

# Chapter 182-557 WAC

## CHRONIC CARE MANAGEMENT

### WAC

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**WAC 182-557-0050 Chronic care management program—General.** (1) The department's chronic care management program:

(a) Offers care management and coordination activities for medical assistance clients determined to be at risk for high medical costs;

(b) Provides education, training, and/or coordination of services for program participants through statewide care management (SCM) and local care management (LCM) providers contracted with DSHS;

(c) Assists program participants in improving self-management skills and improving health outcomes; and

(d) Reduces medical costs by educating clients to better utilize health care services.

(2) The department's chronic care management program does not:

(a) Change the scope of services available to a client eligible under a Title XIX medicaid program;

(b) Interfere with the relationship between a participant (client) and the client's chosen department-enrolled provider(s);

(c) Duplicate case management activities available to a client in the client's community; or

(d) Substitute for established activities that are available to a client and provided by programs administered through other DSHS divisions or state agencies.

(3) Chronic care management program services provided by a statewide care management (SCM) contractor and a local care management (LCM) contractor must meet:

(a) The conditions of the contract between DSHS and the contractor; and

(b) Applicable state and federal requirements.

(4) The SCM contractor uses a predictive modeling program to review DSHS claims, and eligibility data to identify clients eligible to participate in the chronic care management program.

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**WAC 182-557-0100 Chronic care management program—Definitions.** The following terms and definitions apply to the chronic care management program:

"**Chronic care management program services**" are services provided by DSHS-contracted organizations to clients with multiple health, behavioral, and social needs in

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order to improve care coordination, client education, and client self-management skills.

"**Evidence-based health care practice**" means a clinical approach to practicing medicine based on the clinician's awareness of evidence and the strength of that evidence to support the management of a disease treatment process.

"**Local care management program**" or "**LCM program**" means a comprehensive care management program and medical home program for medical assistance clients (participants) that serves a specific geographical area of the state.

"**Local care management (LCM) contractor**" means an entity or group of entities that contracts with DSHS to provide chronic care management program services to eligible participants (clients).

"**Medical home**" means an approach to providing health care services in a high-quality and cost-effective manner that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent.

"**Participant**" means a medical assistance client who has been contacted by an SCM or LCM, and has agreed to participate in the chronic care management program.

"**Predictive modeling**" means using historical medical claims data to predict future utilization of medical services.

"**Self-management**" means, with guidance from a health care team, the concept of a medical assistance client being the "driver" of their own health care to improve their health care outcome through:

- Education;
- Monitoring;
- Adherence to evidence-based guidelines; and
- Active involvement in the decision-making process with the team.

"**Statewide care management program**" or "**SCM program**" means a comprehensive care management program for clients that serves all areas of the state not served by a local care management (LCM) program.

"**Statewide care management (SCM) contractor**" means an entity that contracts with DSHS to provide chronic care management program services to eligible medical assistance clients (participants). The SCM contractor provides client identification and referral to appropriate local care management (LCM) programs through predictive modeling.

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**WAC 182-557-0200 Chronic care management program—Client eligibility and participation.** (1) To be a participant in the chronic care management program, a client must:

(a) Be a recipient of the supplemental security income (SSI) program or general assistance with expedited medical categorically needy (GAX) program;

(b) Be identified through predictive modeling as being high risk for high medical costs as a result of needing medical treatment for multiple conditions; and

(c) Agree to participate in the program.

(2) A client participating in the chronic care management program must not be:

(a) Receiving medicare benefits;

(b) Residing in an institution, as defined in WAC 388-500-0005, for more than thirty days;

(c) Eligible for third party coverage that provides care management services or requires administrative controls that would duplicate or interfere with the department's chronic care management program;

(d) Enrolled with a managed care organization (MCO) plan contracted with DSHS;

(e) Currently receiving long term care services; or

(f) Receiving case management services that chronic care management program services would duplicate.

(3) Using data provided by DSHS, the statewide care management (SCM) contractor identifies medical assistance clients who are potential participants for chronic care management program services. A client who meets the participation requirements in this section:

(a) Will be served by the SCM program or a local care management (LCM) program, based on the geographical area of the state the client resides.

(b) Will be contacted by an SCM or LCM care manager for an assessment and enrollment in the program;

(c) Will not be enrolled unless the client specifically agrees to the enrollment;

(d) May request disenrollment at any time. Disenrollment is effective the first day of the following month; and

(e) May request reenrollment at any time. Reenrollment is effective the first day of the following month.

(4) A participating client who subsequently enrolls in a DSHS voluntary managed care program is no longer eligible for chronic care management program services.

(5) A client who meets the eligibility and enrollment criteria for participation in the chronic care management services program:

(a) Is eligible to participate for six months from the date of enrollment provided the client continues to meet eligibility and enrollment criteria; and

(b) May participate for additional six-month participation periods if both the department and the SCM or LCM contractor determine that the participant's self-management skills and health care outcome would benefit.

(6) A client who does not agree with a decision regarding chronic care management program services has a right to a hearing under chapter 388-02 WAC.

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**WAC 182-557-0300 Chronic care management program services—Confidentiality and data sharing.** (1) Statewide care management (SCM) and local care management (LCM) contractors must meet the confidentiality and

data sharing requirements that apply to clients eligible under Title XIX medicaid programs and as specified in the chronic care management contract.

(2) DSHS shares health care data with SCM and LCM contractors under the provisions of RCW 70.02.050 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(3) DSHS requires SCM and LCM contractors to monitor and evaluate participant activities and provide to the department:

(a) Any client information collected; and

(b) Any data compiled as the result of the program.

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**WAC 182-557-0400 Chronic care management program services—Payment.** Only a DSHS-contracted statewide care management (SCM) and local care management (LCM) program may bill and be paid for providing the chronic care management program services described in chapter 388-557 WAC. Billing requirements and payment methodology are described in the contract between DSHS and the contractor.

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