Health Home Program for Tribes

Tribal Member Eligibility

- To receive Health Home services, a Medicaid eligible participants must have at least one chronic condition and be at risk for a second condition.
- A PRISM* risk score of 1.5 or greater identifies those participants expected to have high costs in the future due to their chronic conditions.
- The Tribe must identify participants that may be eligible for Health Home services to HCA or the Lead entity so that HCA can enroll the participants in the Health Home program.

Tribal Members Not Eligible

- AI/AN participants enrolled with a Primary Care Case Management (PCCM) clinic must disenrolled from the PCCM before they can be enrolled for Health Home program services if they are eligible.
- Participants enrolled in another care management program such as PACE (Program of all-inclusive care for the elderly).
- If you are covered by Medicare Advantage, Tricare, or Private Insurance you are not eligible for Health Homes.

Tribal Considerations

1. Contract with current Health Home Lead entities as a Care Coordination Organization (CCO) to provide health home services through qualified Care Coordinators directly.
   - A tribal CCO:
     - Will receive additional funding at the Indian Health Services (IHS) rate if the Health Home service is provided by a Tribal CCO, serving an AI/AN in a face-to-face setting, conducted by a tribal care coordinator as approved in the State Plan Amendment. If you are providing care coordination to someone who is not AI/AN or not conducting face to face care coordination, then you will receive the Health Home reimbursement rate at which ever Tier of services they are currently active in.
     - Must bill Health Home Services to the contracted Health Home Lead for the established payment allowed. Health Home Leads are determined by HCA.
     - Must determine which populations to provide services to (eligible AI/ANs only or non-natives as well)
     - Be aware of each Lead Entities data platform and billing processes.
     - Attend the Two-Day Health Home Training for Care Coordinators.
2. Contact list of current Health Home Lead organizations is attached along with the map of the Coverage Areas served by each Health Home Lead.
3. Tribes may partner with other tribes or associations to become a Care Coordination Organization if they are in the same coverage area. Coverage Area Map attached.

For more information about the Tribal Health Home program, contact:
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Tamara.Gaston1@dshs.wa.gov, or healthhhomes@hca.wa.gov.

4. Contract with HCA as a Health Home Lead Entity
   - Business infrastructure must be in place to adequately process Electronic HIPAA managed care transactions (834 Enrollment; 820 Payment; 835 Error; and 837 Encounter Data claims)
   - A tribe:
     - May also provide Health Home services directly if the tribe also becomes a Care Coordination Organization (CCO) and hires internal Care Coordinators in addition to contracting as a Health Home Lead Entity.
     - Must be able to submit managed care encounter data to the HCA to receive payment for services. These are different than the healthcare claims currently submitted by tribes for substance abuse and mental health.
     - Must sign a participation agreement with OneHealthPort to submit Health Action Plan information electronically through the Health Information Exchange (HIE) service to HCA.
     - Must purchase or have a license for the Patient Activation Measure with Insignia Health.
     - Have a data system platform that meets the required elements of the Health Action Plan to collect and maintain information.
     - Decide which populations to provide services to: eligible AI/ANs only, or non-natives as well.
     - Have a dedicated Health Home trainer and provide up to two trainings per year for the state network.
   - Contact HCA at Healthhomes@hca.wa.gov to request assistance on becoming a Health Home Lead Entity.

Tribes may partner with other tribes or associations to become a Lead Entity. Leads must be contracted to serve the county or coverage area.

Health Home Payment

- Health Home services are paid on a per month per participant basis if a service was provided.
- A face-to-face encounter needs to happen for the IHS rate to be paid. The IHS encounter rate is $640.00 as of 1/1/2022.

Tier One – (G9148) Initial engagement and Health Action Planning – Paid only once per participant.

- $73.98 for Lead
- $796.40 for CCOs
- Includes: all outreach and engagement activities, face-to-face meeting with participant (in the home usually); completion of required/optional assessments; developing the Health Action Plan with participant centered goals and action steps to achieve the goals.

Tier Two – (G9149) Intensive Care Coordination

- $20.79 for Lead
- $223.81 for CCOs

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- Includes on-going care coordination with at least one face-to-face visit with the participant during the month. Payment covers all care coordination services provide during the month to assist participant with meeting their Health Action Plan goals.

Tier Three – (G9150) Low Maintenance

- $17.08 for Leads
- $183.86 for CCOs
- This payment is for participants at a higher level of self-management and includes periodic home visits and/or telephone calls to reassess the participant's health care needs in meeting their Health Action Plan goals

Care Coordinator Qualifications

- Health Home Care Coordinators must possess one of the following licenses or credentials in accordance with Washington State RCW and WAC listed in the citations:
    - Current license as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists or certified chemical dependency professionals; or
    - Master's or Bachelor's in social work, psychology, social services, human services, or behavioral sciences; or
    - Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR).
    - Exception to Policy is granted by HCA/DSHS when: The Health Home Lead entity requests approval and provides evidence the education, skills, knowledge, and experience of the individual are an acceptable substitution for care coordinator qualifications.
- Health Home Care coordinator is an individual employed by the Health Home Qualified Care Coordinator Organization or Lead who provides Health Home Services by interaction with participating participants.

Care Coordinator Function - CORE SERVICES

1. Comprehensive Care Management: Initial and ongoing assessment and management aimed at integration of physical, behavioral health, substance use treatment, long term services and supports and community services using a person-centered Health Action Plan (HAP) which addresses clinical and non-clinical needs.
2. Care Coordination: Facilitating access to monitoring or progress toward goals identified in the Health Action Plan (HAP) to manage chronic conditions for optimal health and promote wellness.
3. Comprehensive Transitional Care: The facilitation of services for the participant, family, and caregivers when participant is transitioning between levels of care.

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4. Individual and Family Supports: Coordination of information and services to support the participant and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.
5. Referral to Community and Social Supports: Providing information and assistance for the purpose of referring the participant and their family or caregivers to community-based resources when needed.
6. Health Promotion: Begins with the commencement of the Health Action Plan (HAP), demonstrating use of self-management, recovery and resiliency principles using person-identified supports. Addressing gaps in care.

Other Tribal Considerations – Use of Allied Staff

- Other allied staff within the organization may perform the following tasks under the direction of the qualified Care Coordinator:
    - Contact the participant to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit.
    - Conduct participant outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.
    - Communicate with service providers and health plans as appropriate to secure necessary care and supports.
    - Advocate for services.
    - Assist and support participant with scheduling medical and applicable appointments.
    - Provide health education and other materials including customized educational materials according to the needs and goals of the participant, caregiver, or other social supports as appropriate.
    - Promote participation in community educational and support groups.
    - Provide links to health care resources that support the participant's goals.
    - Support the execution of cross-system care coordination activities that assist participants in accessing and navigating needed services.
    - Educate participant, family, or caregiver on advance directives, participant rights, and health care issues, as needed.
    - Meet with participant and family, inviting any other providers to facilitate needed interpretation services.
    - Refer participant/family to peer supports, support groups, social services, entitlement programs as needed.
    - Identify, refer, and facilitate access to relevant community and social support services that support the participant's health action goals/care plan/treatment goals including medical/behavioral health care; patient education and self-help/recovery, medication adherence, health literacy and self-management.
    - Assist participant to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems.

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- Provide general information and support the participant with connecting to community supports to ensure that needed services or equipment are received.

*Predictive Risk Intelligence System (PRISM) provides prospective medical risk scores that are a measure of expected costs in the next 12 months based on the Beneficiary's disease profiles and pharmacy utilization. PRISM identified beneficiaries in most need of comprehensive care coordination based on risk scores; integrates information from primary, acute, social services, behavioral health, substance use treatment, and long-term care payment and assessment data systems; and displays health and demographic information from administrative data sources.

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Resources for Additional Information

- **Washington Health Care Authority (HCA) Website:**
  http://www.hca.wa.gov/billers-providers/programs-and-services/health-homes

- **Department of Social and Health Services (DSHS) Website:**
  https://www.dshs.wa.gov/altsa/washington-health-home-program

- **Indian Health Services Community Health Representatives:**
  https://www.ihs.gov/chr/

- **Care Coordinator Basic Training Schedule:**
  Care Coordinator Basic Training Schedule.pdf (wa.gov)

- **Health Home Care Coordination Rate Sheet:**
  HH Care coordination rates (wa.gov)

- **Health Home Lead Organization contract information and map of service areas:**
  Health Home Leads Contact List (wa.gov)
  Health Home Coverage Area Map (wa.gov)

Email Questions: Elizabeth Greil at elizabeth.greil2@dshs.wa.gov or Tamara Gaston at Tamara.Gaston1@dshs.wa.gov or healthhomes@hca.wa.gov

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