data System thereby creating a record for each Client.

1.3 CCO's IS Support/Reporting Staff and Care Coordination Project Manager review the demographics, diagnosis, service histories, medications, labs, hospitalizations, emergency department visits, and risk factor of each individual Client documented in PRISM, and the State Consumer Information System ('CIS").

1.4 CCO populates an Initial Client Profile.

1.5 CCO will ensure and demonstrate culturally and linguistically appropriate standards for its staff.

1.6 CCO's Health Home Care Coordinator Project Manager will enter each Client's assignment and other pertinent information in the Provider Data System.

2. **Outreach & Engagement**

2.1. CCO will attempt outreach contact to the Client within seven (7) Work Days of assignment. Outreach will continue following the receipt of assignments until the Client either declines participation or agrees to participate in Care Coordination services.

2.2. Amerigroup and CCO share an expectation that a portion of assigned Client's may not be successfully reached through telephonic or in-person outreach. CCO shall make at least three attempts to reach assigned Client, Client's responsible family member or assigned guardian by telephone. These attempts will be documented and made on different days of the week as well as different times of day.

2.3. Amerigroup acknowledges that CCO, by way of existing programs and partnerships, has opportunities to outreach and engage Amerigroup Clients who may be eligible and require Care Coordination services prior to Amerigroup being able to formally assign the client to CCO. Amerigroup acknowledges and agrees to allow CCO to conduct Care Coordination services for identified Amerigroup beneficiaries prior to obtaining formal assignment from Amerigroup, if it is in the best interest of the Amerigroup beneficiary and abides by the parameters defined in Section 2.4.

2.4. CCO agrees to notify Amerigroup of the self-assigned client and to inform Amerigroup of the context of the initial outreach and engagement with such Client within 24 hours of initial interaction with Client. At that time, CCO will obtain formal assignment and authorization to continue Care Coordination services. Amerigroup will determine if client should receive ongoing services as described in this Agreement and will assign client to CCO to engage in further services as applicable. At any point in time, Amerigroup has the right to notify CCO that a client or group of clients will no longer be participating in the program.

2.5. An Initial Health Assessment & corresponding Health Action Plan (HAP) as defined in Attachment A will be performed by a qualified Clinical professional or CCO's contracted staff.

2.6. Amerigroup and CCO share an expectation that a portion of assigned Beneficiary's will require interpretation services to complete the IHA or HAP. CCO will provide to Amerigroup an invoice to separately bill any costs associated with providing telephonic or in-person interpretation services to such Beneficiary.

3. **Intensive Care Coordination**

3.1. CCO will engage Participants in Intensive Care Coordination frequently, including but not limited to at least one in person interaction per month.

3.2. CCO will collaborate, coordinate, and communicate with Amerigroup Case Managers/Care Coordination staff as needed to facilitate ongoing coordination of health care needs for Participants.

3.3. CCO will reassess Participant Tier of care coordination every four (4) months.

4. **Low-Level Care Coordination**

4.1. CCO will engage "low-level" participants or provide Care Coordination Services at least once per month, by phone or in person.

4.2. CCO will collaborate, coordinate, and communicate with Amerigroup Case Managers/Care Coordination staff as needed to facilitate ongoing coordination of health care needs.

4.3. CCO will reassess Participant Tier of care coordination every four (4) months.

5. **Transitions of Care**

5.1. CCO will provide Transitional healthcare services including but not limited to: assessment for risk of readmission, appropriateness of discharge planning, timely provider follow up post discharge (within seven (7) days of discharge), medication reconciliations, and post Transitions support aimed at effective ongoing self-management.

5.2. Amerigroup will notify CCO of all members requiring Transitions of Care services in the most effective and efficient manner, so that services can be administered before member is discharged from original setting.

5.3. Transitional Care interventions and services shall be documented in the client's record of services in CCO's systems.

6. **Background Checks**

6.1 CCO shall perform and track criminal history background checks on all employees, volunteers, and subcontractor staff who may have unsupervised access to Clients that are children and/or vulnerable adults.

OVERSIGHT AND CONFIDENTIALITY

1. Upon request, and to facilitate oversight, CCO agrees to meet in person with Amerigroup no less than monthly for the purpose of identifying process improvement opportunities and reviewing care coordination performance metrics.
2. Upon request, and to facilitate oversight, CCO will provide its policies and procedures related to Care Coordination to Amerigroup.
3. Upon request, and to facilitate oversight, CCO will make case files available upon reasonable notice for review by Amerigroup. If CCO utilizes an electronic medical records system, CCO shall ensure that Amerigroup has access to such system to review Amerigroup member files.
4. Upon request and with reasonable advance notice, CCO shall provide access to Amerigroup Client and Participant files and records for duly authorized representatives of federal or state government regulatory agencies.
5. CCO and Amerigroup staff shall coordinate activities and share information as necessary to provide timely access to quality services for Amerigroup Clients and Participants. Such information shall be maintained and treated in a confidential manner, consistent with federal and state law. PHI shall mean information defined as such in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ATTACHMENT C
COMPENSATION

Amerigroup agrees to reimburse CCO for Care Coordination Services at the rates outlined below.

A. Rates and Tiers

Tier I:

1. **Outreach, Engagement, and Health Action Plan per Participant: -- $252.93.** This is a one-time only rate and is triggered by the Health Action Plan Encounter code – G9148 that must be submitted before any other encounter can be paid. Participant must complete the Health Action Plan before this encounter code can be submitted.

Tier II:

1. **Intensive Health Home Care Coordination: -- $172.61** per Participant per month. The rate is paid once per month, per Participant and triggered by. Encounter code G9149.

Tier III:

1. **Low-Level Health Home Care Coordination: -- $67.50** per Participant per month. This rate is paid once per month per Participant and triggered by Encounter code - G9150.

For each Participant, CCO will only be reimbursed for either Intensive Health Home Care Coordination or Low Level Health Home Care Coordination on a per month basis. Under no circumstances will CCO receive reimbursement for both Intensive Health Home Care Coordination and Low Level Health Home Care Coordination of a particular Participant in the same month. If no Health Home services are provided during the month for a particular Participant, then CCO will not be paid for that Participant.

B. Billing and Payment

1. CCO shall submit Invoices, or 837 claim files, whichever is applicable, to Amerigroup for appropriate payment of Tiers in accordance with applicable Regulatory Requirements and the then current Amerigroup policies and procedures.

a. Encounters will be submitted for individual Participants based upon provision of an eligible Care Coordination service. Only one Encounter code per Participant will be accepted per month.

b. Encounters Paid. Refer to Section A above.

c. CCO shall ensure that back-up documentation that supports the delivery of one of Care Coordination Services is collected for each submitted encounter.

d. CCO providing Care Coordination Services upon submittal of a valid Encounter code shall receive payment for one Encounter Code per Participant per month.

e. Amerigroup shall consider payments made pursuant to the AGREEMENT to have been made timely if made by Amerigroup within thirty (30) calendar days of Amerigroup's acceptance of a properly and undisputed submitted Invoice.

ATTACHMENT D

Program Contract Requirements for Health Homes

1. CCO agrees to abide by all applicable provisions of the Program Contract, including but not limited to the requirements set forth in this Attachment D.

2. **Health Home Services for Apple Health (AH) Enrollees**

2.1 CCO shall provide Health Home services in addition to the Care Coordination Services described in Section 14 of the Apple Health Contract, to high cost, high needs enrollees who meet Health Home eligibility criteria. Health Home Services shall be community-based, integrated and coordinated across medical, mental health, substance use disorder, and long-term services and supports to enrollees based on the services described in Section 1945(h)(4) of the Social Security Act. CCO shall ensure that the following are operational:

2.1.1 Policies and Procedures: CCO shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated Contractor-specific policies and procedures that address the following:

2.1.1.1 The requirement to maintain frequent, in-person contact between the Health Home enrollee and the Health Home Care Coordinator when delivering Health Home services;
2.1.1.2 Ongoing availability of support staff to complement the work, collaborate, receive direction and report to the Health Home Care Coordinator;
2.1.1.3 Support screening, referral and co-management of individuals with both behavioral health and physical health conditions;
2.1.1.4 CCO's and subcontractor's roles and responsibilities for enrollee engagement;
2.1.1.5 Ensuring an appointment reminder system is in place for beneficiaries;
2.1.1.6 Tracking of enrollee assignment to Care Coordination Organizations;
2.1.1.7 Referrals to HCA for eligibility review of any potential enrollee who seeks or needs Health Home Services;
2.1.1.8 Transitional care services for enrollees transferring to or from hospital or other inpatient setting or emergency departments;
2.1.1.9 A policy and procedure to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA; and
2.1.1.10 Due diligence for contacting the enrollee for affirmation of participation.

2.1.2 Methods to identify and address enrollee gaps in care through:
2.1.2.1 Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the enrollee's age and underlying chronic conditions;
2.1.2.2 Evaluation of enrollee perception of gaps in care;
2.1.2.3 Documentation of gaps in care in the enrollee case file;
2.1.2.4 Documentation of interventions in the HAP and progress notes;
2.1.2.5 Findings from the enrollee's response to interventions; and
2.1.2.6 Documentation of follow-up actions, and the person or organization responsible for follow-up.

2.1.3 A system for emergency consultation and general information available 24/7;

2.1.4 Policies, procedures and agreements with hospitals for transitioning care for Health Home enrollees and referring eligible enrollees who seek or need treatment in a hospital emergency department for Health Home enrollment;

2.1.5 CCO shall require its Designated Staff to timely complete and submit to Amerigroup, for Amerigroup to meet its reporting requirements to DSHS PRISM Administration Team, all necessary forms required by CMS and DSHS for data authorization and PRISM access, including:

2.1.5.1 The PRISM registration form,

2.1.5.2 The Nondisclosure of HCA Confidential Information form (Exhibit Attachment 4),

2.1.5.3 The DSHS provided spreadsheet.

2.1.6 CCO shall ensure Designated Staff receive an annual written reminder of the required Nondisclosure of HCA Confidential Information requirements.

2.1.7 CCO shall promptly notify Amerigroup when established Designated Staff user accounts should be removed due to employment termination, job reassignment, or other changes in circumstances.

2.2 Amerigroup shall ensure that the following are operational:

2.2.1 Submission of completed and updated Health Action Plan (HAP) data through the *OneHealthPort* Health Information Exchange using the OneHealthPort Canonical Guide located at: http://www.hca.wa.gov/medicaid/health_homes/Documents/HAP_CanonicalGuide.pdf. The HAP data will be stored in a Medicaid data base for evaluation purposes;

2.2.2 A system to track and share enrollee information and care needs among providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the enrollee's preferences and identified needs;

2.2.3 A system to track Health Home Services through claims paid or services rendered and report the encounter data in accordance with the HCA Encounter Data Reporting Guide;

2.2.4 Enrollee access to toll-free line and customer service representatives to answer questions, 8:00 AM to 5:00 PM from Monday through Friday regarding Health Home enrollment, disenrollment and how to access services or request a change to another CCO;

2.2.5 A system for emergency consultation and general information available 24/7;

2.2.6 Policies, procedures and agreements with hospitals for transitioning care for Health Home enrollees and referring eligible enrollees who seek or need treatment in a hospital emergency department for Health Home enrollment;

2.2.7 Amerigroup's PRISM Coordinator shall identify all Designated Staff who have a business need to access PRISM.

2.2.7.1 Amerigroup shall provide CCO oversight to ensure that CCO's Designated Staff complete and submit to Amerigroup, for Amerigroup's submission to the DSHS PRISM Administration Team, all necessary forms required by CMS and DSHS for data authorization and PRISM access, including:

2.2.7.1.1 The PRISM registration form,
2.2.7.1.2 The Nondisclosure of HCA Confidential Information form (Exhibit Attachment 4),
2.2.7.1.3 The DSHS provided spreadsheet.

2.2.7.2 Amerigroup shall provide CCO oversight to ensure CCO's Designated Staff receive an annual written reminder of the required Nondisclosure of HCA Confidential Information requirements.

2.2.7.3 Amerigroup shall promptly notify the DSHS PRISM Administration Team when established Designated Staff user accounts should be removed due to employment termination, job reassignment, or other changes in circumstances.

2.3 The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the enrollee's health and health care choices available to Health Home enrollees.

2.4 The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally competent manner that addresses health disparities by:

2.3.1 Interacting directly with the enrollee and his or her family in the enrollee's primary language and recognizing cultural differences when developing the HAP;
2.3.2 Understanding the dynamics of substance use disorder without judgment; and
2.3.3 Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the enrollee and his or her caregivers in addressing the obstacles.

2.5 The Health Home Care Coordinator shall:

2.4.1 Discuss changes in enrollee circumstances or conditions with the treating/authorizing entities who serve the enrollee;
2.4.2 Document changes in the enrollee's circumstances or conditions in the HAP in a timely manner;
2.4.3 With the enrollee's permission, include paid and unpaid caregivers who have a role in supporting the enrollee to achieve health action goals and access health care services;
2.4.4 Collaborate with health care professionals such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers;
2.4.5 Have access to providers from the local community who authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), substance use disorder and medical services. This group may include RSNs BHOs, DSHS-Home and Community Services (HCS), Community Mental Health Agencies (CMHA's), Area Agencies on Aging (AAAs), substance use disorder providers, and community supports that assist with housing; and

2.4.6 Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialists, family members and housing representatives or others, to support the enrollee's HAP.

2.6 Lead Entities must have executed a Memorandum of Understanding or Agreement with organizations that authorize Medicaid services such as DSHS Home and Community Services (HCS), RSNsBHOs, DDA, and Area Agency on Aging to ensure continuity of care. MOU/MOAs must contain information related to enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.

3. Training Requirements. CCO shall ensure that:

3.1 Health Home Care Coordinators and affiliated staff complete client confidentiality and data security training upon hire and annually thereafter.

3.2 Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to completing the HAP with an enrollee.

3.3 Health Home Care Coordinators complete the following special-topic modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.

3.3.1 Outreach and Engagement Strategies;
3.3.2 Navigating the LTSS System: Part 1;
3.3.3 Navigating the LTSS System: Part 2;
3.3.4 Cultural and Disability Competence Considerations;
3.3.5 Assessment Screening Tools; and
3.3.6 Coaching and Engaging Clients with Mental Health Needs.

3.4 Health Home Care Coordinators and affiliated personnel comply with continued training requirements as necessary.

3.5 Evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.

3.6 CCO has a Health Home Care Coordinator trainer on staff, or shall subcontract for Health Home Care Coordinator training services.

3.6.1 The trainer shall be certified qualified by DSHS prior to providing Health Home Care Coordinator training.

3.6.2 Trainer Certification Qualification includes:

3.6.2.1.1 Completion of the Health Home Care Coordinator training course;
3.6.2.1.2 Completion of a State-sponsored trainer's preparation course;
3.6.2.1.3 Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS;
3.6.2.1.4 Receipt of a State-issued certificate of completion or letter authorizing the individual to provide training to Health Home Care Coordinators.

3.7 CCO shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.

3.7.1 The Health Home Care Coordinator training is delivered using all of the DSHS materials including the small group activities using de-identified PRISM data, training agenda, training manual inserts, and handouts.

3.7.2 The trainer does not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials or include unauthorized topics, curriculum, or material in the Health Home Care Coordinator training.

4. Eligibility and Enrollment

HCA shall determine eligibility and identify enrollees who are eligible for Amerigroup's Health Home program.

4.1 Those determined eligible for Health Home services must have at least one chronic condition and be at risk of a second as determined by a minimum PRISM score of 1.5. The chronic conditions are:

4.1.1 Mental health conditions;
4.1.2 Substance use disorders;
4.1.3 Asthma;
4.1.4 Diabetes;
4.1.5 Heart disease;
4.1.6 Cancer;
4.1.7 Cerebrovascular disease;
4.1.8 Coronary artery disease;
4.1.9 Dementia or Alzheimer's disease;
4.1.10 Intellectual disability or disease;
4.1.11 HIV/AIDS;
4.1.12 Renal failure;
4.1.13 Chronic respiratory conditions;
4.1.14 Neurological disease;
4.1.15 Gastrointestinal disease;
4.1.16 Hematological conditions; and
4.1.17 Musculoskeletal conditions.

4.2 HCA shall include a Health Home Clinical Indicator in the monthly enrollment listing of AH enrollees that meet Health Home criteria.

4.2.1 CCO shall ensure eligible Health Home enrollees are offered Health Home services through a contracted Qualified Health Home or a CCO until they either agree to participate or decline to participate in the Health Home program. CCO shall follow the HCA documented due diligence process in offering services to eligible enrollees.

4.2.2 CCO must document in the client record why an eligible enrollee declines to participate, unless the enrollee does not want to explain his or her decision.

4.3 CCO shall ensure Health Home eligible enrollees are assigned a Health Home Care Coordinator through a Qualified Health Home.

4.4 Enrollees who have agreed to participate may disenroll from the Health Home program at any time. CCO shall maintain a record of all enrollees who choose to disenroll from the Health Home

program. Amerigroup shall track those enrollees who choose to disenroll from the Health Home program and the reasons why and shall report such information as required to HCA.

4.5 Enrollees who disenroll from the Health Home program may re-enroll at any time.

4.6 Amerigroup shall use a standardized tool provided by the State to determine initial eligibility for Health Home services if the enrollee has less than fifteen (15) months of claims history or is referred by a provider. Amerigroup shall notify HCA when the enrollee has been screened. When HCA determines the enrollee qualifies, Amerigroup shall ensure the enrollee receives Health Home services unless the enrollee declines to participate in the program.

4.7 Amerigroup shall accept referrals for Health Home services from any health care provider, whether or not the health care provider is contracted with Amerigroup.

5. Assignment, Engagement, and Participation.

5.1 Whenever possible, Amerigroup shall assign Health Home enrollees to CCO using a smart assignment process that takes into account the enrollee's current health care provider(s). This may be achieved by:

5.1.1 Using PRISM or other data systems to match the enrollee to a CCO that provides most of the enrollee's services; or

5.1.2 Allowing enrollee choice of CCOs.

5.2 The CCO selected must have a written agreement with a Qualified Health Home or the MCO.

5.3 CCO shall ensure each enrollee file includes a contact log that includes the date of assignment to the CCO or internal Health Home Care Coordinator, the date the client agrees to participate, the date and purpose of each contact, and identifies the staff that interacts with the enrollee.

5.4 CCO shall ensure the Health Home Care Coordinator uses the following resources to develop enrollee HAPs:

5.4.1 The enrollee's medical record, if available, and PRISM data;

5.4.2 Treatment plans, CARE assessments, and results of previous screens and assessments, if available;

5.4.3 Information from CCO's authorization and service utilization systems; and

5.4.4 Input from the enrollee and his or her family and/or caregivers.

5.5 CCO shall ensure the Health Home Care Coordinator completes the initial HAP within ninety (90) calendar days from the date of notification of Health Home eligibility. A complete HAP must include documentation of agreement by the enrollee to participate in the Health Home program.

5.5.1 CCO must ensure that:

5.5.1.1 The Health Home Care Coordinator meets in-person with each enrollee at the enrollee's choice of location to explain, develop, and complete the HAP with input from the enrollee and/or the enrollee's caregiver(s);

5.5.1.2 The HAP documents the enrollee's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;

5.5.1.3 The HAP includes the required BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores;
5.5.1.4 The HAP includes the required Patient Activation Measure (PAM), or Patient Parent Activation Measure (PPAM), or Caregiver Activation Measure (CAM) activation level and screening score;
5.5.1.5 The HAP identifies optional screenings administered, if applicable, and
5.5.1.6 The HAP includes the reason the enrollee declined assessment or screening tools.

5.5.2 HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:
5.5.2.1 After every four (4) month activity period to update the PAM, PPAM, CAM, BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores and reassess the enrollee's progress towards meeting self-identified health action goals, add new goals or change in current goals;
5.5.2.2 Whenever there is a change in the enrollee's health status or a change in the enrollee's needs or preferences.

5.5.3 Completed and updated HAP content, enrollee's goals and action steps must be shared with enrollees and with consent of the enrollee, the enrollee's caregiver and family

5.5.4 Additional information not included in the State-developed HAP form must be included as an addendum. Written information in the HAP must use language that is understandable to the enrollee and/or the enrollee's caregiver(s).
5.5.5 Upon request, completed and updated HAPs must be shared with other individuals identified and authorized by the enrollee on the signed Health Home Information Consent form.

5.5.6 The Health Home Care Coordinator or affiliated staff shall:
5.5.6.1 Arrange an in-person visit in the enrollee's choice of location.
5.5.6.2 Describe the program to the enrollee, including a description of Health Home Services and care coordination.
5.5.6.3 Arrange an appointment with the Health Home Care Coordinator to complete the HAP.

5.5.7 The Health Home Care Coordinator shall meet with the enrollee in person to complete the HAP, including the following:
5.5.7.1 Explain the HAP and the development process to the enrollee;
5.5.7.2 Complete a Health Home Information Sharing Consent form;
5.5.7.3 Evaluate the enrollee's support system; and
5.5.7.4 Administer and score either the Patient Activation Measure (PAM), Parent Patient Activation Measure (PPAM) or Caregiver Activation Measure (CAM).

5.5.8 The Health Home Care Coordinator uses the PAM; PPAM; or CAM to:
5.5.8.1 Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent declines and access appropriate and high quality health care;
5.5.8.2 Target tools and resources commensurate with the enrollee's level of activation;
5.5.8.3 Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;

5.5.8.4 Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the enrollee; and
5.5.8.5 As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

5.6 **Comprehensive Care Management Services**

CCO shall ensure the Health Home Care Coordinator:

5.6.1 Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;

5.6.2 Assesses enrollee's readiness for self-management and promotion of self-management skills;

5.6.3 Reassesses the HAP and Health Home enrollee's progress in meeting goals;

5.6.4 Manages barriers to achieving health action goals;

5.6.5 Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;

5.6.6 Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;

5.6.7 Reassesses patient activation at minimum every four (4) month activity periods, or more frequently if changes warrant reassessment using the PAM; PPAM or CAM and documents the results in the HAP; and

5.6.8 Ensures communication, coordination, and care management functions are not duplicated between the Health Home Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS and AAA case managers.

5.7 **Care coordination and health promotion.** CCO shall ensure the Health Home Care Coordinator:

5.7.1 Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;

5.7.2 Fosters communication between the health care providers, including treating primary care provider, medical specialists, behavioral health providers and entities authorizing behavioral health and long-term services and supports;

5.7.3 Maintains a caseload that ensures timely intervention;

5.7.4 Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services;

5.7.5 Provides interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices; and

5.7.6 Provides educational materials that promote the following:

5.7.6.1 Improved clinical outcomes;
5.7.6.2 Enrollee participation in his or her care;
5.7.6.3 Continuity of care;
5.7.6.4 Increased self-management skills; and
5.7.6.5 Use of peer supports to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.

5.7.7 Shares the HAP with individuals identified by the enrollee, with the enrollee's written consent. These individuals may include, but are not limited to: family, caregivers, primary care providers, mental health treatment providers, and authorizers of long term services and supports and/or substance use disorder treatment providers.

5.7.7.1 The HAP shall provide written evidence of:

5.7.7.1.1 The enrollee's chronic conditions, severity factors and gaps in care, activation level, and opportunities to prevent avoidable emergency room, inpatient hospital and institutional use;
5.7.7.1.2 Enrollee self-identified goals;
5.7.7.1.3 Needed interventions and desired outcomes;
5.7.7.1.4 Transitional care planning, including assessment and deployment of needed supports; and
5.7.7.1.5 Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and paid or unpaid caregivers.

5.7.7.2 The Health Home Care Coordinator shall assess the enrollee's patient activation scores and level to determine the appropriate coaching methods and a teaching and support plan that includes:

5.7.7.2.1 Introduction of customized educational materials based on the enrollee's readiness for change;
5.7.7.2.2 Progression of customized educational materials in combination with the enrollee's level of confidence and self-management abilities;
5.7.7.2.3 Documentation of opportunities for mentoring and modeling communication with health care providers provided through joint office visits and communications with health care providers by the enrollee and the Health Home Care Coordinator;
5.7.7.2.4 Documentation of wellness and prevention education specific to the enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;
5.7.7.2.5 Support for improved social connections to community networks, and links the enrollee with resources that support a health promoting lifestyle; and
5.7.7.2.6 Links to resources for, but not limited to: smoking cessation, substance use disorder prevention, nutritional counseling, obesity reduction, increasing physical activity, disease-specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.

5.7.8 Ensures the enrollee is accompanied to critical health care and social service appointments when necessary to assist the enrollee in achieving his or her health action goals.

5.7.9 Ensures treating providers and authorizing entities coordinate and mobilize to reinforce and support the enrollee's health action goals.

5.7.10 Meets with Amerigroup health home and case management staff for member rounds at least monthly. Member rounds shall consist of scheduled meetings where Amerigroup health home and case management staff meet with CCO to discuss member(s) care planning.

5.8 **Transitional Care**.

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

5.8.2 In addition to services described in Transitional Care provisions of this Contract, CCO's transitional care planning process must include:

5.8.2.1 Participation by the Health Home Care Coordinator in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays, post hospital/institutional stay, home visits, and follow-up telephone calls;
5.8.2.2 A notification system between Amerigroup, CCO and facilities that provides prompt notification of an enrollee's admission or discharge from an emergency department, inpatient setting, nursing facility or residential/rehabilitation facility, and if proper permissions are in place, a substance use disorder treatment setting;
5.8.2.3 Progress notes or a case file that documents the notification;
5.8.2.4 Transition planning details such as medication reconciliation, follow-up with providers and monitoring documented in the HAP;
5.8.2.5 CCO may employ staff that have been trained specifically to provide transitional services, as long as the Health Home Care Coordinator is an active participant in the transitional planning process; and
5.8.2.6 Established frequency of communicating hallmark events to the assigned Health Home Care Coordinator.

5.9 **Individual and family support**.

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

5.9.2 CCO shall ensure the Health Home Care Coordinator, with the enrollee's participation:

5.9.2.1 Identifies the role that the enrollee's family, informal supports and paid caregivers provide to help the enrollee achieve self-management and optimal levels of physical and cognitive function;
5.9.2.2 Educates and supports self-management; self-help recovery and other resources necessary for the enrollee, his or her family and caregivers to support the enrollee's individual health action goals;

5.9.2.3 Within the first or second HAP trimester documents discussion of advance directives or representative in the discussion; and
5.9.2.4 Communicates and shares information with the enrollee's family and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

5.10 **Referral to community and social support services.**

5.10.1 The Health Home Care Coordinator shall ensure that:

5.10.1.1 Available community resources are identified and accessible to the Health Home enrollee.

5.10.1.2 Referrals:
5.10.1.2.1 Are overseen by the Health Home Care Coordinator;
5.10.1.2.2 Support the enrollee's health action goals;
5.10.1.2.3 Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
5.10.1.2.4 Are documented in the enrollee's progress notes and HAP.

5.10.1.3 Assistance is provided to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.

5.10.1.4 Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations.

5.11 **Quarterly Quality Reports**

5.11.1 Amerigroup shall submit quality reports to HCA in accordance with the following reporting periods:

5.11.1.1 January through March due May 1st;
5.11.1.2 April through June due August 1st;
5.11.1.3 July through September due November 1st; and
5.11.1.4 October through December due February 1st.

5.11.2 Quarterly quality reports must contain the following elements:

5.11.2.1 Summary and overview of Health Home Service:
5.11.2.1.1 Activities;
5.11.2.1.2 Strengths and best practices; and
5.11.2.1.3 Barriers encountered during the reporting period.
5.11.2.2 Updated Care Coordination network of providers in the format provided by HCA.

5.11.2.3 De-identified individual Health Home enrollee success stories for two (2) to five (5) enrollees that may include the following:

5.11.2.3.1 Risk score at initial engagement;
5.11.2.3.2 Gender; age; race; and ethnicity;
5.11.2.3.3 Health concerns;
5.11.2.3.4 Initial PAM Score/Activation Level;
5.11.2.3.5 Current PAM Score/Activation Level; and

5.11.2.3.6 The enrollee story describing how the Health Home program provided support to the enrollee.

5.11.2.4 Number of Health Home enrollees identified and enrolled with Amerigroup during the quarter;

5.11.2.5 Total number of Health Home enrollees referred to a CCO or internal Health Home Care Coordinator regardless of enrollment date;

5.11.2.6 Total number of Health Home enrollees not yet referred to a CCO or Health Home Care Coordinator because of lack of capacity or inability to contact after due diligence;

5.11.2.7 Total number of newly engaged Health Home enrollees during the reporting period.

ATTACHMENT E

Health Home Care Coordinator Qualifications

1. Behavioral Health Professionals or Specialists:
   a. Psychologists licensed as a psychologist pursuant to chapter 18.83 RCW.
   b. Child psychiatrists licensed as a physician and surgeon in Washington State, who has had a 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. 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. "Psychiatric nurse" shall also mean any other registered nurse who has three years of such experience.
   d. Counselor means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee.
      - A mental health counselor may be:
        - A Licensed Mental Health Counselor with a master's degree in a related field;
        - A doctorate in Psychology;
        - Marriage and Family Counselor with a master's or doctoral degree or behavioral science master's or doctoral degree with equivalent course work from an approved school;
        - A master's degree in Counseling/Psychology;
        - A Certified Mental Health Counselor with a bachelor's degree in a related field. Chapter 19/10 RCW. 246-910 WAC;
        - An Agency Affiliated Registered Counselor with a bachelor's degree in Psychology. Agency affiliated counselors may not engage in the practice of counseling unless they are currently affiliated with an agency pursuant to chapter 18.19.210;
        - A bachelor's degree in a related mental health field with two years of experience. Qualified Health Homes must submit the position description and gain approval from HCA before posting the position. See process below.
2. Nurse Care Coordinators and Nurses:
   a. Registered nurses licensed to practice registered nursing under chapter 18.79 RCW.
   b. Nurse Practitioners licensed to practice advanced registered nursing under chapter 18.79 RCW.

c. Licensed Practical nurses licensed to practice practical nursing under chapter 18.79 RCW. Licensed Practical nurses must not act out of their scope of practice. Refer to 18.79.070 RCW.

3. Physician Assistants: Must be licensed by the Department of Health, Medical Quality Assurance Commission to practice medicine to a limited extent only under the supervision of a physician as defined in chapter 18.71 RCW and who is academically and clinically prepared to provide health care services and perform diagnostic, therapeutic, preventative, and health maintenance services. Physician Assistants must have graduated from an accredited physician assistant program approved by the commission and be certified by successful completion of the NCCPA examination.

4. Social Workers:

    a. A master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

    b. A bachelor's degree in social work, human services or related field. Qualified Health Homes must submit the position description and gain approval from HCA before hiring posting the position. See process below.

5. Chemical Dependency Professionals: Must be certified in chemical dependency counseling under chapter 18.205 RCW. Certification is through the Department of Health.