King County

Health Home Frequently Asked Questions (FAQ) Guide

I. Health Homes Overview

What is the Health Home program?
The Health Home program is a care coordination service available to eligible Medicaid clients of all ages including Medicaid clients who also receive Medicare. To receive services, clients must have a chronic condition and be at risk for a second, as demonstrated by a PRISM risk score of 1.5 or greater. The program focuses on care coordination between the client's medical, behavioral and social needs providers.

What is the primary goal of the Health Home Program?

- Improve the quality and coordination of care across systems of care
- Reduce expenditures
- Increase confidence and self-management of health goals
- Provide a single point of contact to bridge systems of care

II. Onboarding of New Health Home Staff

What is a Care Coordinator?
A "Care Coordinator" is the person who provides Health Home services. The care coordinator works with clients to help them identify and meet their goals for self-management, improving health and providing comprehensive care management.

Who can be a Care Coordinator?
Care Coordinators may be employed by a Health Home Provider contracted with the King County Behavioral Health Organization (KCBHO).
Care Coordinators education or licensing requirements are as follows:

- Educational/licensure requirements for Care Coordinator(s) include: Registered Nurses (RNs), Advanced Registered Nurse Practitioners (ARNPs), Psychiatric ARNPs, licensed practical nurses (LPNs), bachelor or master's-level Social Workers, licensed mental health counselors (LMHCs), and Chemical Dependency Professionals (CDPs), and Agency Affiliated Counselor Registration (AACR). Exceptions to these criteria may be made on a case-by-case basis.

What is an Allied Staff?
An Allied Staff is community health workers, peer counselors or other non-clinical personnel who provide supportive services to the client and Health Home program under the direction and supervision of the Health Home Care Coordinator

What are the onboarding requirements for Allied Staff?
The requirements for Allied Staff vary slightly between Managed Care Organizations (MCOs) but overall the onboarding process is simpler than it is for Care Coordinator. There is minimal paperwork that will need to be completed for Allied Staff. Please include the name, email, phone number and position (Allied Staff) for the new hire in the body of the email.

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** **Molina Only**- Molina will not allow Allied Staff to have access to their platform.*

What are the onboarding requirements for new staff?
The Health Home Provider should contact Bill Wilson BillR.Wilson@kingcounty.gov at the KCBHO to let him know a new Care Coordinator or Allied Staff has been hired. Staff from the BHO will send you paperwork that needs to be completed. KCBHO will schedule trainings for the new hire and get access set up for the necessary platforms. Sara Hoffman and JanRose Ottaway-Martin will contact the new staff to register them for the applicable trainings.

New staff shall complete and submit the required forms listed in the table below for each MCO that your agency will received referrals from.

Community Health Plan of WA (CHPW)	Amerigroup	Coordinated Care	United Healthcare	Molina
PRISM Form (All fields must be typed other than signature)	PRISM Form	PRISM Form	PRISM Form	PRISM Form
CHPW Health Home Attestation Form	CCO Staff Registration Spreadsheet			Resume
MHITS Form				CCA External Access Request Form
Care Coordinator Completion Dates Form				

What training is required for Care Coordinators?
Prior to performing Health Home Services, Care Coordinators must complete and maintain evidence of satisfactory completion of all applicable training requirements, in accordance with Health Home Policies and Procedures.

Training requirements include:

- The two-day, Washington State-mandated certification training. The 2018 training calendar can be found here.
- Database platform trainings for each MCO
- Annual confidentiality and data security training provided by the Heath Home's agency.
- Washington State mandated trainings/webinars within six months of completing the two-day certification training.
    - Outreach and Engagement Strategies
    - Navigating the LTSS System: Part 1
    - Navigating the LTSS System: Part 2
    - Cultural Considerations
    - Assessment and Screening Tools
    - Medicare Grievance and Appeals (Dual Eligible)

- Coaching and Engaging Clients with Mental Health Needs

**CHPW only- CHPW requires Care Coordinators to complete the above trainings within three months of completing the two- day certification training.*

To register for the two-day Washington State- mandated certification training please click the link below for available training dates. To register, you must contact the assigned trainer listed on the calendar. To register for one of the MCO platform trainings, please contact Bill Wilson BillR.Wilson@kingcounty.gov .

Care Coordinator - Two Day Training Schedule

III. Qualifying Services

What are the Six Qualifying Health Home Services?
Qualifying Health Home services include:

1. **Comprehensive Care Management:** The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered Health Action Plan (HAP).
   Examples of Comprehensive Care Management may include:
   - Conduct outreach and engagement activities
   - Develop the HAP setting client centered goals and action steps
   - Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
   - Identify possible gaps in services and secure needed supports

2. **Care Coordination:** The Health Home Care Coordinator shall play a central and active role in development and execution of cross-system care coordination to help the Health Home member access and navigate needed services. The Care Coordinator shall assure communication is fostered between the providers of care. Care Coordination is the bridge between all the client's systems of care, including non-clinical support such as food, housing, and transportation.
   Examples of Care Coordination include:
   - Promote optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;
   - Engagement activities that support the client's participation in their care and promotes continuity of care;
   - Communicate and consult with provider and conduct or participate in interdisciplinary teams; and
   - Use of peer supports, support groups and self-care programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment

2. **Health Promotion:** Monitoring of progress toward goals identified in the HAP to promote optimal health and wellness. This is accomplished through face-to-face contacts with the client, family, caregivers, and providers.
   Examples of Health Promotion may include:
   - Opportunities for mentoring and modeling communication with health care providers;
   - Encourage and monitor progress towards individualized short and long term goals;
   - Assist and support the client with scheduling health appointments and accompany if needed;
   - Provide wellness and prevention education specific to the client's chronic conditions and HAP;
   - Support for improving social connections to community networks; and
   - Linking beneficiaries with resources that support a health promoting lifestyle including but not limited to smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity

3. **Comprehensive Transitional Care:** The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.
   Examples of Comprehensive Transitional Care may include:
   - Follow-up with hospitals/ED upon notification of admission or discharge
   - Provide post-discharge contact with client and support network to ensure discharge orders are followed
   - Assist with access to needed services or equipment
   - Ensure follow-up with Primary Care Provider (PCP)
   - Review and verify medication reconciliation post discharge is completed

4. **Individual and Family Supports:** Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life.
   Examples of Individual and Family Supports may include:
   - Provide education and support of self-advocacy including referral to Peer Support specialists
   - Identify and access resources to assist client and family supports
   - Educate client, family or caregivers of advance directives, client rights, and health care issues
   - Communicate and share information with the client, family, and caregivers with appropriate consideration of language, literacy and cultural preferences

5. **Referral to Community and Social Supports:** The provision of information and assistance for the purpose of referring the client to community based resources as needed.
   Examples of Referral to Community and Social Supports may include:
   - Identify, refer and facilitate access to relevant community and social services that support the client's HAP
   - Assist the client to apply for or maintain eligibility for health care and social services

- Monitor and follow-up with referral resources to ensure appointments and other activities were established

IV. Tiers, Rates and Billing

What are the Health Home Tiers?
Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Tier One (code G9148) =Initial engagement and completion of the HAP
2. Tier Two (code G9149) =Intensive level of care coordination
3. Tier Three (code G9150) = Low level of care coordination

How does a Care Coordinator know which tier to select?

1. **Tier One – Outreach, Engagement and HAP Development (code G9148)**
Clients are referred to Health Home providers by the KCBHO using data to match the client to requirements defined by each Health Home provider. Once the client agrees to participate in the Health Home program and the HAP is developed, a Tier One claim using procedure code G9148 may be submitted for payment. **The Tier One payment will only be paid once in a client's lifetime to a lead entity for each enrolled and engaged client**

2. **Tier Two** - **Intensive Health Home Care Coordination (code G9149)**
Intensive Health Home care coordination is the highest level of care coordination. This level of care coordination includes evidence that the Care Coordinator, the client and the client's caregivers/family are actively engaged in the HAP, participating in activities that are in support of improved health and well-being. Tier Two billing typically requires a face-to-face visit between the client and the care coordinator during the month in which qualifying health home services are provided. **At least one of the six qualifying Health Home services must be provided during the month prior to submitting a Tier Two claim using procedure code G9149 for payment.**

3. **Tier Three – Low Level Health Home Care Coordination (code G9150)**
Tier Three is selected when one of the situations described below matches the care coordination needs of the client. Typically after the Tier One activity of establishing the HAP is completed a client will move to the Tier Two level. In some cases, based on the preference of the client, and their individual needs, they may move directly from Tier One to Tier Three. **At least one of the six qualifying Health Home service must be provided prior to submitting a Tier Three claim with procedure code G9150 for payment.**

What are the payment rates for each tier level?
Care Coordination services are reimbursed at the rates outlined below:

Can an agency bill for a Tier 2 service if a there was no face to face service with the client for that month?

Tier	Health Home Tier	Community Health Plan of WA (CHPW) Rates	Amerigroup Rates	Coordinated Care Rates	United Healthcare Rates	Molina Rates
1	Outreach, Engagement, and Health Action Plan (G9148)	$252.93	$252.93	$252.93	$250.40	$252.93
2	Intensive Health Home Care Coordination (G9149)	$172.61	$172.61	$172.61	$170.89	$172.61
3	Low-Level Health Home Care Coordination (G9150)	$67.50	$67.50	$67.50	$66.83	$67.50

Face-to-face meetings are the standard for Tier 2 billing. Billing for a Tier 2 without a face-to-face meeting with the client is an exception and should not be considered the standard practice. A Care Coordinator can bill for Tier 2 if one of the six core services is well documented and the alternate services provided are issues or goals outlined on the client's HAP. The Care Coordinator must document why the client is inaccessible and a face to face meeting was not possible for that month.

MCOs will not approve Tier 2 billing for more than one month in a row if there is no face-to-face.

Amerigroup only: Amerigroup does not allow for exceptions to the Tier 2 standards and requires that at least one face-to-face meeting occurs with the client in the month to allow for Tier 2 billing.

Can an agency bill for a Tier 3 service if there is no contact with the client that month?
Yes, an agency can bill for a tier 3 services if one of the six qualifying Health Home services is provided within that month.

Can a client move between Tiers?
Clients are not intended to switch between tiers each month based on the type of contact. Tiers only switch when the client demonstrates a consistent need for a lower or higher level of care coordination.

Examples of moving a client from **Tier Two to Tier Three may** include:
a. The client's Patient Activation Measure (PAM) score has stabilized over the past four month period with optimal level of activation and HAP goals have been achieved.
b. The client's PRISM risk score is under 1.0 for eight months and the client's PAM Level is at least a three.
c. A client has met their goals and is actively sustaining self-management activities.

Examples of moving a client from **Tier Three to Tier Two may** include:

a. An adverse health condition or new diagnosis resulting in increased emergency department use, hospital admissions, or exacerbation of a behavioral health or social concern.
b. The client expresses a desire to set a new HAP goal.
c. Life events trigger a need for higher Health Homes Services.

Can a Care Coordinator submit a Tier One claim just for outreach and engagement attempts?
No, a Tier One claim must include the completion of HAP. Some clients may not be successfully reached or engaged in Health Home services despite multiple attempts to contact them. In these situations a Tier One claim for the engagement attempts cannot be submitted.

KCBHO Invoicing Process
Agencies will be paid according to the data entered into the KCBHO Information System (IS). KCBHO will calculate an invoice/remittance according to the data in the KCBHO IS.

5th of the month following the reporting period

- KCBHO sends agencies a preliminary BHRD Reporting Tool including encounters entered for the previous month.
- Agencies review and correct any data submissions that are incorrect or missing.

15th of the month following the reporting period

- KCBHO re-runs the BHRD Reporting Tool for payment.
- KCBHO verifies each encounter in the applicable MCO platform.
- KCBHO pays each agency based on the encounters that were reported and verified
- KCBHO will send each agency record of payment which includes a copy of their invoices, encounters that were paid and notes indicating needed corrections.

Agency process

- Agency reviews record of payment and identifies any encounters and/or documentation that needs to be corrected.
- Agency completes and submits a Health Home Billing Adjustment Form by the 15th of the following month to be paid for any corrected encounters.

V. Data Submission and Authorizations

What is the Health Home Program Number?
The Health Home Program number is 100.

When should an agency request an authorization for a client?
An authorization should be requested once a HAP has been completed with a client. The assessment date in the authorization request should be the same date used as the HAP start date.

Is there a requirement for a face to face appointment on the day a benefit is requested?
Yes, both the HAP and the benefit authorization require a face to face appointment.

What Code should be used for "Referral In" when submitting an authorization?
The Program Referral code is a required transaction and must be entered to ensure correct billing. Select the appropriate referral code that aligns with the MCO that the client is enrolled in.

Program Referral Code	MCO
1025	Amerigroup
1026	CHPW
1027	Coordinated Care
1028	Molina
1029	United Healthcare

What data elements are required for a Health Home authorization?
The data elements needed to complete a Health Home authorization are outlined in the ISAC notebook.

Will the CPT (G-codes) be added to the Service Encounter Reporting Instructions (SERI) manual?
No, the Health Home G codes will not be added to the SERI.

VI. Outreach and Engagement

Tips to outreach and engagement

1. **Educate staff at your agency**
   Present and/or meet with your agency's clinical teams to talk about Health Homes. This is a new program and many people have not heard of it yet. Be sure to include how this program benefits the client, what your role is, how you anticipate collaborating with other staff (i.e. client's case manager), and how to contact you.

2. **Educate community partners**
   Educate the agencies that your clients may be connecting with for services. Building a relationship with these agencies and informing them of this new program will increase your response rate when reaching out to them trying to locate a client.

3. **Contact Attempts**
   Many of the clients we work with do not have a telephone, may have changed their number, or their phone may be shut off. It is not unusual for a client to be receiving services at more than one agency. Reach out to staff at other agencies if you know your client accesses services there. They can be a great resource when trying to locate a client.

4. **ECLS**
   If a client is enrolled in the KCBHO, you can look that client up in ECLS. This database includes information about the client including agencies that are serving the client. This may provide useful information that can help you locate the client.
5. **PRISM**

Every Care Coordinator has access to the PRISM database. This database contains insurance claim information as well as contact information. The insurance claims identify a client's medical providers and dates of service.

6. **Pre Manage**
   Pre-Manage alerts on pre-enrolled members provide an opportunity to engage and enroll members when they are most in need of assistance. The alerts can be helpful for hard-to-reach and homeless individuals.

VII. Due Diligence

A Care Coordinator must demonstrate good-faith efforts to engage newly referred clients and meet the HCA and MCO standards for due diligence before processing a client for disenrollment. All contacts and attempted contacts must be documented in the MCO platform.

Due Diligence efforts must be recorded on the KCBHO Due Diligence Template and uploaded onto the KCBHO secure server by the 5th of each month.

Due Diligence Process for CHPW, Amerigroup, UHC and Coordinated Care:

Step 1. The MCO will mail an HCA approved welcome letter prior to calling the client. If the letter is returned, the MCO must check alternate databases or resources to secure an updated address and mail a second welcome letter to the new address.
Step 2. The Care Coordinator or Allied Staff must attempt and document at least three (3) calls to the client. The calls must be made on different days of the week and at different times of the day. At least one call must be made each month for two (2) months following the initial attempts.
Step 3. If the client cannot be contacted after 90 days from the effective date of enrollment and the above procedures have been followed, the MCO may request disenrollment of the client from the Health Home Program according to the Disenrollment Process below.

- The MCO will send the Health Home Disenrollment letter to the last known address of the client giving the client at least ten (10) business days to reply. Place a copy into the clients file.
- If the client contacts the MCO and wants to participate in the program before the disenrollment is effective, the MCO must reassign them via a "warm hand-off" to a CC.
- If there is no response to the letter, fill out the Health Home Due Diligence Registry, which is to be submitted monthly to HCA via secure email. Note that the Health Home Due Diligence Registry does not replace the required documentation in the client's case file

***UHC only:** **Who closes the client out in the platform when due diligence has been completed?**
The Care Coordinator closes the program using the same process as OPT OUT but puts Unable to Reach (UTR) instead.

For Previously Engaged Clients: The due diligence process may begin after one month of attempted contacts to meet the monthly face- to-face home visit requirement. Example: Face-to-face meeting with client in August, unable to contact client in September, begin the due diligence process in October starting with Step 2 above.

Due Diligence Process for Molina ONLY:

Step 1. The MCO will mail an HCA approved welcome letter prior to calling the client. If the letter is returned, the MCO must check alternate databases or resources to secure an updated address and mail a second welcome letter to the new address.

Step 2. Molina will outreach members telephonically to introduce Health Homes and solicit their participation. Individuals that express interest will be referred to KCBHO.

Steep 3. The Care Coordinator or Allied Staff must attempt and document at least three (3) calls to the client. The calls must be made on different days of the week and at different times of the day. All due diligence attempts must be completed within 30 days of receiving the referral.

Step 4. If the client cannot be contacted after three attempts, the Care Coordinator or Allied Staff must attempt to contact the client using an alternate attempt such as: sending an Unable to Reach (UTR) Letter. You can find a template for the letter on the Healthcare Authority (HCA) Health Homes resource page here. Examples of alternate attempts are as follows:

☐ Send Mailing
☐ Check alternate database/resource (K2, PRISM, etc.)
☐ Connect with most recent pharmacy information via Caremark
☐ Connect with most recent Case Manager, Provider, Caregiver or program for assistance with contact
☐ Assess need for Lexis Nexis to find different number

Step 5. Upon completing due diligence, send an email to *WAHealthHomes@molinahealthcare.com* with "UTC" in the subject line. Provide the name(s), date(s) of birth and – if available – ProviderOne number(s) identifying those members for whom due diligence has been completed. Multiple names may be listed in one email. However, do NOT include Opt-Outs in the "UTC" email. Opt-Out list must be emailed separately with "OPT OUT" in the subject line.

The due diligence process begins again if you have a "successful outreach contact" with a member that does NOT result in an opt- out or enrollment. , A "successful contact" is one in which the member's identity is confirmed. An example involved a Care Coordinator's successful phone contact with a member (member's identify confirmed) who was ambivalent about enrolling but requested literature be

mailed to her. In this example, due diligence would restart following the call. The mailing of literature would constitute the first outreach attempt via an "alternate method".

Conversely, if a Care Coordinator calls a member and the member asks to be called back at a later date before the Care Coordinator can verify the member's identity, then that constitutes an unsuccessful contact attempt in the due diligence process. Due diligence does NOT begin again.

For Previously Engaged Clients: The due diligence process may begin after one month of attempted contacts to meet the monthly face- to-face home visit requirement. Example: Face-to-face meeting with client in August, unable to contact client in September, begin the due diligence process in October starting with Step 3 above.

VIII. Consent Forms

What Consent Forms are Care Coordinators required to complete with each client?
When clients are enrolled in the Health Home program, Care Coordinators will need to talk and coordinated services with other providers and people involved in the client's care. Care Coordinators may also need to share information about the client's care to keep others informed. The Health Home Information Sharing and Consent Form and other applicable consent forms must be completed. All consent forms can be found here.

Required for all clients
Health Home Information Sharing and Consent Form

Complete if applicable
Adolescent Sharing Consent Form
Release of Information for Substance Use Services Form

How do we engage and/or enroll a dependent adult when their caregiver (frequently a parent) has not obtained legal guardianship?
This is a delicate situation in which we want to ensure the dependent adult's privacy rights without denying them access to needed services because of their disability. After consulting with privacy experts it seems the best course of action is for the Care Coordinator to contact the caregiver and request a meeting with the individual by generally explaining the Health Home project and its eligibility criteria. (The caregiver is most likely all too aware of the individual's medical and/or developmental problems.) The Care Coordinator can then solicit the individual's consent for caregiver participation and Health Home enrollment at the meeting. Adaptations to written or verbal consent may be negotiated if the individual is non-verbal or significantly disabled. This may include a non-verbal nod or gesture of assent.

IX. Client Opt-Out

What if a client Opts-out and refuses Health Home Services?

If a client declines services, the Care Coordinator must complete the Opt Out form. This form can be found here. The Care Coordinator must indicate that the client declined services and the reason why the client declined. The Opt-Out Form must be uploaded into the MCO portal for that client. Basic instructions may be found on following instructional aide.

Health Home Opt out Training Version.pdf

In addition, some of the MCOs have an additional requirement around emailing the Opt Out form. Please see below for more information.

Coordinated Care only – Upload Opt-Out form into Coordinated Care's platform. If the client would like a copy of their Opt-Out form once it has been processed by Coordinated Care, please send an email to Coordinated Care Health Homes mailbox with the client's Medicaid ID #, and Coordinated Care will mail the client a copy.

UHC only- Upload Opt-Out form into the UHC platform **and** send it via secure email to Andrea Ray at andrea.ray@uhc.com with the Subject line, "Opt Out".

Molina only- Upload Opt-Out forms into the Molina platform **and** send a secure email with subject line of "OPT OUT" to WAHealthHomes@molinahealthcare.com. The body of the email must include the name(s), date(s) of birth and ProviderOne number(s) of member/s that opted out. Multiple names may be listed in one email. Molina prefers that a copy of the completed Opt Out form(s) also be attached to the email but are not required.
*Do NOT include UTC's in the "Opt-Out" email. The UTC list must be emailed separately with "UTC" in the subject line***.**

CHPW only- Upload Opt-Out form into the CHPW Portal and notify CHPW via their online.link**.**https://docs.google.com/forms/d/e/1FAIpQLScM1Khu94OosbWj9anv6cxZt9NMvvREas0o9RCbOUFrKxiHmg/viewform

Amerigroup only- Complete Opt out forms in the platform unless the form is signed by the client. If the client signs the form, you must fax the Opt Out form to Amerigroup at 844-778-5093**.** Amerigroup will upload the signed form into the platform.

X. HAPs and Screenings

What is HAP?
The client-directed plan identifying the client's long-term and short-term goal(s). The HAP identifies the action steps to be taken by the client and Care Coordinator to achieve the HAP goal(s), including the use of health care or community resources and services that support the client's action plan.

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What information should be included in the HAP?
The client's HAP shall provide evidence of:

- Chronic conditions, severity factors, gaps in care, the client's activation level, opportunities for potentially avoidable emergency department visits, inpatient hospitalizations and institutional placement;
- Client self-identified goals, needed interventions or action steps, transitional care planning; and
- Use of self-management, recovery and resiliency principles using person-identified supports, including family members, and paid and non-paid caregivers.

** **Molina Only-** You must upload the assessment's into Molina's platform. The assessments are not available to complete in the portal*.

HAP Flowchart

C.01.55 HAP Instructions Rev 9-20

When is HAP completed?
Care Coordinators shall complete a comprehensive and culturally appropriate HAP within 30 days of the client agreeing to participate in Health Home services.

How many short-terms goals are required on each HAP?
HAPs are required to have at least one short-term goal for each HAP period (a HAP period is 4 months)

Are Health Home Coordinators required to give the client a copy of the HAP?
Yes, the HCA requires Care Coordinators to give every client a copy of their HAP.
Molina Only- Molina requires Care Coordinators to provide a copy of the HAP to the client's Primary Care Physician.

When is HAP updated?
The client shall be reassessed every four months while receiving Health Home Services.

Where can I find a blank copy of the HAP form?
A template for the HAP can be found here on the Washington State Department of Social and Health Services website.

Are any other screenings/assessments required?
Yes, the HAP should include screening for depression and alcohol or substance use disorder appropriate to the age of the client and referral to services, as appropriate. Required Screenings include:

- BMI
- KATZ-ADL (only required for client 18 years or older)
- PAM/CAM/PPAM
- PHQ-0/PSC-17

Additional screening should be included as appropriate. These may include:

- AUDIT
- DAST
- Fall Risk Checklist
- GAD-7
- Pain Assessment (Faces, FLACC, Numeric)

How often are the screenings required to be completed?
The mandatory screenings should be administered within each of the three HAP activity periods (Initial/Annual, Four Month Update, and Eight Month Update). If the client, their caregiver, or parent is unable or declines to complete a required screening, enter the date the assessment was offered and provide an explanation in the HAP in the "if not complete / explain" field. **Do not enter zero for the score**. If a screening was completed enter the date, the score and activation level if indicated.

Can a Care Coordinator complete the HAP without completing one or more of the required screenings at that time?
Yes, if the client, their caregiver, or parent is unable or declines to complete a required screening, you can still complete the HAP. The Care Coordinator will need to note why they are not completing the screening/s in two places.

- In the HAP
  - Enter the date the assessment was offered and provide an explanation in the "if not complete / explain" field. **Do not enter zero for the score**.
- In the screening
  - The Care Coordinator will need to complete a note in the "notes" section of the screening stating why they were unable to complete the screening.

For UHC only- Please reference the attachment below for steps on what to do in the platform if a client declines to complete a screening.


UHC Screening.docx

XI. Progress Notes

What should a Health Home progress note include?
The HCA has outlined what a Health Home Progress Notes should include. The PDF below includes those expectations.


B.01.10 Documentation Matrix

Do progress notes have to be completed for clients every month, even if there is no service provide?

Yes, a progress note has to be completed every month even if there is no contact with the client. Contact attempts and efforts to engage clients must be documented.

Should a progress note be entered in the platform for every service?
Yes, a progress note needs to be entered into the MCO platform for every services. Please be sure in to include the following:

- Specify if the service was face-to face with thee client
- If a HAP was completed, state that in the note
- Specify which of the six qualifying Health Home services was provided
- State the client Opted-out (if applicable)
- All due diligence attempts

XII. Care Transitions

Care Coordinators shall provide comprehensive transitional care for Health Home enrollees to prevent avoidable readmission after discharge from in inpatient facilities and to ensure proper and timely follow up care. Whenever possible, the Care Coordinator should visits the client face-to-face while in the inpatient setting and coordinate the discharge plan with hospital staff. The following are the main components/areas of focus for the Care Coordinator during a care transitions:

- The client receives a follow-up phone call within 3 business days of discharge
- Ensure the client has a follow-up appointment with their Primary Care Physician (PCP)
- Transportation to the follow-up appointment with their PCP
- Medication Reconciliation
- The client understands the discharge plan
- Care transitions should occur within 7 days of discharge

**Molina only-* Molina requires that clients are seen face-to-face within 7 days of discharge

Does a Care Coordinator have to completed care transitions every time the client visits the emergency room or hospital? No, you only complete care transitions for inpatient admissions**.**

Does a Care Coordinator have to enter a progress note every time I receive notification that a client visits the hospital? No, a progress note only has to be entered if you received notification that for inpatient or emergency room admissions.

XIII. Exiting a Client

When should a client be exited from Health Homes?

- Clients may be exited from the Health Home program for the following reasons:
- The client requests to be exited from the program;
- The client is passes away;
- The client moves out of the state;

- PRISM score falls below 1.0 for at least 6 months
- Client loses Medicaid or gets comparable insurance coverage (such as Medicare Part C or private insurance) – for the latter, the state notifies the MCO and provides a grace period of 2 months before their HH eligibility is terminated

What should a Care Coordinator do if they received a referral for a client who is deceased?
If a client is deceased upon receipt of referral, you will want to notify KCBHO as soon as possible. If the client is active in the MCOs system, it means the state and MCO are not aware the client is deceased. Please be sure to include the following information in your email. Amerigroup and Molina will close out the client's case in the platform.

- Name
- ID number
- Date of death
- Cause of death
- How/who the CC got the information

**** For Coordinated Care and CHPW only***- the care coordinator must close the member's case in the platform. Please use "death" as the reason for exit.

**** For Molina only***- Send a secure email to WAHealthHomes@Molinahealthcare.com including the member's name, date of birth, date member passed away (if known) and how they received the information.

XIV. Pre-Manage EDIE Alerts

Care Coordinators receive Pre-Manage EDIE alerts when Health Home members are admitted to inpatient medical facilities or emergency department (ED) units. Care Coordinators will receive alerts on both pre-enrolled and enrolled members. These alerts are valuable tools that can enable a Care Coordinator to successfully manage duties critical to Health Home services.

- Outreach and Engagement – Pre-Manage alerts on pre-enrolled members provide an opportunity to engage and enroll referred individuals when they are most in need of assistance. The alerts can be helpful for hard-to-reach and homeless individuals.
- Transitions of Care – This is a required health home service for enrolled members. Pre-Manage alerts provide Care Coordinators the information they need to respond in real time and begin immediately to work on care transitions.

XV. Advanced Care Planning/Advanced Directives

Are Care Coordinators required to discuss Advanced Care Planning (ACP) and Advanced Directives (ADs) with each client?
Where can agencies find more information about Advanced Directives and Power of Attorney?

Care Coordinators must provide the opportunity for clients to consider and discuss ACPs. While Care Coordinators do not draft ADs (legal documents) they are required to assist the client and their families in accessing legal assistance if they wish to complete an AD. A discussion about ACP must be offered within the first year of the client's agreement to participate in the Health Home program. Care Coordinators are expected to simply begin the conversation to determine the client's interest in ACP. This offer of assistance and any actions taken should be documented in the client's case record.

Information about Advanced Directives can be found online. Here are a couple of websites that contain useful information.

https://www.dshs.wa.gov/altsa/stakeholders/chronic-disease-and-education-materials

https://www.washingtonlawhelp.org/issues/aging-elder-law/powers-of-attorney-health-care-directives

XVI. Incident Reports

Do I need to submit and Extraordinary Occurrence (EO) with King County along with a Health Home Incident Report?

Health Home providers are not required to submit an EO to King County. However, if the client is enrolled with a KCBHO behavioral health provider, then the provider is the responsible for submitting the EO report to King County.

**** For Amerigroup, Coordinated Care, CHPW and UHC***

When is a Health Homes Incident Report completed?

The HCA requires an incident report to be completed when:

An "Incident" is a negative event or occurrence which was not desired and/or anticipated, for which the care coordinator* was present or came into contact, or was otherwise made aware of.

Further explanation of a negative event includes:

- Any injury to the Beneficiary requiring action by the Health Home Care Coordinator to ensure emergency medical care is provided;
- Any mental health crisis that occurs in the presence of the Health Home Care Coordinator requiring intervention by law enforcement or medical personnel; and
- Any event involving a credible threat towards the Health Home Care Coordinator or affiliated staff. A credible threat is defined as "a communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family.

What is the process for completing an Incident Report?

- The Health Home incident report form can be found on the HCA website https://www.hca.wa.gov/assets/billers-and-providers/22_813.pdf
- The Care Coordinator should complete the top portion of the form and submit it to the HCA at healthhomes@hca.wa.gov and Bill Wilson at King County at BillR.Wilson@kingcounty.gov

within 24 hours of learning of an incident. King County will submit the form to the appropriate MCO so they can complete the "Supervising Organization" portion of the form.

**** For Molina Only***

When is a Health Homes Incident Report completed?

Critical Incidents are when a Molina member committed or is a victim of the following:

- Homicide or attempted homicide by enrollee
- The unexpected death or serious injury of an enrollee
- Including completed suicides
- Abuse, neglect or exploitation of an enrollee(APS/CPS reporting)
- Violent acts allegedly committed by an enrollee to include:
  - o Arson
  - o Assault resulting in serious bodily harm
  - o Homicide or attempted homicide by abuse
  - o Drive by shooting
  - o Extortion
  - o Kidnapping
  - o Rape, sexual assault or indecent liberties
  - o Robbery
  - o Vehicular homicide
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions
- Any event involving an enrollee that has attracted or is likely to attract media attention
- Attracting media attention is defined as any of the above-per Kathie Olson Molina AVP
- A credible threat to enrollee safety
- Any allegation of financial exploitation of an enrollee
- Attempted suicide

What is the process for completing a Molina Incident Report?

Fill out Molina Critical Incident Report Form the same day as incident. Send completed Molina Incident Report Form to wahealthhomes@molinahealthcare.com via secure email. The subject of the email should state "Critical Incident"

XVII. Interpreter Services

In Person Services

As of 7/01/18[t], the HCA contracted with Universal Language Services **for in-person** interpreter services. Health Home Care Coordinators need to register to access Universal Language interpretation services. For information on registration and training, please visit the following webpage.
https://www.hca.wa.gov/billers-providers/programs-and-services/interpreter-services
Additional questions regarding changes to interpreter services should be forwarded to interpretersvcs@hca.wa.gov .

Telephonic Services
Amerigroup and UHC do not offer telephonic interpreter services. Care Coordinators can access telephonic services for CHPW, Molina and Coordinated Care via the following steps.

Community Health Plan of WA

Dial (866) 998-0338	
Enter Account #	14767
Enter Pin #	0077
Enter Cost Center Code	40
Enter 4- digit extension	1027

Molina

Spanish (Molina)	**Other Languages (Globo)**
Dial (844) 885-3950 Extension 762139	**Dial** Number (844) 311-9777
Enter WA State Code	1050
Enter Department Code	088

Coordinated Care

Dial (866) 998-0338	
Enter Account #	13982
Enter Pin #	7002

XVIII. Request to Add a Client to the Health Home Eligibility List

How does an agency request to add a client to the Health Home Eligibility List?
An agency's request to add a client to the Health Home Eligibility List is possible but not a frequent circumstance. An agency is responsible to make sure the client meets the Health Home eligibility prior to making a request. The client must have a PRIMS score of 1.5 or higher for the agency to request the client is added to the eligibility list.

The agency should complete the following steps:

1. Look up the client in ProviderOne to see if they are already listed as Health Home eligible. If they are, there is no need to complete the Clinical Eligibility tool. The Care Coordinator would submit

a request to KCBHO to add the client to the eligibility list. KCBHO who will then request that the individual be assigned to the KCBHO CCO network.

2. If the client is not listed as Health Home eligible, the agency must complete the Clinical_Eligibility_Tool.xls on the HCA website. *Note-– if the client has recent medical problems or new medications it is of value to complete the tool.

3. There are instructions for completing the tool - HH_Clinical_Eligibility_Tool_Instructions.pdf *Note- for adults (18 years and older), you can only include claims and health information pertaining to the last 15 months. For young adults (17 and under), you can only include claim and health information pertaining to the last 24 months.

4. Send the results of the Clinical Eligibility tool (and any related documentation) to the client's assigned MCO.
   - *UHC – Forward materials to Andrea Ray at andrea.ray@uhc.com*
   - *Coordinated Care- Forward materials to CCWHealthHomes@CENTENE.COM. Coordinated Care only needs a screen shot of the 2nd page of the tool validating that the new adjusted score is greater than or equal to 1.5.*
   - *CHPW – Forward material to healthhomes@chpw.org*

XIX. Non-Emergency Medical Transportation (NEMT) for Health Home Clients

Why would a Health Home client need NEMT?
Health Home care coordination is person-centered and based on the development of a HAP by the Care Coordinator and the client. The development of the HAP, as well as some on-going health home services, require face-to-face visits that usually takes place in the clients home. If a client is homeless or lives in an unhealthy environment, the Care Coordinator may identify an alternate location for the face-to-face visit. In these instances, the client may need transportation to the alternate location.

Who can request NEMT?
Only a client's Care Coordinator can request NEMT services from a transportation broker for providing Health Home services. Clients may not schedule this service. The Care Coordinator must contact the NEMT broker available in the client's county of residence and submit a NEMT Health Home Services Request Form. The list of Transportation Brokers is available at: http://www.hca.wa.gov/medicaid/transportation/pages/phone.aspx.


C.01.150 NEMT Request Form.rtf

What are acceptable alternate locations to use NEMT for Health Home services?

The Care Coordinator must identify an alternate location where the client may be met in person. Examples of acceptable alternate locations include but are not limited to:

- A medical office or behavioral health setting
- A community-based social or health services location such as senior center, community services office, area agency on aging, or local health department

What are the distance standards for transportation of Health Home clients?
NEMT for Health Home services is limited to the following distance standards:

- Within 10 miles of the beneficiary's residence in urban/suburban areas
- Within 25 miles of the beneficiary's residence in rural areas

Exceptions may be made to the distances criteria on a case-by-case basis in remote areas of the state and be approved by Health Care Authority (HCA). To request an exception, the Health Home Provider with whom the client is enrolled must request the approval by sending an email to healthhomes@hca.wa.gov. Include the client name and ProviderOne ID, and the reason for the exception. HCA will notify the Health Home Provider and the transportation broker of approved exceptions to the distance standards.

How does the Care Coordinator know when the NEMT is scheduled?
The NEMT broker will contact both the Care Coordinator and the Client when the request for the trip is approved and scheduled.

XX. Miscellaneous

CHPW Referrals
Upon receipt of a CHPW referral, agencies need to request "Record Access" in order to enter the client's case in the platform. Instructions on how to request access is attached in the document below "Managing CHPW Referrals".


MHITS-Tools-1-4.pdf


Managing CHPW Referrals.docx

If a Care Coordinator receives a referral for siblings, should they do one meeting each month where they focus on both children or meet with them individually?
If the Care Coordinator engages both siblings, we recommend doing the face-to-face visits and HAP's etc. at the same time. Not only does it save time, but it puts fewer burdens on the family around scheduling. However, if either sibling expresses the desire to meet individually, the Care Coordinator should honor that and meet with each person separately. If the Care Coordinator meets with the siblings together, they should bill for each child separately even though it was completed in one visit.

Are Dual-Eligible individuals having both Medicaid and Medicare benefits eligible for Health Homes?

Yes however, Dual- Eligible individuals are managed by three MCOs: CHPW, UHC and Full Life. Individuals that are not enrolled in these plans but wish to enroll or keep their Health Home services must be transferred to one of these three MCOs. Please contact KCBHO for assistance with the transfer process.

Is the Care Coordinator required to get a copy of the Power of Attorney paperwork (POA) if the client is over 18 and their POA opts-out?
No, the Care Coordinator would complete the opt-out form as normal and document the details in the platform.

XXI. Resources

What is the CHPW Toolkit?
The toolkit is a CHPW that has information, policies, forms and resources for Health Home staff.

How do I access the CHPW toolkit?
The CHPW tool kit can be accessed here CHPW Toolkit.

- **Username: KINGBHRD**
- **Password: Chpwapple1**

Where can I find forms and additional resources for the Health Home program?
Health Home forms, tools and additional resources such as Due Diligence Requirements, brochures and more can be found here on the Health Care Authority website.

KCBHO specific Health Home materials, including the KCBHO FAQ, may be found here.

XXII. Contact Information for the MCOs and Participating Agencies

How do Health Home Providers contact the MCOs?
Molina
For provider questions call (800) 869-7165 or email the Molina Health Home team directly at WAHealthHomes@molinahealthcare.com.

Coordinated Care
To contact Coordinated Care with questions call 877-644-4613 or send inquires to our Health Home Mailbox: CCWhealthhomes@centene.com

IMPORTANT NOTE
To help streamline Health Home calls into their Customer Service Department, Coordinated Care's Health Home Team has implemented a password: ***PEPPER.*** *The password is only to be used for Coordinated*

Care's Health Home program, and will allow Health Home Care Coordinators to call into our Customer Service team, without the need to provide a NPI & TIN.

Community Health Plan of Washington (CHPW)
To contact Community Health Plan of Washington with questions please email HealthHomes@chpw.org
For questions related to a client's CHPW plan, call 1-800-440-1561.

IMPORTANT NOTE
Please use the password **MISSION** to help streamline the call. This will inform CHPW that you are calling on behalf of a Health Home client and they have permission to speak with you.

Amerigroup
To contact Amerigroup with questions please email AMG_WAHealthhomes@anthem.com
For member services, call 1-800-600-4441.

United Healthcare
To contact United Healthcare with questions, please call (877) 542-8997.

What agencies in King County participate in the Health Home program and what is the contact information?

Agency	Contact Person and/or	Contact Number
Asian Counseling and Referral Services	Hannah Kang	206-774-2451
Catholic Community Services	Casey Wishart/Lisa Bowie	206-956-9570
Center for Human Services	Paula Thomas	206-331-0599
Consejo	Neiba Salcedo	206-471-9398
IKRON	Monica Negrila/Hannah Roberts	425-242-1713
Ryther	Molly Pilisuk	206-462-7453
Sound Mental Health	Erin Smith	206-302-2399
Valley Cities	Amber Rhodes	206-408-5369