**MEMORANDUM OF UNDERSTANDING
BETWEEN
COORDINATED CARE AS HEALTH HOME LEAD ENTITY
AND King County Behavioral Health and Recovery Division OF GOVERNMENTS AS
CARE COORDINATION ORGANIZATION**

This Memorandum of Understanding ("MOU") is between Coordinated Care Corporation ("Coordinated Care"), who is contracted with the Washington State Health Care Authority to provide Health Home services to the Apple Health population under the Washington State Health Home Model, and **King County Behavioral Health and Recovery Division**, referred to as a Care Coordination Organization ("CCO").

Purpose

This memorandum delineates the roles and responsibilities of the Health Home Lead Entity and Care Coordination Organization related to the provision of services to beneficiaries receiving health home services from Coordinated Care ("Beneficiaries").

This memorandum demonstrates a shared commitment by the Health Home Lead Entity and **King County Behavioral Health and Recovery Division** to the cooperative method of coordinating service delivery to and for those individuals receiving Health Home services.

Definitions

"Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering the six Health Home services to the participating enrollee. The six Health Home services are 1) Care Coordination and Health Promotion, 2) Comprehensive Care Coordination, 3) Individual and Family Support, 4) Transitional Care, 5) Referral to Community and Social Support Services, and 6) Health Information Technology.

"Care Coordinator" means an individual employed or contracted by the Care Coordination Organization that provides or oversees Health Home services. Services are delivered or overseen by registered nurses, licensed practical nurses, Physician's Assistants, Bachelors in Social Work or Masters in Social Work or related professionally prepared social workers and Chemical Dependency Professionals.
"Health Home" means an entity composed of community-based providers, qualified by the state to provide Health Home Services to Medicaid enrollees. The entity is responsible for coordinating and integrating care across the continuum of services needed and used by eligible enrollees. Each Health Home acts as the lead entity responsible for administrative and oversight functions and includes broad representation of community-based organizations representing primary, acute, mental health, substance use disorder and long term services and supports that provide intensive care coordination to eligible enrollees. A Qualified Health Home includes providers from the local community that authorize Medicaid, state or federally funded behavioral health, long-term services and supports, and primary and acute services.

Background

A. Health Home Lead Entity

Coordinated Care has contracted with the Washington State Health Care Authority ("HCA") to serve as a Health Home Lead Entity and as a Care Coordination Organization. This program was created to implement portions of the federal Affordable Care Act. This effort is a partnership between HCA and DSHS and provides Health Home services to Managed Care beneficiaries being served by Coordinated Care in its designated coverage areas.

A Health Home is a coordinated, person-centered system of care. An individual who is eligible and assigned by HCA for health home services can receive coordinated care services across medical, mental health and drug and/or alcohol addiction treatment as well as long-term services and supports. Coordinated Care may provide or contract with Care Coordination Organizations ("CCOs") to coordinate the care of individuals assigned to their health home. Coordinated Care selects the CCO that is most qualified to coordinate the individual's care based upon his/her needs. Coordinated Care or contracted CCO's will perform the following:

Roles and Responsibilities

The Parties voluntarily agree to the following roles:

1. **Coordinated Care**

As a Health Home Lead Entity shall ensure that, the following are operational:

- The ability to submit completed and updated Health Action Plan (HAP) data through the OneHealthPort Health Information Exchange. The HAP data will be stored in a Medicaid data base for evaluation purposes;
- A system to track and share enrollee information and care needs among 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 enrollee's preferences and identified needs;
- Enrollee access to toll-free line and customer service representatives to answer questions, with minimum coverage 8:00 to 5:00 from Monday through Friday regarding Health Home enrollment, disenrollment and how to access services or request a change to another Care Coordination Organization;
- A system for emergency consultation and general information available 24/7;
- Policies, procedures and agreements with hospitals for transitioning care and referring eligible enrollees who seek or need treatment in a hospital emergency department for Health Home enrollment;
- A list of subcontracted CCOs and their assigned Health Home enrollees, regularly updated;
- PRISM Registration: Each Designated Staff person shall complete the PRISM Registration form available at PRISM.admin@dshs.wa.gov and submit it to the Coordinated Care PRISM User Coordinator along with a Nondisclosure of HCA Confidential Information form.
- Policies and procedures that support care coordination interventions to:
    1. Maintain frequent, in-person contact between the enrollee and the Care Coordinator when delivering intensive care coordination services;
    2. Ensure availability of support staff to complement the work of the Care Coordinator;

3. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions; and
4. Ensure an appointment reminder system is in place for enrollees.
5. Identification and actions to address enrollee gaps in care through:
6. Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the age and the enrollee's underlying chronic conditions;
    i. Evaluation of client perception of gaps in care;
    ii. Documentation of gaps in care in the enrollee case file;
    iii. Documentation of interventions in HAP and progress notes;
    iv. Findings from the enrollee's response to interventions;
    v. Documentation of follow-up

2. **King County Behavioral Health and Recovery Division**

As a Care Coordination Organization will provide:

- Care Coordination and Health Promotion

  Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;
    a. Fosters communication between the care providers, including the treating primary care provider, medical specialists and entities authorizing behavioral health and long-term services and supports;
    b. Maintains a caseload that ensures timely intervention;
    c. Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home services;
    d. Provides interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices;
- Comprehensive Care Coordination
    1. Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;
    2. Assesses enrollee's readiness for self-management and promotion of self-management skills;
    3. Reassesses the HAP and Health Home enrollee's progress in meeting goals;
    4. Manages barriers to achieving health action goals;
    5. Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;
    6. Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
    7. Reassesses patient activation at minimum every four (4) months, or more frequently if changes warrant reassessment using the Patient Activation Measure (PAM) or Caregiver Activation Measure (CAM) and documents the results in the HAP; and
    8. Ensures communication, coordination, and care management functions are not duplicated between the Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS case managers.
- Individual and Family Support
    1. The CCO shall use peer supports, support groups and self-management programs as needed, to increase the enrollee's and Caregiver's knowledge of the enrollee's

chronic conditions, promote the enrollee's capabilities and engagement in self-management, and help the enrollee improve adherence to prescribed treatment.

2. The CCO shall ensure the Care Coordinator, with the enrollee's participation:
    a. Identifies the role that the enrollee's family, informal supports and paid caregivers provide to help the enrollee achieve self-management and optimal levels of physical and cognitive function;
    b. Educates and supports self-management; self-help recovery and other resources necessary for the enrollee, his or her family and caregivers to support the enrollee's individual health action goals;
    c. Documents discussion of advance directives and includes the enrollee's family in the discussion;
    d. Communicates and shares information with the enrollee's family and other caregivers, with appropriate consideration

- Transitional Care

As required by Section 3.11 of the Apple Health Managed Care Contract between Coordinated Care and the Washington State Health Care Authority (the Apple Health Contract):

1. The CCO shall provide comprehensive transitional care for Health Home enrollees to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.
2. In addition to Transitional care services described in Section 14.5 of the Apple Health Contract, Transitional Care, the CCO's transitional care planning process must include:
    a. Participation by the Care Coordinator in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays, post hospital/institutional stay, home visits, and follow-up telephone calls.
    b. A notification system between MCOs, hospitals, nursing facilities and residential/rehabilitation facilities that provides prompt notification of an enrollee's admission or discharge from an emergency department, inpatient setting, nursing facility or residential/rehabilitation facility, and if proper permissions are in place, a substance use disorder treatment setting.
    c. Progress notes or a case file that documents the notification.
    d. Transition planning details such as medication management and monitoring documented in the HAP.
    e. The CCO may employ staff that has been trained specifically to provide transitional services, as long as the Care Coordinator is an active participant in the transitional planning process.
    f. The CCO shall establish the frequency of communicating hallmark events to the assigned Care Coordinator.

- Referral to Community and Social Support Services
    1. The Care Coordinator shall ensure that available community resources are identified and accessible to the Health Home enrollee.
    2. Referrals:
        a. Are overseen by the Care Coordinator;
        b. Support the enrollee's health action goals;

c. Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
d. Are documented in the enrollee's progress notes and HAP.

e. Assistance is provided to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.
f. Services are coordinated with appropriate departments of local, state and federal governments and community-based organizations;

Mutual Roles and Responsibilities of the Parties

The parties agree together to:

- **Sharing Protected Health Information**

The parties agree that information shared under this MOU is shared for the purpose of coordination of treatment, authorized services and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this MOU, HIPAA, the Health Information Technology for Economic and Clinical Health Act (HITECH) and any other applicable federal or state privacy regulations. The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e) and other applicable state and federal laws and regulations, as amended from time to time. In addition, any data sharing shall be conducted under the requirements of HCA as specified in the Qualified Health Home Client Service Contract.

- **Coordination of Care and Care Transitions**

King County Behavioral Health and Recovery Division and Coordinated Care have the responsibility to assure that Beneficiaries who have multiple needs and make frequent use of the systems of care are provided with quality-coordinated care. The Care Coordination Organization and Coordinated Care and their respective designees (e.g., care managers, contractors, provider networks, authorizing entities) will collaborate on coordination of care for Beneficiaries.

- **Relationship of the Parties**

1. Coordinated Care and **King County Behavioral Health and Recovery Division** are independent parties.
2. No agent or employee of the identified arties shall be deemed as an agent or employee of the other Party.
3. Each party will solely and entirely be responsible for the acts of its agents, employees, interns or volunteers.
4. This MOU is executed for the benefits of the parties and the public. It is not intended, nor may it be construed, to create any third-party beneficiaries. This is not a contract.

Health Home Encounter Codes and Data

The following are the 3 encounter codes and reimbursement rates for the Health Home Program. It has been determined that all encounters will use the following diagnosis code: V6540, which has been designated by HCA for encounter data reporting. Claims need to be submitted in a timely manner as well as the other required Health Home assessments and HAP.

1. **G9148** – Outreach, Engagement, and Health Action Plan (Tier One Services)
    a. Completion of the Health Action Plan
    b. This must be submitted prior to any other encounters
    c. This is only for the Initial outreach/connection with the patient
    d. Use Diagnosis Code: Z71.9 for processing purposes

2. **G9149** – Intensive Health Home Care Coordination (High Touch, In-Person, Home Visits, Telephonic Outreach) (Tier Two Services)
    a. Comprehensive Case Management, including one face-to-face visit with the patient each month (exceptions may be made with evidence that the patient and the patient's caregivers are actively engaged in the HAP, participating in activities that are in support of improved health and well-being, have value for the client and caregivers, and support an active level of care coordination through delivery of the Health Home services)
    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
    f. At least one qualified Health Home service must be provided prior to submitting a Tier Two claim. Qualified Health Home service categories include comprehensive care management, care coordination, health promotion, individual and family support, and comprehensive transitional care.
    g. Use Diagnosis Code: Z71.9 for processing purposes

3. **G9150** – Low-Level Health Home Care Coordination (less home visits, more telephonic Outreach) (Tier Three Services)
    a. Comprehensive Case Management, including review of the HAP at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.
    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

f. At least one qualified Health Home Service must be provided prior to submitting a Tier Three claim. Qualified Health Home service categories include comprehensive care management, care coordination, health promotion, individual and family support, and comprehensive transitional care.
g. Use Diagnosis Code: Z71.9 for processing purposes

Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this MOU, nothing in this MOU is intended to establish a legally binding MOU between the parties.
2. The parties of this MOU will hold one another including their contractors, employees, interns, and volunteers harmless for failure to perform any of the roles identified above, including termination of this MOU with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.
4. Except for co-payments, deductibles, or co-insurance required to be paid by or on behalf of the individual(s) at the time of delivery of Health Home Services, **King County Behavioral Health and Recovery Division** will only to look to Coordinated Care for compensation of Health Home Services performed by **King County Behavioral Health and Recovery Division** for Beneficiaries. **King County Behavioral Health and Recovery Division** will not assert any claim, attempt to balance bill the Beneficiary(s), or maintain any action for compensation against the Beneficiary(s) for Health Home Services. Nothing in this agreement shall prohibit the **King County Behavioral Health and Recovery Division** from billing and recovering payments from Beneficiary (s) for non-Home Health Services.

Communication

1. Primary contact persons. The names, titles, and contact information for current primary contacts for each Party will be shared via letter or email between the parties. Updates to contact information will be shared via letter or email.

Dispute Resolution

1. All disputes occurring between the parties of this MOU shall be resolved through informal negotiation between the parties of the MOU. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the MOU.

Term and Termination

1. The effective date of this MOU will be upon the final signature of the parties to this MOU and it shall remain in effect for two (2) years from the date of final signature.
2. Any of the parties to this MOU may withdraw and terminate their participation from this MOU for any reason and at any time. Thirty (30) days written notice is preferred but not required. Such notice and other correspondence related to this MOU should be sent to the contacts and addresses listed below.

Compensation

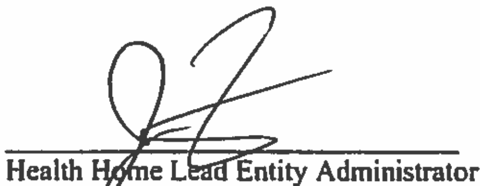
Coordinated Care shall pay claims **King County Behavioral Health and Recovery Division** for Health Home Services provided to Beneficiaries in according to the following less applicable copayments, cost-sharing or other amounts that are the Beneficiary's financial responsibility:

- Tier 1, Encounter Code: G9148
  Rate of $252.93 per Initial Assessment/Outreach
- Tier 2, Encounter Code: G9149
  Rate: $172.61 per participant (patient) per month
- Tier 3, Encounter Code: G9150
  Rate: $67.50 per participant (patient) per month

Amendment

This MOU may be amended at any time by written amendment to the MOU and signature of all the parties.

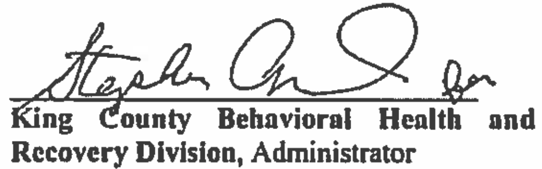
IN WITNESS WHEREOF, the parties here to have caused this MOU to be executed by the dates and signatures herein under affixed. The persons signing this MOU on behalf of the parties represent that each has authority to execute the MOU on behalf of the party entering this MOU.



Health Home Lead Entity Administrator

9/23/16
Date

1145 Broadway, Suite 300
Tacoma, WA 98402



King County Behavioral Health and Recovery Division, Administrator

9-21-16
Date

401 Fifth Avenue, Suite 400
Seattle WA 98104
Tax ID: 91-6001327