Exhibit C - ESSENTIAL REQUIREMENTS

(Excerpt from Request for Application 12-005C, Pages 38-41)

Under Washington State's approach, Health Homes are the bridge to integrate care within existing care systems. A Health Home is the central point for directing patient-centered care and is accountable for the following:

1. Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits;

2. Providing timely post discharge follow-up; and

3. Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health, and long-term care services and supports.

Health Home Care Coordinators must be embedded in community-based settings to effectively manage the full breadth of beneficiary needs.

Health Home Provider Network – A Health Home provider network is administered by a lead entity. The lead entity contracts with one or more Care Coordination Organizations (CCOs) that will deliver Health Home services. The provider network must include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency, and medical services, some of which will be CCOs. If the qualified Health Home supports managed care beneficiaries, the lead entity must have working agreements with all five (5) Healthy Options Managed Care Organizations (MCO) contracted with the state to ensure continuity of care if the Health Home beneficiary enrolls in a different MCO[1]. Other examples of providers to be included in Health Home networks are Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have identified specific administrative functions for both lead entities and CCOs. Our intent is to assure these functions are accounted for in the Health Home qualification process and documented in signed contracts and subcontracts. We are not restricting the accountability of the administrative functions. A qualified Health Home may delegate some or part of these functions to downstream contracts with proper oversight.

Lead Entity Requirements – The lead entity is accountable for administration of the Health Home. The lead entity:

1. Has experience operating broad-based regional provider networks.
2. Contracts directly with the state as a Qualified Health Home.[2]

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[1] This does not mean that FFS lead entities or MCO lead entities have to contract with every other lead entity in the coverage area.

[2] Healthy Options MCOs may also serve as Lead Entities as long as the network is qualified by the state.

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(Excerpt from Request for Application 12-005C, Pages 38-41)

3. Have capacity to provide Health Home services to 1,000 to 2,000 beneficiaries within their Health Home provider network.

4. Provides a toll-free line and customer service representatives to answer questions regarding Health Home enrollment, disenrollment, and how to access services or request a change to another CCO.
5. Subcontracts with organizations to directly provide the Health Home care coordination services.[3]

6. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
    a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
    b. Optimizes beneficiary choice.

7. Maintains a list of CCOs and their assigned Health Home population.

8. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.

9. Collects and reports encounters to the HCA.

10. Disburses payment to CCOs based upon encounters.

11. Ensures person-centered and integrated Health Action Planning. This includes providing high touch care management; such as meeting the required beneficiary-to- care coordinator ratio and ensuring and documenting the availability of support staff that complements the work of the care coordinator.

12. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Care Coordination Organization Requirements – The Care Coordination Organization must:

1. Subcontract with the lead entity.
2. Assign a Health Home Care Coordinator to provide Health Home services.
3. Ensure Health Home Care Coordinators actively engage the beneficiary in developing a Health Action Plan.

[3] Contractual relationships between the lead entity and their Care Coordination partners must be developed and in place prior to beneficiary assignment.

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(Excerpt from Request for Application 12-005C, Pages 38-41)

4. Ensure documentation by all staff, including those complementing the work of a care coordinator.

5. Implement a systematic protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

6. Establish methods to share hallmark events with the Health Home Care Coordinator within established time periods, such as emergency department visits, inpatient hospitalizations, inpatient discharges, missed prescription refills, institutional placement and/or discharge, and the need for preventive care.

7. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate recommended changes in care, as necessary, to address achievement of health action goals including the beneficiary's preferences and identified needs.[4][4]

8. Provide 24/7 availability of information and emergency consultation services to the beneficiary.

9. Assure 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.

10. Use informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices.

11. Provide Health Home services in a culturally competent manner that addresses health disparities. Examples of cultural competency:

    a. Interacting directly with the beneficiary and his or her family by speaking their language,

    b. Recognizing and applying cultural norms when creating the Health Action Plan, and

    c. Understanding the dynamics of substance use disorder without judgment.

13. Ensure Health Home Care Coordinators (within the care coordination organization) can discuss with the 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 changes in treatment or services.

    a. A HIPAA-compliant data sharing agreement must be in place when sharing either hard copy or electronic health information;

[4] Preferences means an informed decision, input into a decision and decisions that have value to the beneficiary

b. The beneficiary must sign a "Health Home Patient Information Sharing Consent Form" before the Health Home Care Coordinator can share protected health information.

14. Ensure Health Home Care Coordinators:

a. Have access to PRISM, a clinical decision support tool, to view cross-system health and social service utilization to identify care opportunities.

b. Provide in-person beneficiary health screening and Health Action Planning, using HCA and DSHS standardized and approved screens and Health Action Plan template.