# Chapter 22: Managed Care and Health Homes

***Ask the Expert***

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## Overview of Managed Care

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual’s services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

HCA, DSHS, and CMS have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the MCO is responsible for. Contract examples include:

* Apple Health (Medicaid)
* Program for all Inclusive care for the Elderly (DSHS & CMS)
* Medicare Advantage and D-SNP (CMS)

## Apple Health Managed Care and Dual-Special Needs Population (D-SNP)

### Apple Health Managed Care

See [WAC 182-538](http://apps.leg.wa.gov/WAC/default.aspx?cite=182-538&full=true) Washington State Health Care Authority Managed Care for full details.

The Health Care Authority (HCA) is the single state Medicaid agency and is responsible for managing Medicaid medical benefits for eligible recipients. HCA also manages the medical benefits of state employees (PEBB).

HCA has transitioned to mostly contracting with plans to administer the Medicaid benefits, some of most relevant programs for our clients are:

1. Fully Integrated Managed Care (FIMC)  
   HCA contracts with MCOs who are responsible for the full scope of Medicaid physical, mental and substance use disorder services. For more information, please see the HCA publication: [“Welcome to Washington Apple Health: Managed Care” benefits book](https://www.hca.wa.gov/assets/free-or-low-cost/22-1298.pdf).
2. Behavioral Health Services Only (BHSO)

HCA contracts with MCOs who are responsible for mental and substance use disorder services. Clients who are eligible for BHSO benefits are not eligible for FIMC due to having another Third Party Liability (TPL) for their physical health benefits. This is most commonly Medicare and are referred to as Dual Eligible clients. For more information, please see the HCA publication: “Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book.

1. Fee for Service (FFS) (See [Special Populations](#_Special_Populations) for more information)  
   Provider is paid directly by HCA for services provided. All dual eligible (those on both Medicare & Medicaid) are FFS for their medical but enrolled in managed care for behavioral health services only. For more information, please see the HCA publication: [“Welcome to Washington Apple Health: Coverage without a managed care plan” benefits book](https://www.hca.wa.gov/assets/free-or-low-cost/19-065.pdf).
2. Apple Health Managed Foster Care (AHFC) (See [Special Populations](#_Special_Populations) for more information)  
   HCA contracts with Coordinated Care (an MCO) to provide medical services and coordination to foster children, foster care alumni and individuals who receive adoption support services.
3. Primary Care Case Management (PCCM) (See [Special Populations](#_Special_Populations) for more information)  
   Mostly tribal clinics. Providers are paid FFS, clinic is given a monthly per member per month payment to fund care coordination activities.

### Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE:

Staff may need to explore further with a client to determine the client’s actual coverage. Here are the ways staff can find a client’s managed care plan and eligibility:

#### ACES Online:

First pull up a client by entering name or ACES ID. Hover over the Details drop down and select Medical Information.

#### ProviderOne:

First hover over the Managed Care dropdown and select Manage Client Enrollment. Search the client by their ProviderOne ID number. Click the black triangle next to their ProviderOne ID. You will now be on the screen that shows Managed Care information.

#### CARE:

First open the client’s file in CARE. Expand the Client Details section. Click on the ProviderOne option. Click the View ProviderOne Details. This will open a web browser and click on the Managed Care hyperlink. This will display their managed care plan.

If the client is enrolled in managed care, the health plan name, program and start and end dates will be visible. You can view managed care information, Primary Care Case Management, Health Home, and PACE enrollments on this screen. Clients who are Fee-For-Service (FFS) will not show any managed care enrollment plan but will be active on a Medicaid program in ACES.

Please see the [Resources section](#_Web_Resources) for screenshots.

### Integrated Managed Care

Additional web resources for benefits and eligibility can be found in the [Resources section](#_Web_Resources) at the end of this manual.

#### Benefits:

Please see the [HCA Benefit Matrix](https://www.hca.wa.gov/billers-providers-partners/programs-and-services/program-benefit-packages-and-scope-services) for more detail. Coverage includes:

* Outpatient care such as: Wellness exams, immunizations, maternity care
* Pharmacy, including over the counter (OTC) and prescription medications
* Laboratory services
* Inpatient Hospital/Emergency Room
* Nursing facility for rehab/skilled nursing services
* Outpatient Mental Health

#### Eligibility:

Eligibility for Apple Health Medical coverage is handled through:

* The Health Benefit Exchange [www.WAHealthPlanFinder.org](http://www.wahealthplanfinder.org/)
* The local DSHS community service office for SSI-eligible aged, blind and disabled clients.
* [www.washingtonconnection.org](https://www.washingtonconnection.org/home/home.gowww.washingtonconnection.org)

Mandatory AH Integrated Managed Care enrollees include:

* Parents, children & pregnant women
* SSI Categorically Needy Blind and Disabled
* COPES/CFC & institutional clients
* Medicaid Expansion adults without children (MAGI)
* Foster Care (if they do not elect Fee-For-Service [FFS] coverage)
* Clients with Third Party Liability

### Enrollment

Medicaid clients will be enrolled into an MCO in the month they are determined eligible for Medicaid. This means they will be enrolled back to the first of the month in which they are determined eligible. This reduces gaps in managed care coverage and increases care coordination for individuals who are newly eligible or have lost eligibility and are reestablishing their Medicaid eligibility.

### My client should be enrolled in managed care but isn’t?

There are several reasons a client should be enrolled in a managed care plan but they are not. For example, the exemptions section shows groups of clients that are eligible Fee-For-Service (FFS) program. However, there are clients that can be approved on a program in ACES, but not be eligible for FIMC or BHSO. These programs are:

* Unmet Spenddowns (Any program that ends in 95 or 99)
* QMB (S03)
* SLMB (S05)
* QI-1 (S06)

Also there can be situations when a client has been determined functionally and financially eligible for a LTSS program (L-Program in ACES) but due to being in an Acute or State Hospital setting they are still pending in ACES due to the client’s residence needing to be in a Long-Term Care facility before the program can be made active in ACES.

Finally, per WAC 182-503-0535, there are clients that may have State-Funded FFS Medicaid eligibility due to their Citizenship or Immigration status. Those individuals are:

* Qualified aliens who have not met the five-year bar
* Non-Qualified aliens
* Undocumented person

**Fully Integrated Managed Care (AH-FIMC)**

**FIMC** for **Medicaid Only** includes the full scope of Medicaid physical plus mental health and substance use disorder services. Clients with physical health and pharmacy coverage will be enrolled in FIMC Apple Health.

* Apple Health Family (Healthy Options)

Dual eligible clients will not be enrolled in FIMC.

* Apple Health Blind Disabled
* Apple Health Adult Coverage
* State Children’s Health Insurance Program

#### Benefits:

* Medicaid clients have a choice of at least two managed care organizations in an IMC region.
* Medicaid State Plan services will remain the same and clients will continue to a have access to block grant or state-funded behavioral health services that complement the Medicaid benefits.
* Clients will now have one point of contact for medical and behavioral health services instead of navigating up to three systems.

#### Services covered include:

* Outpatient care such as: Wellness exams, immunizations, maternity care
* Pharmacy, including OTC and prescription medications
* Laboratory services
* Inpatient Hospital/Emergency Room
* Nursing facility for rehab/skilled nursing services
* Mental Health services with the exception of crisis services
* Substance Use Disorder treatment

### Behavioral Health Services Only (BHSO)

The **BHSO** program for **Dual Eligible clients** provides specialty mental health and substance use disorder services ONLY and is a separate product than FIMC that is offered by the same MCOs.

Clients who are typical FFS populations are able to access behavioral health services through the BHSO program (For example: Medicare coverage or someone exempt from managed care). They will get physical health services through the FFS system.

Apple Health – BHSO = FFS Medical and Managed Care for behavioral health services.

* Medicare/Medicaid duals
* Clients with third party medical coverage (TPL)
* PCCM
* Foster Care clients that elect to have FFS benefits

#### Exceptions

* Dually eligible and otherwise managed care exempt individuals will not be enrolled in FIMC but will be required to be enrolled in a managed care plan for BHSO
* An undocumented person (as defined by WAC [182-503-0535 (1)(e)](https://app.leg.wa.gov/wac/default.aspx?cite=182-503-0535) will not be enrolled in either program and will remain in FFS medical except undocumented pregnant women, during their pregnancy will be enrolled in BHSO.
* Foster Care adoption support have the option of FFS Medical and CCW BHSO or available BHSO plan in Spokane RSA and SWWA.

### Special Populations

There are clients who can be enrolled in programs outside of the five managed care programs or may not be enrolled in a managed care plan at all, known as Fee-For-Service (FFS). These special populations are:

* American Indian/Alaskan Native (AI/AN)
  + Eligible for Primary Care Case Management (PCCM)
  + Eligible for FFS
* Foster Care
  + Eligible for Apple Health Foster Care
  + Eligible for FFS
* Non-Citizen Clients, specifically:
* Qualified aliens who have not met the five-year bar
  + Only eligible for FFS
* Non-Qualified aliens
  + Only eligible for FFS
* Undocumented person
  + Only eligible for FFS

American Indian/Alaskan Native and Foster Care clients may elect to be part of the FFS program.

Per WAC [182-503-0535](https://www.hca.wa.gov/health-care-services-and-supports/program-administration/wac-182-503-0535-washington-apple-health) Non-Citizen Clients as defined in the above section are not eligible for Managed Care Plans and are only eligible for FFS benefits if found eligible for a State Funded Medicaid Program.

Click to return to [Apple Health Managed Care](#_Apple_Health_Managed)

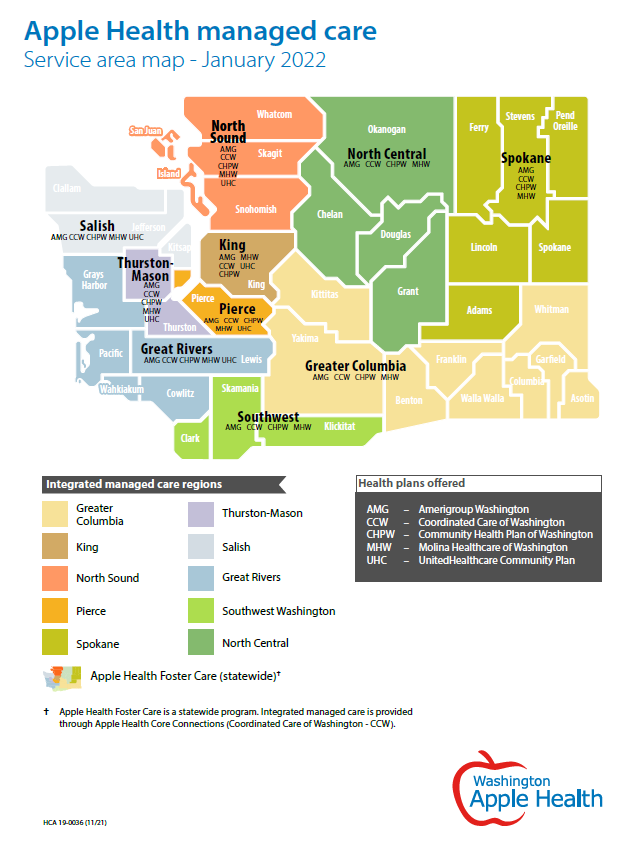
### Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county and RSA please visit [HCA’s website](https://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf).

#### Regional Service Areas (RSA):

RSAs are the new geographical boundaries or service areas for Medicaid purchasing of physical and behavioral health care through managed care contracts.

* Authorized by legislation in 2014
* Regions on a map, not an organization that oversees services



#### Health Plan Contact Information (for Clients/Providers)

|  |  |  |
| --- | --- | --- |
| AMGlogo.png | Customer Service  Website  Provider Line  Provider Website | 1-800-600-4441  [www.amerigroup.com](http://www.amerigroup.com)  1-800-454-9790  [http://washington.joinagp.com](http://washington.joinagp.com/) |
|  | Customer Service  Website  Provider Line  Provider Website | 1-800-440-1561  [www.chpw.org](http://www.chpw.org)  1-800-440-1561  [www.chpw.org/for-providers](http://www.chpw.org/for-providers) |
|  | Customer Service  Website  Provider Line  Provider Website | 1-877-644-4613  [www.coordinatedcarehealth.com](http://www.coordinatedcarehealth.com)  1-877-644-4613  [https://www.coordinatedcarehealth.com/ providers.html](https://www.coordinatedcarehealth.com/providers.html) |
|  | Customer Service  Website  Provider Line  Provider Website | 1-800-869-7165  [www.molinahealthcare.com](http://www.molinahealthcare.com)  1-800-869-7165  <https://www.molinahealthcare.com/providers/wa/medicaid/pages/home.aspx> |
| UHClogo.gif | Customer Service  Website  Provider Line  Provider Website | 1-877-542-8997  [www.uhccommunityplan.com](http://www.uhccommunityplan.com)  1-877-542-9231  [www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html](http://www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html) |

### Changing Plans

Apple Health enrollees may change plans every month (effective the 1st of the following month):

* Via telephone at 1-800-562-3022. Clients may either wait for a customer services representative or use automated telephone Individual Voice Recognition
* Online at [www.waproviderone.org/client](http://www.waproviderone.org/client)
* Via paper enrollment form mailed to HCA
* The Health Benefit Exchange [www.WAHealthPlanFinder.org](http://www.wahealthplanfinder.org/) (MAGI and Family medical-not SSI)

### MCO Funded Behavioral Health Personal Care

Clients who have need for wraparound support due to a behavioral health condition, to be successful at their home or in a residential setting could be eligible for MCO funded Behavioral Health Personal Care. This can help a client receive additional support. Please refer to [chapter 7H](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207h.docx) appendices for specifics regarding authorization process and requesting funding for MCO funded behavioral health personal care. The contact list can be found under the Contractors section of the HCS/AAA intranet at <http://intra.altsa.dshs.wa.gov/hcs/> named Behavioral Health Personal Care Contact List.

### Behavioral Health Administrative Services Organization (BH-ASO)

Some services, such as response services for individuals experiencing a mental health crisis, must be available to all individuals regardless of their insurance status or income level. For this reason, the HCA will have a contract with an organization known as a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services in integrated regions.

#### BH-ASO

The BH-ASO is only responsible for a subset of crisis-related services for Medicaid clients in integrated region and is responsible for providing limited services to individuals who are not eligible for Medicaid, as well as managing certain administrative functions.

#### Services Provided – Regardless Insurance Status or Income

The following services may be provided by the BH-ASO to anyone in an integrated region who is experiencing a mental health or substance use disorder crisis:

* A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
* Mental health crisis services, including the dispatch of mobile crisis outreach teams staffed by mental health professionals and certified peer counselors;
* Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
* Designated Mental Health Professionals (DMHPs) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
* Chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc. The chemical dependency specialist will also manage case findings and legal proceedings for substance use disorder involuntary commitment cases.

#### Services Provided – Uninsured and Low-Income

The BH-ASO may provide certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. For some services, like those funded through the federal Substance Abuse Prevention and Treatment (SAPT) block grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Medicaid:

* Mental health evaluation and treatment services for individuals who are involuntarily detained or agree to a voluntary commitment;
* Residential substance use disorder treatment services for individuals involuntarily detained as described in state law;
* Outpatient mental health or substance use disorder treatment services, in accordance with a Less Restrictive Alternative court order;
* Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient substance use disorder and/or mental health services or residential substance use disorder and/or mental health services, to low-income individuals who are not eligible for Medicaid and meet other eligibility criteria.

### What is a D-SNP

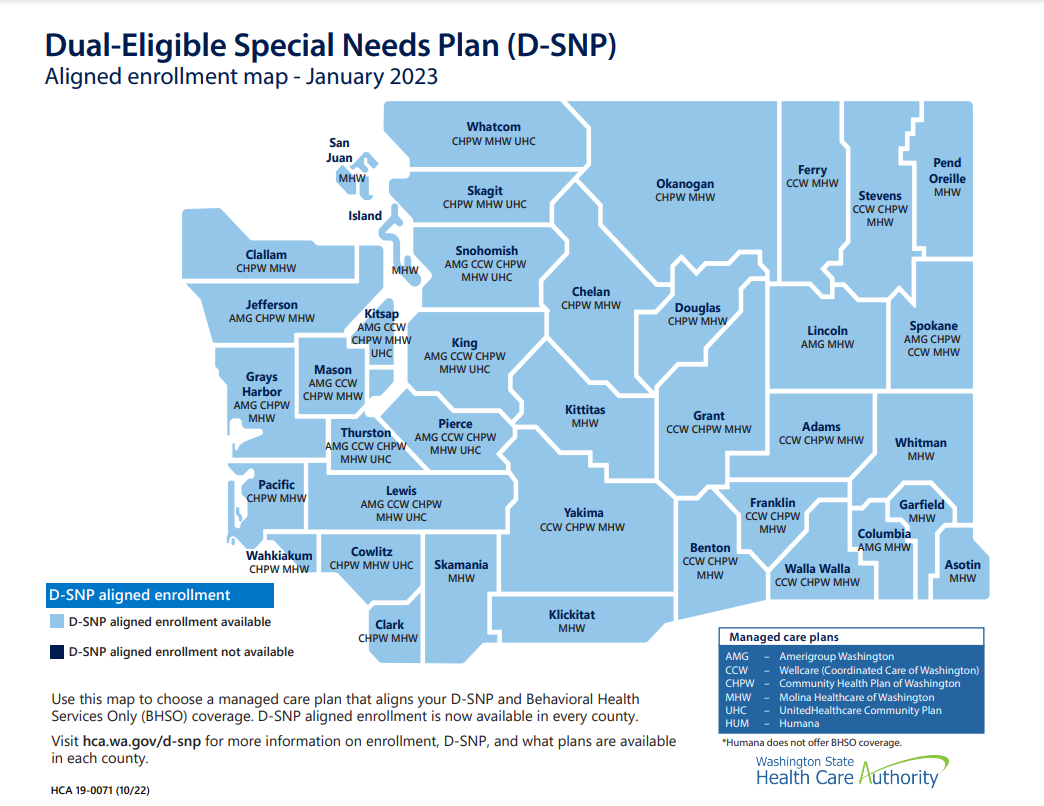
A Dual-Eligible Special Needs Plan (D-SNP) is a special kind of Medicare Advantage plan for dual-eligible individuals. A D-SNP combines Medicare and Apple Health (Medicaid) services under one managed care plan.

### Who is a dual-eligible individual

A dual-eligible individual has both Medicare coverage and Apple Health coverage. This includes physical and behavioral health care coverage. If a client is a dual-eligible client, Medicare is the primary coverage for their physical health care needs. They also have Apple Health as secondary coverage. Dual-eligible clients also have behavioral health coverage through an Apple Health managed care plan. This is a Behavioral Health Services Only (BHSO) plan. Behavioral health includes mental health and substance use disorder treatment.

### D-SNP Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county please visit [HCA’s website](https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/dual-eligible-special-needs-plan-d) or use the service area guide found in the attachments. D-SNPs are not available of every county.



### Care Coordination

#### Apple Health Managed Care & Nursing Facilities

Managed care, like Medicare, covers a rehabilitative/skilled nursing benefit if the authorization criteria is met. When a managed care enrollee is hospitalized and needs to be discharged to a nursing facility, the plan must be contacted for nursing facility authorization.

MCOs have transitional care requirements for moves from the hospital to the nursing facility and home.

Once it has been determined that the rehab/skilled stay will end or an enrollee does not meet authorization criteria, that enrollee should be referred to Home and Community Services (HCS) for a nursing facility level of care (NFLOC) assessment. HCS should also review available options with the client.

#### Contacted Regarding Discharges:

* If contacted by a hospital/facility for the NFLOC assessment or for discharge options
* Staff must ask if the hospital stay is covered by an MCO ***and*** if the client is enrolled in Medicaid managed care.
* If the client is enrolled in Medicaid managed care (Apple Health):
* The facility must have a denial from the MCO before the stay can be covered by HCS.

#### Assisting with Coordination (Case Managers)

For additional information on Nursing Facility billing see the [HCA Nursing Facility Provider billing Guide](https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides)

* If you receive billing questions, refer the provider to the health plan the client is enrolled in.
* Assist clients who have Apple Health medical coverage by knowing the health plan contact phone numbers.
* Find out which plan(s) contract with doctors and specialists in their area. This will help you assist the client in choosing the right Apple Health managed care plan. It will also help when the client has a provider/plan coordination issue.
* If you need assistance with acute hospital or skilled nursing facility transitional care activities, please use the plan contacts in this list:

|  |  |
| --- | --- |
| **MCO** | **Transitions of Care Contact** |
| Amerigroup |  |
| Inpatient Settting (UM Complex Hospital Discharges) | [cmrefwash@amerigroup.com](mailto:cmrefwash@amerigroup.com) |
| Community Setting (Medical Case Management Referrals) | [Discharges\_Amerigroup@Anthem.com](mailto:Discharges_Amerigroup@Anthem.com) |
| Community Health Plan of Washington |  |
| Inpatient Setting (Transition of Care) | cyndi.stilson@chpw.org cc sharon.mcmillen@chpw.org |
| Community Setting (Case Management) | [Caremgmtreferrals@chpw.org](mailto:Caremgmtreferrals@chpw.org) |
| Coordinated Care of Washington |  |
| Inpatient Setting (Transition of Care) | [complexdischargeplanning@coordinatedcarehealth.com](mailto:complexdischargeplanning@coordinatedcarehealth.com) |
| Community Setting (Case Management) | [caremanagement@coordinatedcarehealth.com](mailto:caremanagement@coordinatedcarehealth.com) |
| Molina Health Care of Washington |  |
| Inpatient Setting (Transition of Care) | [MHW\_TOC\_Referrals@molinahealthcare.com](mailto:MHW_TOC_Referrals@molinahealthcare.com) |
| Community Setting (Case Management) | [MHWCMReferrals@molinahealthcare.com](mailto:MHWCMReferrals@molinahealthcare.com) |
| United Health Care |  |
| Inpatient Setting (Transition of Care) | [ComplexCare\_DTD complexcare\_dtd@uhc.com](mailto:complexcare_dtd@uhc.com) |
| Community Setting (Case Management) | [WA\_CareCoordinationRequests@uhc.com](mailto:WA_CareCoordinationRequests@uhc.com) |

* Report issues to the plan, the ALTSA HQ Managed Care Program Manager Ethan Leon at [Ethan.Leon@dshs.wa.gov](mailto:Ethan.Leon@dshs.wa.gov)
* For additional information regarding Nursing Facility coordination, see the [Nursing Facility Case Management Chapter, Chapter 10](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/documents/Chapter%2010.docx).

#### Managed Care Organization (MCO) Assistance with Transition of Care

MCOs, who are responsible for physical health benefits, should offer the following support to clients, HCS and/or the hospital when clients are discharging from inpatient hospital settings:

* Coordinate medically necessary services, supplies, and resources. For example:
  + Transition planning:
    - Arranging for DME (Durable Medical Equipment) approval and delivery
    - Assigning a PCP (Primary Care Provider) for the client to see post discharge
    - Assisting in community transition setting searches
    - Negotiating contracts with SNFs and paying for Enrollees’ SNF stays that meet rehabilitative or skilled criteria
    - Completing a written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care
  + Post Discharge care:
    - Organized post-discharge skilled and rehabilitative services, such as home health care services, after-treatment services, and occupational and physical therapy service
    - Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
    - For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee’s PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge.  The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals
    - Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge
    - Follow-up to ensure the Enrollee saw his/her provider
    - Planning that actively includes the patient and family caregivers and support network in assessing needs.
* Assist with facilitating authorizations for covered medical services and behavioral health services.
* Ensure continuity of care for enrollees transitioning to the MCO during an active course of treatment for an acute or chronic health condition

MCOs should offer the following care coordination to enrollees who meet criteria:

* Individual needs support coordinating access to service with their primary/private insurance provider
* Individual encounters difficulty accessing prescribed treatment, services, or supplies
* Individual has complex healthcare needs and could otherwise benefit from assistance in coordinating care. For example:
  + An individual receives a new diagnosis and they or their guardian feel like they “don’t know where to start”
  + An individual has had frequent or long-term hospitalizations
  + An individual has had frequent emergency department use

All HCS and AAA case managers should use the MCO Transitions of Care Contact List found at <http://intra.altsa.dshs.wa.gov/hcs/> on the right side of the webpage, under Contractors for the most current Transitions of Care contacts. When corresponding please use the Transitions of Care (discharge) email attachment found at the end of this chapter to frame HCS and AAA emails to the MCO for Initial Contacts, Follow Up, and Day of Discharge coordination.

If you experience any issues with this process, please contact to HQ Managed Care Program Manager.

#### Managed Care Assistance with Care Coordination

When an HCS/AAA client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the CM must assist the client and their guardian, if applicable, to request “care coordination” from the client’s Apple Health MCO or Medicare Advantage (MA) Health Plan (including clients who have managed care only for behavioral health services).

A Transitions of Care and Care Coordination contact list can be found on the HCS/AAA intranet website at <http://intra.altsa.dshs.wa.gov/hcs/> on the right side of the webpage, under Contractors. For D-SNP Coordination please use the Medicare MCO (DSNP) Care Coordination Contacts List. (Please see the Attachment section at the end of this chapter.)

1. To request care coordination, the CM may send a secure email\* to the client’s MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health. Email addresses for the five Apple Health plans are:
   1. Molina Healthcare of Washington, Inc. (MHW)
   2. Community Health Plan of Washington (CHPW)
   3. Coordinated Care of Washington (CCW)
   4. Wellcare (for Dual Special Needs Population [D-SNP] operated by CCW)
   5. United Healthcare Community Plan (UHC)
   6. Amerigroup (AMG)
   7. Humana (for [Dual Special Needs Population [D-SNP]](#_Dual_Special_needs))

\*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of an HCS/AAA client.

1. When making a care coordination request include the following in your email:
   1. In the Email “Subject” line, provide the reason for care coordination request. For example:
      1. Mental health treatment
      2. Durable medical equipment
      3. Needs Primary Care Provider
   2. In the body of the email, provide the following information:
      1. Client Name
      2. Client ProviderOne ID: (9-digit number ending in WA)
      3. Date of Birth
      4. Residence Type
      5. CM Name and Contact Information
      6. Summary of client barrier/issue/need
2. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with ‘escalation’ in the title of the email.
3. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.

* 1. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to [Ethan.Leon@dshs.wa.gov](mailto:Ethan.Leon@dshs.wa.gov)

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps.

If you experience any issues with this process, please contact the HQ Managed Care Program Manager [Ethan.Leon@dshs.wa.gov](mailto:Ethan.Leon@dshs.wa.gov).

## Program for All-Inclusive Care for the Elderly (PACE)

PACE stands for Program of All-inclusive Care for the Elderly. It is an innovative Medicaid/Medicare program that provides frail individuals age 55 and older comprehensive medical and social services coordinated and provided by an interdisciplinary team of professionals in a community-based center and in their homes, helping program participants delay or avoid long-term nursing home care.

Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals working at the center. The team meets regularly with each participant and his or her representative in order to assess the participant's needs. A participant's care plan usually integrates some home care services from the team or residential placement with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities and dining.

The PACE model was developed in San Francisco in the 1970s as ON LOK, the Chinese American community’s alternative to nursing home placement. It was formally established by CMS as a permanent Medicare Advantage option in 1997.

### Offering PACE as a Choice

The following elements are directed and required by legislation (SBH 1499) to ensure that PACE is provided as an option for possibly eligible clients living within a PACE available service area. At each assessment, AAA and HCS staff within the PACE service area will see a required question on Care Plan screen in CARE related to PACE. The question is:

**“PACE is available in certain zip codes in the county the client resides, would the client like to receive more information about the PACE integrated managed care program?” Yes/No/Already enrolled.**

Assessor is to ask client and respond to question accordingly. If response is “yes” and client resides in King County, it will ask an additional question if client has a preference as to which PACE program:

**“If yes, are you interested in a particular PACE program?”**

* **Providence Elderplace**
* **International Community Health Services**
* **PNW PACE**
* **No preference**

For clients whose response is “yes”, PACE organizations will contact them to provide more information on PACE managed care.

Staff will no longer complete nor submit form 17-218 “PACE Request for More Information”.

A report that has the “yes” responses compiled will be generated weekly to the PACE Organization (PO) of clients who indicated they would like more information about the PACE program. The PO will coordinate with the client and inform HCS/AAA should client choose to enroll and be accepted.

#### Staff Training

Training is set up and offered through the PACE Organization (PO) at regular intervals for both HCS and AAA staff. Trainings are meant to be interactive and jointly held. The PACE training link is provided below as an ongoing resource for HCS and AAA staff.

**Please use Chrome for the below link:**

[http://intra.altsa.dshs.wa.gov/videos/PACE/story.html](https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fintra.altsa.dshs.wa.gov%2Fvideos%2FPACE%2Fstory.html&data=05%7C01%7Ckathryn.pittelkau%40dshs.wa.gov%7C1dd3a61f25cc4471d68c08da4a40bffe%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C637903939199879503%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=wweClKuVWiWayCLYwzitnTyz%2BGSb6MJVJhyNSCYl%2B1Y%3D&reserved=0)

#### Private Pay

HCS/AAA is also responsible for assessing individuals not eligible for Medicaid or Medicare who are interested in enrolling in PACE to determine initial functional eligibility as well as ongoing functional eligibility. These referrals generally come directly from PACE organization.

### Service Providers

DSHS currently contracts with Providence Elderplace (PEP), International Community Health Services (ICHS) and PNW PACE Partners to administer the PACE program.

To be enrolled in PACE the client must live in a zip code in the Pace Organization’s (PO’s) service area. There are nine PACE centers in Washington State.

|  |  |
| --- | --- |
| **PROVIDENCE – LOCATIONS AND ZIP CODES** | |
| **Providence ElderPlace - Seattle**  4515 Martin Luther King Way South, Suite 100  Seattle, WA 98108  (206) 320-5325  **Providence ElderPlace - West Seattle**  4831 35th Ave. SW  Seattle, WA 98126  (206) 923-3940  **Providence ElderPlace - Redmond**  (PACE)  8632 160th Ave. NE  Redmond, WA 98052  Phone: (206) 320-5325  **Providence Elderplace Spokane**  6018 N Astor  Spokane, WA 98208  Phone: (509) 482-2475  King County Zip Codes | **Providence ElderPlace - Kent**  7829 S 180th St.  Kent, WA 98023  (206) 320-5325  **Providence Elderplace - Alder**  1404 Central Ave S  Kent, WA 98032  (206) 320-5325  **Providence Elderplace Everett**  1615 75th Street SW  Everett, WA 98203 |
| 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98011, 98015, 98023, 98027, 98028, 98029, 98030, 98031, 98032, 98033, 98034, ,98038,98039, 98040, 98042, ,98047, 98052, 98053, 98055,98056,98057,98058,98059,98072, 98074, 98075, 98077, 98092,98101, 98102, 98103, 98104, 98105, 98106, 98107, 98108, 98109, 98112, 98115, 98116, 98117, 98118, 98119, 98121, 98122, 98125, 98126, 98131, 98133, 98134, 98136, 98144, 98146, 98148, 98155, 98166, 98168, 98177, 98178, 98188, 98195, 98198, 98199  Snohomish County Zip Codes  98012, 98020, 98021,98026, 98036, 98037, 98043, 98072, 98077, 98087, 98201, 98203, 98204, 98205, 98208, 98258, 98270, 98271, 98275, 98290, 98296  Spokane County Zip Codes  99001, 99004, 99005, 99006, 99016, 99021, 99027, 99037, 99201, 99202, 99203, 99204, 99205, 99206, 99207, 99208, 99209, 99210, 99212, 99214, 99216, 99217, 99218, 99220, 99223, 99224, 99228, 99251 | |
| **ip Codes** | |
| **International Community Health Services (ICHS)**  803 S. Lane St.  Seattle, WA 98104  Phone: (425) 755-1100  King County Zip Codes  98004, 98005, 98006, 98007, 98008, 98009, 98015, 98033, 98034, 98039, 98040, 98052, 98055, 98056, 98057, 98083, 98101, 98102, 98103, 98104, 98105, 98106, 98107, 98108, 98109, 98112, 98115, 98116, 98117, 98118, 98119, 98121, 98122, 98124, 98125, 98126, 98134, 98144, 98145, 98146, 98154, 98164, 98168, 98178, 98181, 98185, 98191, 98195, 98199.  **Pacific Northwest PACE Partners (PNW PACE)**  6442 Yakima Ave  Tacoma, WA  Phone: (253) 459-7270 | |

King County Zip Codes

98001, 98002, 98003, 98010,98023, 98030,98031, 98032, 98042, 98047, 98092, 98198

Pierce County Zip Codes

98321 98323 98327 98329 98332 98333 98335 98338 98354 98360 98371 98372 98373 98374 98375 98385 98387 98388 98390 98391 98396 98402 98403 98404 98405 98406 98407 98408 98409 98416 98418 98421 98422 98424 98430 98433 98438 98439 98443 98444 98445 98446 98447 98465 98466 98467 98498 98499 98580

### Services

PACE provides its participants with all services covered by Medicare and Medicaid, without the limitations normally imposed by these programs. It also provides any other services deemed necessary by the interdisciplinary team that would allow program participants to remain in the community.

Services provided by PACE include, but are not limited to:

* Primary care (including doctor, dental and nursing services)
* Prescription drugs
* Adult day health care
* Home and personal care services
* Nutrition services,
* Case management
* Hospital and nursing home care if and when needed.
* Transportation to and from the center and all off-site medical appointments

### Eligibility

To participate in PACE, an individual must be 55 years of age or older, require NFLOC but be able to live `safely in the community at time of enrollment with the services of PACE, and reside in the service area of a PO. PACE participants may disenroll from the program for any reason and those with Medicare or Medicaid who disenroll will be assisted in returning to their former or preferred health care coverage.

**This may mean that the participant will need to change providers including PCP.**

Both the PO and the client agree to the PACE enrollment by signing an enrollment agreement. This agreement means the client agrees to receive services exclusively through the Pace Organization (PO) and its contracted network.

#### Determining Eligibility

HCS/AAA will assess clients and determine whether they:

**In Spokane, Pierce and Snohomish Counties, the breakdown of which entity handles ongoing PACE assessments is as follows:**

**AAA – in home PACE clients**

**HCS – residential PACE clients**

* Are age 55 or older;
* Meet nursing facility level of care (NFLOC) as defined in WAC [388-106-0355](https://app.leg.wa.gov/WAC/default.aspx?cite=388-106-0355);
* Reside in the PACE service area/or will at the time of enrollment; ***and***
* Are financially eligible per WAC [182-515-1505](https://app.leg.wa.gov/WAC/default.aspx?cite=182-515-1505). (MAGI clients are financially eligible); Remain functionally eligible by Reassessing Clients (Annual or Significant Change)

The PO is responsible for notifying HCS/AAA of any significant changes in the client’s condition:

1. Collaborate with the PACE social worker prior to each assessment. Review the previous assessment/SERs and information given by the PO before the visit.
2. Communicate with collateral contacts as needed to obtain information and include relevant parties to complete an accurate assessment.
3. Complete the face-to-face assessment. Be sure that you have:

* Assigned the PO as the paid provider
* Assigned relevant tasks to the PO. No provider schedule is necessary.

1. Verify financial eligibility at least annually, document on the Financial Screen in CARE and document in the file.
2. Once complete, move the assessment to current per procedures in Chapter 3 of the LTC Manual, send the CARE Assessment Details and Service Summary to the PO. Send Service Summary and CARE Results (when necessary) to client.
3. Extend PACE RAC, if applicable, for the new plan period (only available and needed if care plan is in-home).

#### Continued Functional Eligibility

PACE services can continue even though a PACE participant no longer meets State Medicaid NFLOC *if* the HCS case manager reasonably expects that the participant would again meet NFLOC in the next 6 months should PACE services end. This is called “deeming”. “Deemed eligible for PACE” is what will display in care plan as the desired program choice in this situation.

**State Staff Responsibilities:**

1. HCS/AAA staff will continue to complete annual reassessments of all PACE participants. If the assessment results in the client not meeting NFLOC, staff will review the assessment and consider whether the:
   1. Participant’s health status is maintained or benefited, at least partially, because of the services PACE currently provides; *and*
   2. Participant’s health and/or functional status are likely to decline over the next six (6) months without PACE services.

Examples of information that would support deeming of continued eligibility could include, but are not limited to:

* + - * Physician and/or nursing progress notes documenting the treatment and impact of a chronic/disabling condition;
      * List of services currently provided to the participant (OT, PT, dietary management, blood glucose/blood pressure checks, diabetic foot care, etc.);
      * Frequency of medical appointments and/or frequency of medical treatments/ interventions that point to an unstable medical condition that must be treated/ monitored regularly to avoid complications;
      * Decline or loss of mobility combined with cognitive decline or progression; etc.

1. If HCS/AAA case managers deem continued eligibility, they will continue to conduct full annual reassessments (and any significant change assessments) and determine NFLOC and/or that deeming criteria continues to be met.
2. If the client meets deeming criteria, staff will choose “Deemed Eligible for PACE” in the program drop down in CARE.
3. HCS/AAA staff will note in a CARE SER the decision to deem eligibility in the PACE program.
4. If HCS/AAA staff determine that a previously deemed participant no longer meets NFLOC or deemed continued eligibility or the client is not financially eligible for Medicaid a denial notice and appeal rights will be issued to the participant with a copy sent to the PO.
5. If the participant requests a Department administrative hearing to dispute the State’s denial of continued eligibility, PACE services may continue until the appeal is heard and a decision is rendered. If the denial is upheld, the participant may be required to pay the cost of PACE services rendered after the initial denial effective date.
6. If a request for administrative hearing is not received, PACE enrollment will be terminated at the end of the month in which the PAN was issued if the PAN was issued at least 10 days prior to the end of the month; if PAN was issued less than 10 days prior to the end of the month, PACE enrollment will be terminated at the end of the following month.

#### Forms

AAA/HCS Case Managers are required to complete the following forms:

* **PAN** – Once you assess the client in CARE, you must send the client the Planned Action Notice. The Planned Action Notice for PACE clients must include information that tells the client:
* They are eligible for services;
* That PACE is the program of choice;
* The number of personal care hours or daily rate they are eligible for.
* **Rights and Responsibilities**
* **Consent Form** – Complete when working with collateral contacts to gather/share information. The PO is an “ALTSA paid provider”.

#### Roles

Note: Clients are eligible for PACE services on the first of the month in which they are enrolled following the date the client is financially/functionally eligible. Clients can only be enrolled effective the first of the month.

|  |  |
| --- | --- |
| **HCS/AAA Assessor** | **Determine Eligibility**  Complete the CARE assessment to determine functional eligibility (specifically nursing facility level of care) for long-term care services. If the client is functionally eligible for nursing facility level of care, offer PACE as an option for receiving services.  **Client Seeks Enrollment**  Once you receive confirmation from the client that they wish to enroll, provide a copy of the CARE Assessment Details and Service Summary to the PO for review.  **Enrollment Confirmed**  Once you received notification from PO that client will enroll in PACE:   * Send a copy of the Service Summary and Assessment Details in “current” status to the PO (if not already done). * Send a Planned Action Notice (DSHS 14-405) to the client or their representative stating the effective enrollment date along with Service Summary (and CARE Results if necessary) * Send DSHS 14-443 to Financial with enrollment start date, and ProviderOne ID of PACE provider\*, and indicate if it will be in-home or residential care. For the latter include the CARE daily rate. * \* ProviderOne IDs of PACE providers:   Providence ElderPlace ProviderOne #: **105011001**  ICHS ProviderOne #: **209579901**  PNW PACE ProviderOne # **217922601**   * Add PACE RAC in CARE. This will only be available if the setting is in-home. * End all ProviderOne authorizations for end of month prior to enrollment. * ProviderOne payment authorizations are not done by HCS. * Add PO as the “formal caregiver” in collateral contacts. * Assign all unmet and partially met tasks to the PO as paid provider on care plan support screen. * If client is receiving wellness education service under COPES complete interim to remove this treatment. This service is not available to clients in PACE. * If client is receiving ADH service under COPES and any ADLs are partially met and informally assigned to ADH provider, complete interim to make these ADLs unmet. |
| **Public Benefit Specialist** | If not already established, determine financial eligibility for long-term care (PACE). Upon confirmed enrollment: enter P1 ID in ACES so award letters and all correspondence gets sent to the PO. |
| **PACE Organization (PO)** | **Prior to Enrollment**   * Contact interested clients to discuss program * Schedule site visit and evaluation * Review CARE assessment   **Enrollment Denied**   * PO informs client and sends information to HQ with reason as to why   **Enrollment Confirmed**   * Notify HCS/AAA of enrollment decision including enrollment start date. * Send a monthly electronic enrollment file by the 23rd of the month for enrollment the following month that contains client enrollment effective dates to the PACE Program Manager with a cc to the HCS/AAA field supervisor. Enrollments only occur at the start of a given month. * Send disenrollment letters for enrollees with other coverage. |
| **PACE HQ Program Manager** | * Enroll the client into PACE via the ProviderOne system if eligible. * Review and evaluate any enrollment denials submitted by the PO. |

Ongoing Client Management / Roles & Responsibilities

#### Case Management for PACE Clients

Once a client is enrolled in the PACE program, the PO assumes case management responsibilities.

|  |  |
| --- | --- |
| **Ongoing HCS/AAA SW Responsibilities** | **Ongoing PO Responsibilities** |
| * Annual functional assessments * Significant change assessments * Verify financial eligibility for each face-to-face assessment * Coordination with PO case managers * Obtain medical records from PO * Process disenrollments * Communicate necessary info to financial as needed * Notify financial of SNF stays that go beyond 30 days | * Implement and oversee care plan * Day to day case management * Enlist, contract, and pay providers (including IPs) * Communicate changes to HCS (address, telephone #, milieu of care (including SNF placements) * Request significant change assessments (vetting request/reviewing current CARE first) * Staff cases with PO interdisciplinary team as needed * Distribute CARE assessment and plan of care to providers * Assist clients with eligibility reviews |

#### HCS/AAA and PO Coordination

HCS/AAA and the PO must report the following client changes to one another when they occur:

* Admit or discharge from a nursing facility. HCS must notify financial if over 30 days;
* Need for home maintenance allowance (HMA). Requested by PO, HCS processes.
* Change in address or phone number;
* Change in plan of care which includes:
* Change in care setting (in home, residential, SNF)
* Disenrollment from plan (including expedited disenrollment);
* Move out of the service area;
* Changes in or termination of Medicaid eligibility;
* Change from Medicaid to private pay and vice versa. PO makes HCS aware.
* Financial reports changes in cost of care to the PO via award letter.
* Client passes away

#### PO Responsibilities

* Must maintain services for the enrollee while enrolled, regardless of how much service needs increase or decrease;
* Is responsible for admitting and/or discharging PACE enrollees from the various living environments.
* Must collect participation from the enrollee.
* Will contract providers for all PACE services).
* Must have an internal “exception to rule” policy as it relates to needed services above what CARE assessment indicates. (HCS ETR is N/A for PACE)
* Review current CARE assessment prior to requesting significant change
* Must notify HCS of any:
* Address changes;
* Changes in income or resources; *or*
* Changes in living situations (in-home, residential, nursing facility);

#### HCS/AAA Field Manager/Supervisor Responsibilities

* Point person for HQ PACE PM as it relates to PACE programs’ field-level operations
* Point person for other HQ PMs as needed (ProviderOne, contracts, FLSA, etc.)
* Point person for PO management related to day-to-day operations of PACE programs
* Troubleshoot and address enrollment issues including lapses in enrollment
* Point person to provide assistance to PO (or their subcontractor) navigating ProviderOne as it relates to payment authorizations for individual providers
* Point person for PO intake and management staff related to enrollments and disenrollments
* Point person for work with RCS as needed related to PACE clients in residential settings
* Oversee and receive new enrollments monthly and assign to HCS workers
* Assist HQ PM reconciling payment issues with PO on a monthly basis
* Meet with PO and their subcontractors as needed or requested

### CARE Rules & PACE Enrollees

* All CARE minimum standards are applicable to PACE enrollee assessments.
* When determining “status” for PACE enrollee, the PO is considered the ALTSA paid provider, not the IP, Homecare Agency, Residential or other provider. The actual providers are not to be considered “informal” supports because they are being paid by the PO.
* On the Support Screen, assign the PO as the paid provider for all applicable “unmet” and “partially met” needs. As well, tasks that would otherwise be assigned to PCP/MD should generally be assigned to PO.
* Potential referrals triggered from the CARE assessment are the responsibility of the HCS/AAA worker prior to enrollment into PACE, including the assessment that determines functional eligibility. Once the client is enrolled, the PO assumes all case management for the client.

The PO may request and be granted view access in CARE for clients enrolled in the contractor’s PACE program. The PO should contact the HQ program manager to request access to CARE.

### Payment

POs receive a set amount of Medicare and Medicaid funds each month to ensure participant care, whether services are provided in the home, community or in a nursing home setting. This capitated funding arrangement rewards providers who are flexible and creative in providing high quality care and gives them the ability to coordinate care across settings and medical disciplines.

The program also accepts participants who pay privately.

#### Provider Payments

* The PO contracts & enlists their own providers for all PACE services. This includes homecare agencies, AFH’s, AL’s and all other covered services.
* The PO is responsible for directly paying all their providers.
* IPs are paid via ProviderOne though the PO is billed back for the costs.
* The PO inputs IP payment authorizations directly into ProviderOne using their own RU.
* No other payment authorizations will be visible in CARE for PACE clients.

### Disenrollment

Disenrollment is effective the last day of the month.

#### Voluntarily

* Request disenrollment;
* Are no longer Medicaid eligible; i.e. client is not financially or functionally NFLOC;

#### Involuntarily

* Move out of the PACE service area or leave for more than 30 days (unless an arrangement has been made or client is receiving referred treatment from the PO); *or*
* Engage in disruptive or threatening behavior and involuntary disenrollment is reviewed and approved by the HCS Headquarters Program Manager; *or*
* Fail to pay or to make satisfactory arrangements to pay any amount due to the provider after a 30-day grace period; *or*
* Are enrolled with a PO that loses its contract and/or license and is no longer able to offer services.

#### Process

1. The PO must send a written notice to the Headquarters Program Manager that fully documents that one of or more of the conditions exist to justify involuntary disenrollment.
2. The Headquarters Program Manager will consult with the regional supervisor regarding any concerns with the disenrollment or timeframes. Once approved/denied the HQ Program Manager will notify the regional supervisor and the PO of approval/denial within 15 days of receipt.

#### Roles

HCS/AAA Case Manager

1. Send the client a Planned Action Notice (DSHS 14-405), stating effective disenrollment date.
2. Follow procedures for setting up other long-term care program/services and supports, if desired by client. This would include enlisting a new formal/paid caregiver and, if it’s an IP, work with CDWA to get IP in place to provide services for the client.
3. Coordinate with HQ and the PO.

PACE Organization

1. Send a monthly electronic disenrollment file by the 15th of the month to HQ PM with a cc to the regional supervisor with the effective dates of participant disenrollments.
2. Coordinate with HCS (field and HQ) and AAA on any disenrollments. Timely notification to HCS/AAA field is critical; HCS/AAA field should be notified at the time PACE becomes aware of a disenrollment to allow time for HCS to implement new plan of care.
3. Determine and communicate safe, ongoing plan of care to HCS/AAA for implementation.
4. Assist client in establishing new PCP.
5. Assist client in signing up for new Medicare Part D plan.

HCS HQ Program Manager

1. Process disenrollments in the ProviderOne payment system.
2. Approve/deny any involuntary disenrollment requests.
3. Coordinate with the field and the PO.

### Grievance, Appeals and Hearing Rights

* The PO must report to the HQ PM quarterly regarding all grievance and appeals filed.
* If the PO denies or reduces a previously authorized service, the participant may appeal the denial to the PO.
* If the PO upholds its denial or does not respond timely to a request, the participant may request an administrative hearing.
* The participant must exhaust the appeal process before requesting an admin hearing on a PO determination.

#### Grievance

The client has the right to file a grievance either verbally or in writing to the PO any time they are dissatisfied with a service, the quality of care received or an interaction with PO staff.

#### Appeal

The client has the right to appeal any decision made by the PO to reduce, deny or terminate a service or an enrollment. This includes the right to appeal an involuntary disenrollment by the PO. The client should contact the PO to file an appeal.

#### Administrative Hearing

A client has a right to an administrative hearing only when entitled by the law and when aggrieved by a Department or PO decision or action. Clients have a right to a hearing:

1. For any action taken by the Department and indicated on the Planned Action Notice (PAN) including approval, denial, reduction or termination of services or eligibility.
2. When the department determined a client received more benefit than they were eligible for an overpayment was issued; *and*
3. When they have exhausted the appeal process regarding a PO determination or the PO did not respond timely to the request.

Administrative hearings are coordinated through the admin hearing coordinator for the service area. The department may be a witness.

Per WAC 182-526-0155, an appellant may represent themselves or may be represented by a lawyer, paralegal, relative, friend or any other person of his or her choice. **The appellant cannot be represented by an employee of the Department or the PO.**

## Health Home Program

### Overview

The Health Home (HH) program was created out of the Affordable Care Act, section 2703, which allowed states to provide specific services to Medicaid and Medicare/Medicaid (Duals) eligible clients. This program is a collaboration between [ALTSA](https://www.dshs.wa.gov/altsa/washington-health-home-program) and [HCA](https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes).

#### Integrated Care Coordination

The HH program promotes person-centered health action planning to empower clients to take charge of their own health care. This is accomplished through better coordination between the client and all their health care providers.

HH services are a set of optional Medicaid benefits available to eligible clients. Participation is voluntary, at no cost to clients, and does not change or duplicate services currently being delivered. A Care Coordinator (CC) steps in when a service is needed and is not already being provided, to bridge gaps in care. The HH program is designed to:

* Ensure cross systems coordination and care transition;
* Increase confidence and skills for self-management of health goals; and
* Create a single point of contact responsible for bridging all systems of care.

#### Client Advocacy

Clients receiving HH services will be assigned a CC who will partner with them, their families, caregivers, representatives, doctors, and other agencies providing services to ensure coordination across these systems of care. The CC will:

* Work with their client to develop a Health Action Plan (HAP) that is person-centered;
* Make in-person visits and provide support by telephone to help the client, their families and service providers;
* Assist the client in accessing the right care at the right time, at right place and with the right provider; and
* Provide at least one of the HH services each month.

The client and CC meet at a location of the client’s choice: their home, clinic, or other community location to receive services. Care Coordinators, sometimes work with a team for the delivery of HH services.

#### Health Action Plan (HAP)

The HH program emphasizes person-centered care with the development of the HAP. The HAP includes routine screenings such as the Patient Activation Measure (PAM®), an assessment that gauges the knowledge, skills, and confidence level essential to managing one’s own health and healthcare.

Other tools CCs use include screenings for body mass index, depression, level of independence in accomplishing activities of daily living, fall risk, anxiety, substance use, and pain. The HAP and the assessment screens are updated periodically. The centerpiece of the HAP is identifying the client’s self-identified short and long-term health related goals, including action steps that the client and others plan to do to improve their health.

#### HAP Form DSHS 10-481 and Instructions

### Structure – who provides these services?

HCA contracts with both community-based organizations and managed care plans to provide HH services. These designated “Health Home Leads” contract with Care Coordination Organizations (CCOs) to provide the services. Some HH Leads hire internal CCs as well. The HH program is structured as a community-based delivery system and focuses on matching clients with a CCO that has a preexisting relationship or has expertise that would enhance their ability to provide HH services to that particular client.

### Enrollment

Clients are passively enrolled into the HH program by HCA. Enrollment into the HH program is voluntary and clients may disenroll at any time by their CC or by signing an Opt Out form.

### Eligibility

To be eligible for Health Home Services clients must:

To be eligible clients must:

* Be on Medicaid or have both Medicaid and Medicare (Dual Eligible); and
* Have an identified chronic condition; and
* Be at risk for a second chronic condition
  + **P**redictive **R**isk **I**ntelligence **S**yste**M (PRISM)** score of 1.5 or higher (indicates risk for a second chronic condition).

PRISM is used to determine which clients are eligible. Specifically, the client must have a chronic condition and be at risk of another as determined by a PRISM risk score of 1.5 or more. A risk score of 1.5 means a client's expected future medical expenditures to be 50% greater than the average for Washington’s Supplemental Security Income disabled population.

Not all clients are eligible. For example, clients on spend down, enrolled in PACE or a Medicare Advantage Plan, are not eligible.

For those with limited PRISM data, there is a Clinical Eligibility Tool that may be used to determine a risk score and can be found at <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home-resources#clinical-eligibility-tool>

### Payment – how do Leads get paid?

Health Home services are Medicaid covered benefits and paid for by the state through its contracts with managed care organizations providing HH services to their members and community based HH Lead entities. HCA pays the HH Leads through ProviderOne. Case Managers never authorize HH services.

### Services Provided

As defined by CMS, the HH program provides the following six services beyond the traditional Medicaid or Medicare benefits.

#### Comprehensive Care Management

The initial and ongoing assessment and care management services aimed at the integration of primary, specialty, behavioral health, long-term services and supports, and community support services, using a comprehensive person-centered HAP which addresses all clinical and non-clinical needs. Examples include:

* Conduct outreach and engagement activities
* Complete required and optional screenings
* Develop the HAP
* Develop goals and action steps to achieve those goals
* Prepare crisis intervention and resiliency plans

#### Care Coordination

Facilitating access to, and the monitoring of, services identified in the HAP to manage chronic conditions. Includes updates to the HAP, monitoring service delivery, and progress toward goals. Care coordination is accomplished through face-to-face and collateral contacts with the client, family, caregivers, medical, and other providers. Examples include:

* Implement the HAP
* Monitor progress towards short and long term goals
* Coordinate with service providers, case managers, and health plans as appropriate to secure necessary care and supports
* Conduct or participate with multidisciplinary teams
* Assist and support the client with scheduling health related appointments and accompany if needed
* Communicate and consult with providers and the client as appropriate

#### Health Promotion

Providing information for optimal health outcomes and promoting wellness. Examples include:

* Provide individualized wellness and prevention information specific to the needs and goals of the client
* Provide links to health care resources that support the client’s HAP goals
* Promote participation in community educational and support groups
* Act as a health coach to support the client in initiating and sustaining behavioral change

#### Comprehensive Transitional Care

Facilitating services for the client and family/caregiver when the client is transitioning, between levels of care. Examples include:

* Participate on multidisciplinary planning teams such as nursing facility discharge planning
* Review post discharge with client/family to ensure discharge orders are understood and acted upon including medication reconciliation
* Assist with access to needed services or equipment and ensure it is received
* Providing education to the client and providers that are located at the setting from which the person is transitioning

#### Individual and Family Supports

Coordinating information and services to support clients and their families or caregivers to maintain and promote the quality of life, with particular focus on community living options. Examples include:

* Provide education and support of self-advocacy
* Identify and access resources to assist client and family supports in finding, retaining, and improving self-management, socialization, and adaptive skills
* Educate client, family or caregiver regarding Advance Directives, client rights, and health care issues

#### Referral to Community and Social Services Supports

Providing information and assistance for the purpose of referring clients and their families or caregivers to community-based resources that can meet the needs identified on the client’s HAP. Examples include:

* Identify, refer, and facilitate access to relevant community and social services
* Assist clients to apply for or maintain eligibility for health care services, disability benefits, housing and legal services not provided though other case management systems
* Monitor and follow-up with referral sources to confirm appointments and other activities were established and clients were engaged in services

### Working with Care Coordinators

Care Coordinators do not duplicate or replace services or case management provided by HCS, DDA, or AAA. Clients who participate in the HH program will continue receiving their primary medical, specialist, behavioral health, and long-term services and supports from their current providers. Participation will not change the way a client’s other services are currently, managed, authorized or paid.

The CCs complement the work of HCS/AAA/DDA Case Managers. A CC may contact you to inform or share information about one of your clients to help support them in reaching one of their health-related goals, to work together on an issue that needs resolution, or provide advocacy in the work you do.

#### HCS/AAA/DDA Case Manager Roles

Once a client is participating in the HH program, staff should:

* Coordinate with the CC to facilitate resources and referrals. In some cases, the CC may request a copy of a client’s CARE assessment. If requested, a consent form (HCA 22-852) will be shared.
* Include the CC as a collateral contact in CARE
* Collaborate and communicate with the CC
* Know that the CC is considered a member of the client’s health care team. In some instances, they may attend the CARE assessment visit.

Table: HCS v CC Case Management

| **Service Description** | **HH CC** | **HCS/AAA/DDA** |
| --- | --- | --- |
| Determine eligibility for LTC services and supports. |  | **X** |
| Perform a face-to-face CARE assessment with the client in their residence to determine service needs and program eligibility at least annually. |  | **X** |
| Assist the client to develop a plan of care to enable them to reside in the setting of their choice and monitor that plan. |  | **X** |
| Authorize services with the client’s choice of qualified provider according to their plan of care. |  | **X** |
| Termination Planning for personal care services/LTSS. |  | **X** |
| Report abuse, abandonment, neglect, self-neglect, or financial exploitation to Adult Protective Services or the Complaint Resolution Unit. | **X** | **X** |
| Report Suicide Ideation | **X** | **X** |
| Make referrals for services identified by the client to improve health and prevent additional disease or disability. | **X** | **X** |
| Provide comprehensive care management including review of PRISM risk scores to Health Home high needs and utilization patterns. | **X** |  |
| Assist to develop and implement a person-centered Health Action Plan | **X** |  |
| Provide transitional care services following a discharge from institutions into the community. | **X** |  |
| Administer the Patient Activation, Caregiver Activation, or Parent Activation Measure used for Health Action Planning and self-management skill development. | **X** |  |
| Provide care coordination and comprehensive care management across the client’s team of health care professionals. | **X** |  |
| Provide health promotion services/information to the client including health education, development of a self-management plan and improving social and community networks promoting healthy lifestyles (smoking cessation, weight loss, and physical activity). | **X** |  |
| Identify resources for the client and their family in the community to allow the client to attain their highest level of health and functioning. | **X** |  |
| Educate family members about disease processes, what to expect, and caregiving skills necessary to assist the client in achieving their HAP goals. | **X** |  |

#### Determining if a client is enrolled for HH services

There is no notification system to let the HCS/AAA/DDA Case Manager know when a client is part of the HH program. Case managers will need to:

* Check CARE ProviderOne screen
  + Click on Managed Care and it may indicate HH program and the Lead organization
* Check ProviderOne
  + Select client search with ProviderOne ID
  + Check if the Health Home Clinical Indicator is populated with current dates
  + Check Managed Care Enrolled screen which may indicate HH and the Lead organization
* Contact the clients Apple Health managed care organization, HH Community Lead in your area, or HCA at [HealthHomes@HCA.WA.GOV](mailto:HealthHomes@HCA.WA.GOV) regarding questions of enrollment or to refer a client
* Find the contact information for Health Home Leads at <https://www.hca.wa.gov/assets/billers-and-providers/hh-leads-contacts.pdf>

## Resources

### Related WACs & eCFRs

[WAC 182-526-0155](http://apps.leg.wa.gov/wac/default.aspx?cite=182-526-0155) HCA & Appellant’s Representation

[WAC 182-538](http://apps.leg.wa.gov/WAC/default.aspx?cite=182-538&full=true) Washington State Health Care Authority Managed Care

[WAC 182-538-130](http://apps.leg.wa.gov/WAC/default.aspx?cite=182-538&full=true#182-538-130) Exemption

[WAC 182-513-1230](https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-all-inclusive-care-elderly-pace) PACE (HCA website)

[CFR 42-438](https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=17a59e566cbe374c613e6f21c488f0c8&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl) Managed Care

[CFR 42-460](https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=17a59e566cbe374c613e6f21c488f0c8&tpl=/ecfrbrowse/Title42/42cfr460_main_02.tpl) PACE

### Acronyms

AAA Area Agency on Aging

ACES Automated Client Eligibility System

AHC Apple Health Foster Care

CC Care Coordinator

CCW Coordinated Care of Washington

CFC Community First Choice

CMS Centers for Medicare and Medicaid Services

COPES Community Options Program Entry System

DDA Developmental Disability Administration

DSHS Department of Social and Health Services

D-SNP Dual Special Needs Plan

FFS Fee-for-Service

FIMC Fully Integrated Managed Care

HAP Health Action Plan

HCA Health Care Authority

HCS Home and Community Services

HH Health Home

LTSS Long-Term Services and Supports

MAGI Modified Adjusted Gross Income

MCO Managed Care Organization

NFLOC Nursing Facility Level of Care

PACE Program for All Inclusive Care for the Elderly

PCCM Primary Care Case Management

PO PACE Organization

RSA Regional Service Area

SSI Supplemental Security Income

TPL Third Party Liability

### Glossary

|  |  |
| --- | --- |
| **Care Coordination** | An approach to healthcare in which all of a patient’s needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient’s caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated. |
| **Disenrollment** | The process by which an enrollee’s participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable. |
| **Fee-For-Service** | A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure). |
| **Long-Term Services and Supports** | A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services. |
| **Managed Care** | A prepaid, comprehensive system of medical and health care delivery.  *- Medical*: Includes preventive, primary, specialty care and ancillary health services  *- Integrated***:** Includes Medical services PLUS behavioral health and long term services and supports. |
| **Third Party Liability** | Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan. |

## Revision History

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | MADE BY | CHANGE(S) | MB # |
| 8/2/19 | Integration Unit | Updated into new template |  |

### Health Home Print Resources

### Web Resources

Return to [Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE](#_Identifying_clients_who)

Return to [Integrated Managed Care](#_Integrated_Managed_Care)

#### Apple Health & Managed Care

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[HCA Managed Care webpage](https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/apple-health-managed-care)

Fee-For-Service (FFS)/Apple Health Coverage without managed care

[ProviderOne Find a Provider List for FFS](https://fortress.wa.gov/hca/p1findaprovider/)

[Washington Healthplanfinder](https://www.wahealthplanfinder.org/_content/Homepage.html)

[“Welcome to Washington Apple Health: Managed Care” benefits book](https://www.hca.wa.gov/assets/free-or-low-cost/22-1298.pdf)

“Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book

[“Welcome to Washington Apple Health: Coverage without a managed care plan” benefits book](https://www.hca.wa.gov/assets/free-or-low-cost/19-065.pdf) [Apple Health Enrollment Form](https://www.hca.wa.gov/assets/free-or-low-cost/13-862.pdf)

[HCA Dual-Eligible Special Needs Plan (D-SNP) Website](https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/dual-eligible-special-needs-plan-d)

#### PACE

[DSHS – PACE webpage](https://www.dshs.wa.gov/altsa/program-all-inclusive-care-elderly-pace)

[HCA – PACE webpage](https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-all-inclusive-care-elderly-pace)

#### Health Home

[Health Home | Department of Social and Health Services](https://www.dshs.wa.gov/altsa/washington-health-home-program)

[Health Home | Washington State Health Care Authority](https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes)

[Health Home – Washington’s State Plan Amendment](https://www.medicaid.gov/Medicaid/spa/downloads/WA-20-0031.pdf)

Health Home – Washington Signed Demonstration Agreement

