MEDICARE/MEDICAID HEALTH HOME PROVIDER APPLICATION INSTRUCTIONS

The Washington Health Care Authority and the Department of Social and Health Services, Aging and Disability Services Administration invites interested networks meeting eligibility requirements to apply for participation in the jointly administered Health Home Program.

PROGRAM DESCRIPTION

Health homes are designed to provide intensive care management to high cost high needs individuals served within the Medicaid program to ensure services are integrated and coordinated across medical, mental health, chemical dependency and long term services and supports. Health homes will improve the delivery of medical and social services for individuals receiving care through fee for service or managed care providers by bridging systems of care. The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and increased quality and efficiency of the State's Medicaid ?and Medicare programs. Health homes provide targeted and intensive interventions that will improve health outcomes, beneficiary's experience in accessing and navigating the health care system and save money by reducing preventable hospitalizations, emergency room visits and unnecessary institutionalizations.

Health Homes are defined by a set of six specific care coordination services:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of health information technology to link services, as feasible and appropriate.

APPLICATION

Implementation of the Health Home program is scheduled for January 1, 2013. Interested organizations may apply to participate in the Health Home Program by completing the Medicaid Health Home Provider application from the Health Home website: **Add web address here**.

The state intends to limit the number of qualified health homes to promote: 1) program integrity and fidelity; 2) financial viability of networks; 3) reduction of duplication and confusion for beneficiaries; and 3) increase community health and social services integration.

Washington will qualify Health Homes based upon:

1. Provider Qualifications and Standards;
2. A designated lead entity, with responsibility for all Health Home program requirements, including services performed by the subcontractor;
3. Administrative capacity of the lead entity to perform functions such as payment, disbursement; quality monitoring, contracting, reporting and ensuring standards are met;
4. Network, Memorandums of Understanding, and/or subcontracts;
5. A meaningful choice to beneficiaries of health home network partners;
6. Care Coordination "band width"
    - Networks must represent the full array of expertise needed by high risk populations including mental health, long term services and supports, chemical dependency, primary care and housing;
7. Promotion of the state's vision to fully integrate care by minimizing health care system silos and concentrating volume over a few rather than many health home networks thereby assuring a more limited accountability structure; model fidelity and financial viability of health homes;
8. Equitable payments for health home services delivered by health home partners;
9. Compliance with all Medicaid program requirements;
10. Successful completion of a readiness review.

The Attestation check box and a hardcopy of the Attestation Form must be completed by an official of the lead entity who is authorized to attest to the accuracy of the information contained in the Health Home application. The official is responsible for reading the Attestation statement and checking this box prior to application submission.

The application will not be considered complete until a hardcopy of the Health Home Provider Attestation Form with an original signature is received by HCA. The Attestation Form (pdf) is located at the end of the application near the check box.

Please send the form to: **Add address here**

Applications are due by: **add date here**

HCA and ADSA will be implementing Health Homes on a geographical basis if initial capacity does not support a statewide implementation. If the decision is made to implement on a geographical basis, this application will be reissued.

NOTIFICATION

A letter of decision regarding the application will be sent by the HCA to the lead entities address as listed on the application.

INSTRUCTIONS TO THE APPLICANT

This is an application for designation as a Washington State Medicaid Health Home Provider. The application will be used to assess your organization's ability to meet the Washington Health Home Provider Qualification Standards for Chronic Medical, Behavioral Health and Long-Term Care Supports and Services populations. Supplementary information may be requested from your organization to comply with any additional program rules and regulations promulgated by the Centers for Medicare & Medicaid Services (CMS) or by the State.

The Washington State Medicaid Health Home Provider Qualifications Standards may be accessed at: **Add Web address here**

APPLICANT INFORMATION

Lead Entity Organization Name:		NPI:
Correspondence Address		
City	State	Zip Code
Telephone Number		County
Type of Organization		
Licensure/Certification Number		
Pay-to-Address		
City	State	Zip Code
Organization Contact Person		
Title	Telephone Number	
Fax Number	Email	

Health Home Service Regions (must identify at least one)

Region: County:

Note: Responses to questions must be complete. Responses must be fully contained within this application, except where noted for additional email attachments and the attestation form.

SECTION A - LEAD ENTITY REQUIREMENTS – limit 1,000 characters, except for #1

1. Provide a complete description of the health home organizational structure, including how the applicant will accomplish providing the required services, provider linkages and care coordination. (Limit 5000 characters)

2. Describe your experience in performing administrative functions, such as payment disbursement, quality monitoring, contracting, reporting and ensuring standards are met. (Essential Requirement)

3. Describe your ability to collect, analyze and report financial, health status, and performance and outcome measures to objectively determine progress towards meeting those goals. (Essential Requirement)

4. Provide a general description of your experience in providing integrated care services.

5. Describe your experience in providing direct project oversight, what data, data sources, and management systems will be used to monitor progress. (Essential Requirement)

SECTION B - PROVIDER NETWORK AND CAPACITY SPECIFIC INFORMATION

In order to provide comprehensive and timely, high quality services, qualified health homes are expected to develop health home networks to provide enrollees access to needed services. Health home networks should include medical care providers, specialists, hospitals rehabilitation/skilled nursing facilities, pharmacy or medication management services, home health services, chronic disease self-management and enrollee education services, etc.); behavioral health care providers (e.g. acute and outpatient mental health, inpatient mental health, substance abuse services and rehabilitation providers, etc.); community based organizations and social services providers (e.g. public assistance support services, housing services, job support, etc.) and linkages with jail systems,.

In the Excel Spreadsheet (**see template at website address**), identify each Health Home network provider organization, as well as associated individual practitioners for each of the locations.

1. Include all providers that are part of the Health Home network including all licensed and funded medical, behavioral, residential, homeless and social service providers.

2. Identify those organizations that will provide care coordination services to enrolled beneficiaries.

3. List the service address of the provider. Each service location should be entered on a separate line.
    a. Additional address information should include suite number, floor number, name of department, or a billing address if different.

4. Licensure type – specify the field the practitioner is licensed. Separate multiple licensure types for each provider with a comma.

5. Certification Type – specify any special designation a provider or clinic has, for example, NCQA PCMH, Center of Excellence, CMS approved Accountable Care Organization, etc. For practitioners, please indicate specialty (if any) or any special professional designation or qualification provider has earned: internal medicine, psychiatry, etc. Separate multiple certification types for each provider with a comma.

6. Include information about cultural expertise of network providers.

SECTION C – NETWORK DESCRIPTION, limit 1,000 characters

The high need/high risk population that will receive health home services is extremely diverse in age, culture, race, language and chronic conditions.

1. Describe how your network providers will support integration across the service domains used by high risk high needs populations and how it will improve the beneficiary's experience in accessing and navigating services.

2. Describe the proposed Care Coordinator positions, including professional discipline (if applicable), and relevant requirements for education, training, and experience.

3. Describe how the network will ensure that services are delivered in a culturally appropriate manner.

4. Describe the process that will be used to discuss the beneficiary's condition with treating/authorizing entities on an as needed basis, changes in patient circumstances, condition or Health Action Plan that may necessitate timely, and in some circumstances, immediate treatment or services. (Essential Requirement)

5. How will your Health Home providers ensure the use of evidence-based/informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices? (Essential Requirement)

6. Describe the process and time frames for providing crisis intervention for medical, behavioral health and long-term care events. Long-term care events could be loss of housing.

7. Describe the process that will address the full array of beneficiary needs, as reflected in the implementation of a person-centered Health Action Plan. (Essential Requirement)

8. Describe how your network providers will include and leverage direct care workers (paid and unpaid) who have a role in supporting beneficiaries to achieve health action goals and access health care services. (Essential Requirement)

9. Describe how your network providers will ensure 24/7 availability of information and emergency consultation services to the beneficiary. (Essential Requirement)

10. Describe the process that will be used to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care. (Essential Requirement)

11. Describe the process assuring hospitals have procedures in place for referring health home-eligible beneficiaries who seek or need treatment in a hospital emergency department for health home enrollment. (Essential Requirement)

12. Describe the methods network providers propose to use to engage beneficiaries in establishing health action goals, making behavior changes and increasing confidence and skills in managing chronic conditions. (Essential Requirement)

13. Describe the organization's current health information technology (HIT) capability to meet the initial HIT standards as referenced in Washington Health Home Provider Qualification Standards/Use of Health Information Technology to Link Services. (1,000 character limit for each)

- How will your health home use health information technology to identify and support management of high risk participants in care management?
- How will your health home use conferencing tools to support case conferences/team-based care including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).
- Describe the process/system that will be used to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences. (Essential Requirement)
- How will your health home use web-based health information technology registries and referral tracking systems.
- How will your health home track service utilization and quality indicators and provide timely and actionable information to the Care Coordinator regarding under, over or mis-utilization patterns.
- How will your health home develop a system with hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting. (Essential Requirement)
- Describe how your network providers will establish methods to share real time data on emergency room visits, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care with the care coordinator. (Essential Requirement)
- How will your health home develop methods to communicate real time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to the Care Coordinator? (Essential Requirement)
- Describe how the clinical decision support tool (PRISM)[1] will be utilized to view cross-system health and social service utilization to identify care opportunities.

14. Does your health home provider network use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the enrollee's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

    Yes, capabilities exist today. ☐
    No, capabilities do not exist today. ☐

[1] A secure DSHS web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next 12 months based on the patient's disease profile and pharmacy utilization.

SECTION D - ATTESTATION

I. Health Home Program Requirements

1. Home applicant will be required to attest that their services will include following:

    a. Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
    b. Language access/translation capability;
    c. 24 hour 7 days a week telephone access to a Care Coordinator;
    d. Links to acute and outpatient medical, mental health, substance abuse services, long-term care supports and services, and disability services;
    e. Links to community based social support services, including housing;
    f. Beneficiary consent for program enrollment and for sharing of enrollee information and treatment.

2. The health home applicant must attest that contractual agreements are in place with all organizations included in the provider network prior to the first request for reimbursement when partnerships involve a financial arrangement. A business agreement or MOU is suitable only for partnerships that do not involve a financial arrangement. All agreements (including contracts) should describe the roles and responsibilities of each party to the agreement.

II. Health Home Provider Qualification Requirements

1. Home applicant will be required to attest that their services will include the following: **Web Address Here**

    a. Comprehensive care management;
    b. Care coordination and health promotion;
    c. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
    d. Individual and family support, which includes authorized representatives;
    e. Referral to community and social support services, if relevant; and
    f. The use of health information technology to link services, as feasible and appropriate.

SECTION F - CMS Health Home Provider Functional Requirements (SMD 10-024)

Describe for each of the following how the health home will meet each functional component as required by CMS. (Limit 1000 characters each)

1. How will the health home provide quality-driven, cost-effective, culturally appropriate, and person-and family-centered health home services?

2. How will the health home coordinate and provide access to high-quality health care services informed by evidenced-based clinical practice guidelines?

3. How will the health home coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?

4. How will the health home coordinate and provide access to mental health and substance abuse services?

5. How will the health home coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings? Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of care.

6. How will the health home coordinate and provide access to chronic disease management, including self-management support to individuals and their families?

7. How will the health home coordinate and provide access to individual family supports, including referrals to community, social supports, and recovery services?

8. How will the health home coordinate and provide access to long-term care supports and services?

9. How will the health home develop a person-centered Health Action Plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services?

10. How will the health home use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate?

11. How will the health home establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of car and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level?

SECTION G - RIGHTS OF THE STATE

1. The State reserves the right to assign beneficiaries to a specific health home.
2. The state reserves the right to limit the number of qualified health home providers.
3. The State reserves the right to cancel a Health Home providers approved status based upon failure of the providers to provide health home services in accordance with the Washington Health Home Provider Qualification Standards, provide quality health home services to its clients, or upon other significant findings determined by the State.
4. The State reserves the right to cancel the program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency and decreased costs are not shown, or any other reason determined by the State.

Placing a check mark in this box ☐ certifies that the information submitted in this Health Home Provider Application and any attached pages is true, accurate and complete. The Health Home applicant agrees to comply with all current and future Health Home Provider guidelines, payment and operational policies, regulations and directives from the Washington Health Care Authority and CMS. The Health Home applicant also agrees to immediately notify the Washington Health Care Authority of any changes that may occur either as a Health Home Provider or with any changes of providers/subcontractors with the Health Home partnership.

Attestation Form Here

The application will not be considered complete until a hardcopy with original signature of the Health Home Provider Attestation Form with an original signature is received by HCA. Please send the form to:

Address Here