Health Homes

Ask the Expert

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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 HCLA and HCA.

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

Form 10-481: Health Action Plan (HAP)
Form 10-481: Health Action Plan (HAP) 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:

- 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 or enrolled in PACE, 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 Health Home | Washington State Health Care Authority

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.

Dual Special Needs Plan (DSNP)

In January 2023, the Health Home program was extended as a Medicare benefit to Dual Special Needs Plan (DSNP) enrollees who were actively receiving Health Home services at the time of DSNP enrollment.

The program expanded further in January 2025, when each Medicare Advantage (MA) Health Plan began offering a Health Home program to all full-dual DSNP enrollees who meet Health Home eligibility criteria.

The service delivery structure remains unchanged. Health Home Leads and Care Coordination Organizations (CCOs) continue to provide Health Home services to DSNP beneficiaries. After a client transitions to Health Home services through a DSNP, the Medicare Advantage Plan reimburses the Health Home Lead directly.

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**

SERVICE DESCRIPTION	HH CC	HCS/AAA/DDA
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 regarding questions of enrollment or how 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 WAC

WAC 182-557-0100 Health Home

REVISION HISTORY

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

Health Home Print Resources

Form 10-481: Health Action Plan (HAP)
Form 10-481: Health Action Plan (HAP) Instructions
Health Homes Fact Sheet

Health Home

Health Home | Department of Social and Health Services

Health Home | Washington State Health Care Authority
Health Home – Washington's State Plan Amendment
Final Demonstration Agreement between CMS and the State of Washington December 2024