Health Home Herald

Integrated Managed Care Moving Forward

The Health Care Authority is in the process of expanding integrated managed care across Washington State, which combines each Apple Health (Medicaid) client's physical health and behavioral health services together under a single Managed Care Organization (MCO) responsible for delivery of both sets of benefits.

Apple Health clients enrolled with managed care organizations:

- Have access to MCO provider networks, including primary care and specialists
- Have their bills, prior authorizations, and grievances/appeals handled by their MCO
- Receive additional "add-on" services unique to each MCO, such as car seats and other amenities

Under the integrated model, Apple Health clients no longer contact a Behavioral Health Organization (BHO) when they need behavioral health services. Instead, they contact their managed care plan to find a provider in that plan's network, just as they would for their physical healthcare needs. The exception is for crisis services, which Behavioral Health – Administrative Services Only (BH-ASO) plans cover.

Long-term services and supports are not included in this model. DSHS will continue to authorize and provide these benefits with no changes.

Just as the Health Home program promotes whole-person care through integration of a client's various caregivers and resources, integrated managed care is moving Apple Health ahead in a similar effort by bringing together the payment systems and networks that make whole-person care possible.

HCA is phasing in managed care integration across the state so providers, clients, and stakeholders can adjust to the changes. The first two counties to adopt the new model were Clark and Skamania on April 1, 2016, followed by Chelan, Douglas, and Grant counties on January 1, 2018.

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Above: Lead Organization Community Choice at their office in Wenatchee.

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HCA is currently working on the next phase, which will be significantly larger than the previous two phases. On January 1, 2019, the following counties will adopt the integrated managed care model:

Adams, Asotin, Benton, Columbia, Ferry, Franklin, Garfield, Island, King, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Walla Walla, Whatcom, Whitman, Yakima

Clients in areas adopting the integrated managed care model may have different plan choices compared to those offered before the transition. This means some clients will need to select new providers if their current ones do not accept a client's health plan. However, clients in integrated plans will have the same Apple Health covered services they have today, and will only see a change in how Apple Health pays for and delivers them.

Statewide Service Experience Team Looking to Increase Participation

Home and Community Services (HCS) has created a statewide, consumer-driven advocacy committee called the Service Experience Team (SET). HCS created this team with the goal of increasing their ability to get input and better understand the impact of policies and services on the individuals who receive them. SET membership includes individuals across the state who receive HCS/Area Agency on Aging authorized long-term services and supports through Medicaid.

Responsibilities of the SET include:

- Providing feedback and input into new and ongoing HCS programs and services
- Identifying opportunities to improve the quality of services and the client experience, and addressing gaps in care
- Promoting community involvement in support of the HCS mission and vision

The SET holds meetings in January, May, and September, in locations across the state. Clients also have the opportunity to participate from home through webinars and conference calls.

The SET is currently recruiting consumers receiving long-term services and supports to participate in this important team. We are asking for your assistance with nominating clients based on your integral role as Care Coordinators and thorough knowledge of the clients you serve.

If you work with a client receiving HCS/AAA services and believe they would be interested in joining the SET, please talk with them, complete the nomination form if they are interested, and submit it to the Health Home Herald mailbox:

HealthHomeNewsletter@dshs.wa.gov

Nomination forms and copies of the charter are available upon request.

Spotlight on Resources

Income and Resource Standards

The HCA updates the Federal Poverty Levels (FPLs) and other income standards several times each year. The April 2018 FPLs are now available:

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources

The FPL is an income standard used for initial eligibility for Medicare Savings Programs and in participation calculations for some Medicaid clients receiving long-term care services.

Community Integration in Adult Family Homes

Community Integration (CI) took effect July 1, 2017 and is something you may have heard about if you work with clients who live in Adult Family Homes (AFHs).

CI is a way to:

- Ensure residents in AFHs are not isolated from their community
- Increase the overall quality of life for residents
- Ensure a person-centered approach
- Help residents become more engaged in their communities

CI activities are discussed during the resident's CARE assessment, and then chosen by the resident.

Activities include:

- Assistance in selecting what the resident wants to do and where they want to go
- Planning how to get to the activity
- Problem-solving issues that may come up
- Identification of others who can accompany residents or provide support with transportation
- Participation assistance
- Transportation arrangements
- Personal care support or other assistance needed to do the activity
- Assistance in looking for other things the resident may be interested in

The activities do not include services already paid for by Medicaid.

Care Coordinators can be an integral part of CI efforts. That could include being part of the planning of CI, the follow-through with activities, and for activities over and above the four hours per month that the AFH provides. The client may choose a CI goal in their HAP so it is very important the Case Manager, AFH Provider, and the CC communicate well with each other.

If you have clients living in AFHs, ask if they want to be involved in Community Integration, and see how you may help them get involved.

Fast Facts

20 Seconds

How often a fall happens in the United States, on average.

Participant Portrait

Janice Gruber of Amerigroup submitted the following Participant Portrait:

The Care Coordinator (CC) provided support and health promotion for her 9-year-old Health Home client with Down syndrome who only speaks Spanish.

First, the CC arranged for a Spanish language interpreter through CTS Language Link to support the client and her mother in engaging in the Health Home Program. They began by going over an Individualized Education Program (IEP) and helping them understand both the test results and related goals.

The CC also worked with the client's mother to complete an application for services through the DSHS Developmental Disabilities Administration (DDA).

The mother is a strong advocate for her daughter, but she stated her daughter's school staff were ignoring many of her requests due to a language barrier. The CC helped address this by ensuring the school always provides translated documents and other necessary information.

By advocating for proper accommodations at the client's school, the CC was able to support the client and her mother beyond what any of her other Medicaid providers could accomplish on their own.

Focus on the Participation Opt-Out Form

WHAT?

Health Home Participation Opt-Out/Decline Services form (HCA 22-853).

A client can use this form to declare their wish to:

1. Not participate in the Health Home Program during your initial outreach to engage the client in the program
2. No longer participate in the Health Home Program before or after the client completes a Health Action Plan

WHO?

The form may be completed by:

1. The client or legal representative
2. The client's Care Coordinator or other allied staff working within their Care Coordination Organization

HOW?

If a client chooses to discontinue participation in the Health Home Program, they can complete the form in person or via mail.

However, the client retains the right to refuse to complete and sign the form, in which case the Care Coordinator or allied staff can complete it for them.

WHEN?

When a client declines to engage in the Health Home Program or chooses to discontinue their participation in the program.

Do not use this form for the following reasons:

- Due to a loss of contact with a client
- Due to the inability of the Care Coordinator to locate a new or continuing client
- For the convenience of the Care Coordinator
- Because a client is difficult to serve or lives in an unsafe environment (this is considered an involuntary disenrollment, which your Lead organization can address)
- The client fails to meet their goals and/or action steps in their Health Action Plan
- The client wishes to suspend participation in the program, or is otherwise temporarily unable to participate
- The client moves to another county or state
- The client transfers to another Care Coordination Organization or Lead Organization
- The client becomes ineligible for full Medicaid coverage
- The client is incarcerated
- The client is deceased

WHERE?

You can download this form from the Health Care Authority website:

https://www.hca.wa.gov/billers-providers/forms-and-publications

Search for keyword "Health Home participation form" or "22-853"

Care Coordinator Corner

The following story was submitted by Nicole Watson, BSCH, Care Coordinator with Yakima Neighborhood Health:

One of Nicole's Health Home clients contacted her a few weeks ago to inform her of two life-changing events which had happened recently. First the client's house burned down, and within the same month she lost her significant other. These tragic events left her devastated and at a loss as to how to begin putting the pieces of her life back together.

Nicole set up an appointment to meet with the client and begin gathering important documents and information to get started. They spent nearly two hours working on a list of high-priority issues they needed to address.

With phone and internet access, Nicole and her client were able to call on the following resources for help:

- Health Care Authority for a new ProviderOne card
- Coordinated Care of WA for a new insurance card
- Social Security Administration to begin the process of getting a new ID card
- WASHCAP to update her address and continue food assistance
- SafeLink to get a new phone
- The client's providers to make appointments and continue taking care of her health
- Resources in the community for those coping with grief

At the beginning of the appointment, the client was exhausted, emotional, and overwhelmed with where to start, and did not have access to fundamental resources like the internet or a phone.

With help of the Care Coordinator, at the end of the appointment the client had less stress, more hope, and a smile on her face!

March Recognizes Social Workers…and YOU!

Every year the month of March recognizes Social Workers across the nation. This year's theme was "Social Workers: Leaders. Advocates. Champions", which fits perfectly not only with Social Workers, but also with all Care Coordinators in the Health Home Program.

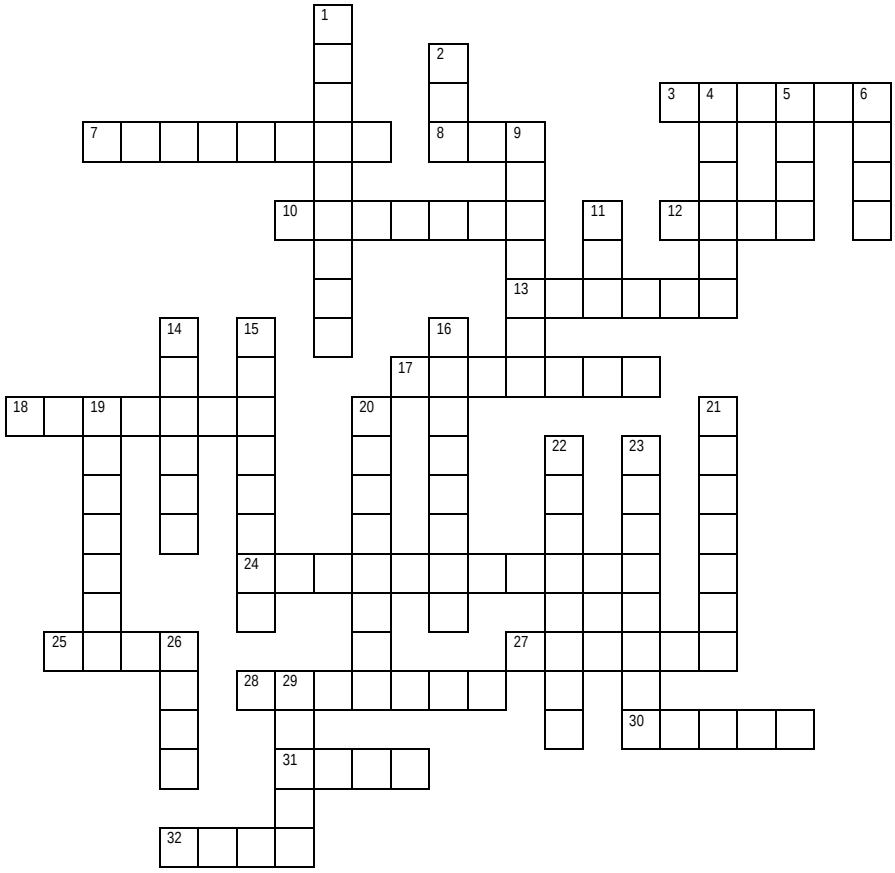
- As a LEADER you respect the dignity of each individual you serve and help guide our most vulnerable clients, working tirelessly to help them clarify their goals in order to improve their lives
- As an ADVOCATE you promote the well-being of your clients and help them address their problems often in innovative ways
- As a CHAMPION you stand up and fight for all your clients when they are not able, addressing and challenging injustice

Thank you for being a Leader…an Advocate…and a Champion to Washington's most vulnerable clients!

Health Home Puzzles & Games

ACROSS

3. Always contact the Children's Administration social worker before contacting a child in _____ care
7. HCA publishes income and _____ standards several times each year
8. A screening tool for measuring the client's activation
10. Integrated _____ care plans cover both physical and behavioral health
12. The number of levels in a PAM
13. Documentation is critical to record activities with your _____
17. I can send stories, ideas and resources to share to the HH Newsletter _____
18. Clients in the Health Home program have at least one chronic _____
24. Community _____ insures residents in AFHs are not isolated from their community
25. Care coordination organizations contract with these organizations
27. Care Coordinators can support clients by working with _____ members
28. This is one of the activities of daily living on the KATZ screening
30. In developing _____ for the HAP consider the clients confidence, conviction, and readiness
31. The FLACC is one of three optional screening that measures this
32. This is the assessment that is required for clients to access Long-Term Services and Supports (LTSS)



DOWN

1. Make sure your clients and their family understand the _____ plan when leaving a facility
2. This is the acronym for your client's main doctor
4. Use this form when a client no longer wants to participate in the HH program (2 words)
5. Payment for Health Home services is based on a three-_____ level
6. My falls free plan identifies fall _____
9. The Non-Emergency Medical Transportation program NEMT transports clients to _____ services
11. Also known as the body mass index
14. _____ Promotion is a core service that provides education and wellness coaching
15. SMART goals are _____, measurable, achievable, relevant, and time-limited
16. Eliminating _____ supports clients in achieving their goals
19. A CC may nominate their clients for this new consumer advocacy group called the _____ Experience Team
20. Due diligence is required for successful _____
21. One of the months the SET is held
22. These are held monthly to provide ongoing training to support you in your work
23. Care Coordinators offer clients and their family the opportunity to discuss advance care _____
26. A client who has Medicaid and Medicare coverage
29. Managed care clients receive Medicaid coverage under the _____ Health Program

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Health Home Program Washington

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