Chapter 182-557 WAC
HEALTH HOMES

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WAC

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WAC 182-557-0050 Health home—General. (1) The agency's health home program provides patient-centered care to participants who:

(a) Have at least one chronic condition as defined in WAC 182-557-0100; and

(b) Are at risk of a second chronic condition as evidenced by a minimum predictive risk score of 1.5.

(2) The health home program offers six care coordination activities to assist participants in self-managing their conditions and navigating the health care system:

(a) Comprehensive or intensive care management including, but not limited to, assessing participant's readiness for self-management, promoting self-management skills, coordinating interventions tailored to meet the participant's needs, and facilitating improved outcomes and appropriate use of health care services;

(b) Care coordination and health promotion;

(c) Comprehensive transitional care between care settings including, but not limited to, after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting);

(d) Individual and family support services to provide health promotion, education, training and coordination of covered services for participants and their support network;

(e) Referrals to community and support services; and

(f) Use of health information technology (HIT) to link services between the health home and participants' providers.

(3) The agency's health home program does not:

(a) Change the scope of services for which a participant is eligible under medicare or a Title XIX medicaid program;

(b) Interfere with the relationship between a participant and his or her chosen agency-enrolled provider(s);

(c) Duplicate case management activities the participant is receiving from other providers or programs; or

(d) Substitute for established activities that are available through other programs administered by the agency or other state agencies.

(4) Qualified health home providers must:

(a) Contract with the agency to provide services under this chapter to eligible participants;

(b) Accept the terms and conditions in the agency's contract;

(c) Be able to meet the network and quality standards established by the agency;

(d) Accept the rates established by the agency; and

(e) Comply with all applicable state and federal requirements.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-065, § 182-557-0050, filed 8/14/15, effective 9/14/15. Statutory Authority: RCW 41.05.021. WSR 13-21-048, § 182-557-0050, filed 10/11/13, effective 11/11/13. Statutory Authority: RCW 41.05.021 and 2011 c 316. WSR 13-12-002, § 182-557-0050, filed 5/22/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-557-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. WSR 07-20-048, § 388-557-0050, filed 9/26/07, effective 11/1/07.]

WAC 182-557-0100 Health home program—Definitions. The following terms and definitions and those found in chapter 182-500 WAC apply to this chapter:

Action - For the purposes of this chapter, means one or more of the following:

(a) The denial of eligibility for health home services.

(b) The denial or limited authorization by the qualified health home of a requested health home service, including a type or level of health home service.

(c) The reduction, suspension, or termination by the qualified health home of a previously authorized health home service.

(d) The failure of a qualified health home to provide authorized health home services or provide health home services as quickly as the participant's condition requires.

Agency - See WAC 182-500-0010.

Chronic condition - Means mental health conditions, substance use disorders, asthma, diabetes, heart disease, cancer, cerebrovascular disease, coronary artery disease, dementia or Alzheimer's disease, intellectual disability, HIV/AIDS, renal failure, chronic respiratory conditions, neurological disease, gastrointestinal, hematological, and musculoskeletal conditions.

Client - For the purposes of this chapter, means a person who is eligible to receive health home services under this chapter.

Clinical eligibility tool - Means an electronic spreadsheet that determines a client's risk score using the client's age, gender, diagnoses, and medications.

Coverage area - Means a geographical area composed of one or more counties within Washington state. The map of the coverage areas and the list of the qualified health homes is located at https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes.

Fee-for-service (FFS) - See WAC 182-500-0035.

Full dual eligible - For the purpose of this chapter, means a fee-for-service client who receives qualified medicare beneficiary coverage or specified low-income medicare beneficiary coverage and categorically needy health care coverage.

Grievance - Means an expression of a participant's dissatisfaction about any matter other than an action. Possible subjects for grievances include the quality of health home services provided when an employee of a qualified health home provider is rude to the participant or shares confidential information about the participant without their permission.

Health action plan - Means a plan that lists the participant's goals to improve and self-manage their health conditions and steps needed to reach those goals.

Health home care coordinator - Means staff employed by or subcontracted by the qualified health home to provide one or more of the six defined health home care coordination benefits listed in WAC 182-557-0050.

Health home services - Means services described in WAC 182-557-0050 (2)(a) through (f).

Medicaid - See WAC 182-500-0070.

Participant - Means a client who has agreed to receive health home services under the requirements of this chapter.

Qualified health home - Means an organization that contracts with the agency to provide health home services to participants in one or more coverage areas and meets the requirements in WAC 182-557-0050(4).

Risk score - Means a measure of the expected costs of the health care a client is likely to incur in the next twelve months that the agency calculates using an algorithm developed by the department of social and health services (DSHS) or the clinical eligibility tool.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-24-111, § 182-557-0100, filed 12/6/17, effective 1/6/18; WSR 15-17-065, § 182-557-0100, filed 8/14/15, effective 9/14/15. Statutory Authority: RCW 41.05.021 and 2011 c 316. WSR 13-12-002, § 182-557-0100, filed 5/22/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-557-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. WSR 07-20-048, § 388-557-0100, filed 9/26/07, effective 11/1/07.]

WAC 182-557-0200 Health home program—Eligibility. (1) To be eligible for the health home program, a client must:

(a) Be a recipient of categorically needy health care coverage or be eligible for services under an alternative benefits plan (ABP), as described in WAC 182-501-0060, through:

(i) Fee-for-service, including full dual eligible clients; or

(ii) An agency-contracted managed care organization.

(b) Have one or more chronic conditions as defined in WAC 182-557-0100; and

(c) Have a risk score of 1.5 or greater measured either with algorithms developed by the department of social and health services or the agency's clinical eligibility tool located at https://www.hca.wa.gov/assets/billers-and-providers/Clinical_Eligibility_Tool.xls.

(2) A person is ineligible to receive health home services when:

(a) The person is enrolled in a third-party medical insurance plan. For purposes of this section, a medical insurance plan does not include plans that offer only dental, vision, pregnancy, or maternity care services.

(b) The person has a risk score of less than 1.0 for six consecutive months and has not received health home services.

(3) When the agency determines a client is eligible for health home services, the agency enrolls the client with a qualified health home in the coverage area where the client lives.

(a) The client may decline health home services or change to a different qualified health home or a different health home care coordinator.

(b) If the client chooses to participate in the health home program, a health home care coordinator will:

(i) Work with the participant to develop a health action plan that describes the participant's health goals and includes a plan for reaching those goals; and

(ii) Provide health home services at a level appropriate to the participant's needs.

(4) A participant who does not agree with a decision regarding health home services, including a decision regarding the client's eligibility to receive health home services, has the right to an administrative hearing as described in chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-04-041, s 182-557-0200, filed 1/29/25, effective 3/1/25; WSR 17-24-111, § 182-557-0200, filed 12/6/17, effective 1/6/18; WSR 15-17-065, § 182-557-0200, filed 8/14/15, effective 9/14/15. Statutory Authority: RCW 41.05.021 and 2011 c 316. WSR 13-12-002, § 182-557-0200, filed 5/22/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-557-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. WSR 07-20-048, § 388-557-0200, filed 9/26/07, effective 11/1/07.]

WAC 182-557-0225 Health home services—Methodology for calculating a person's risk score. The agency uses eight steps to calculate a person's risk score.

(1) **Step 1. Collect paid claims and health plan encounter data.** The agency obtains a set of paid fee-for-service claims and managed care encounters for a client.

(a) For clients age 17 and younger, the agency uses all paid claims and encounters within the last 24 months.

(b) For clients age 18 and older, the agency uses all paid claims and encounters within the last 15 months.

(i) The claims and encounters include the international classification of diseases (ICD) diagnosis codes and national drug codes (NDC) submitted by health care providers. These are used in steps 2 and 3 to create a set of risk categories.

(ii) The agency uses two algorithms developed by the University of San Diego:

(A) Chronic illness and disability payment system (CDPS) which assigns ICD diagnosis codes to CDPS risk categories (see Table 3 in subsection (5)(b) of this section); and

(B) Medical Rx (MRx) which assigns NDCs to MRx risk categories (see Table 2 in subsection (3)(b) of this section).

(2) **Step 2. Group ICD diagnosis codes into chronic illness and disability payment system risk categories.**

(a) To group ICD diagnosis codes into the CDPS risk categories (see Table 1 in (b) of this subsection), the agency uses an ICD diagnosis code to CDPS risk categories crosswalk in subsection (1)(b)(ii)(A) of this section. Each of the ICD diagnosis codes listed is assigned to one risk category. If an ICD diagnosis code is not listed in the crosswalk it does not map to a risk category that is used in the calculation of the risk score.

(b) **Table 1. Titles of Chronic Illness and Disability Payment System Risk Categories**

CARVH	Cardiovascular, very high
CARM	Cardiovascular, medium
CARL	Cardiovascular, low

CAREL	Cardiovascular, extra low
PSYH	Psychiatric, high
PSYM	Psychiatric, medium
PSYML	Psychiatric, medium low
PSYL	Psychiatric, low
SKCM	Skeletal, medium
SKCL	Skeletal, low
SKCVL	Skeletal, very low
CNSH	Central Nervous System, high
CNSM	Central Nervous System, medium
CNSL	Central Nervous System, low
PULVH	Pulmonary, very high
PULH	Pulmonary, high
PULM	Pulmonary, medium
PULL	Pulmonary, low
GIH	Gastro, high
GIM	Gastro, medium
GIL	Gastro, low
DIA1H	Diabetes, type 1 high
DIA1M	Diabetes, type 1 medium
DIA2M	Diabetes, type 2 medium
DIA2L	Diabetes, type 2 low
SKNH	Skin, high
SKNL	Skin, low
SKNVL	Skin, very low
RENEH	Renal, extra high
RENVH	Renal, very high
RENM	Renal, medium
RENL	Renal, low
SUBL	Substance abuse, low
SUBVL	Substance abuse, very low
CANVH	Cancer, very high
CANH	Cancer, high
CANM	Cancer, medium
CANL	Cancer, low
DDM	Developmental Disability, medium
DDL	Developmental Disability, low
GENEL	Genital, extra low
METH	Metabolic, high
METM	Metabolic, medium
METVL	Metabolic, very low
PRGCMP	Pregnancy, complete
PRGINC	Pregnancy, incomplete
EYEL	Eye, low
EYEVL	Eye, very low
CERL	Cerebrovascular, low
AIDSH	AIDS, high
INFH	Infectious, high

HIVM	HIV, medium
INFM	Infectious, medium
INFL	Infectious, low
HEMEH	Hematological, extra high
HEMVH	Hematological, very high
HEMM	Hematological, medium
HEML	Hematological, low

(3) **Step 3. Group national drug codes (NDCs) into MRx risk categories.**

(a) To group the NDC codes into MRx risk categories (see Table 2 in (b) of this subsection), the agency uses a NDC code to MRx risk categories crosswalk in subsection (1)(b)(ii)(B) of this section.

(b) **Table 2. Titles of Medicaid Rx Risk Categories**

MRx1	Alcoholism
MRx2	Alzheimer's
MRx3	Anti-coagulants
MRx4	Asthma/COPD
MRx5	Attention Deficit
MRx6	Burns
MRx7	Cardiac
MRx8	Cystic Fibrosis
MRx9	Depression/Anxiety
MRx10	Diabetes
MRx11	EENT
MRx12	ESRD/Renal
MRx13	Folate Deficiency
MRx14	CMV Retinitis
MRx15	Gastric Acid Disorder
MRx16	Glaucoma
MRx17	Gout
MRx18	Growth Hormone
MRx19	Hemophilia/von Willebrands
MRx20	Hepatitis
MRx21	Herpes
MRx22	HIV
MRx23	Hyperlipidemia
MRx24	Infections, high
MRx25	Infections, medium
MRx26	Infections, low
MRx27	Inflammatory/Autoimmune
MRx28	Insomnia
MRx29	Iron Deficiency
MRx30	Irrigating Solution
MRx31	Liver Disease
MRx32	Malignancies
MRx33	Multiple Sclerosis/Paralysis
MRx34	Nausea
MRx35	Neurogenic Bladder
MRx36	Osteoporosis/Pagets

MRx37	Pain
MRx38	Parkinsons/Tremor
MRx39	Prenatal Care
MRx40	Psychotic Illness/Bipolar
MRx41	Replacement Solution
MRx42	Seizure Disorders
MRx43	Thyroid Disorder
MRx44	Transplant
MRx45	Tuberculosis

(4) **Step 4. Remove duplicate risk categories.** After mapping all diagnosis and drug codes to the risk categories, the agency eliminates duplicates of each client's risk categories so that there is only one occurrence of any risk category for each client.

(5) **Step 5. Select the highest CDPS risk category within a disease group.**

(a) The agency organizes CPDS risk categories into risk category groups of different intensity levels. The high risk category in each group is used in the calculation of the risk score. The lower level risk categories are eliminated from further calculations.

(b) **Table 3. Chronic Disease Payment System Risk Category Groups**

Group Description	Risk Categories (Ordered Highest to Lowest Intensity)
AIDS/HIV and Infection	AIDSH, INFH, HIVM, INFM, INFL
Cancer	CANVH, CANH, CANM, CANL
Cardiovascular	CARVH, CARM, CARL, CAREL
Central Nervous System	CNSH, CNSM, CNSL
Diabetes	DIA1H, DIA1M, DIA2M, DIA2L
Developmental Disability	DDM, DDL
Eye	EYEL, EYEVL
Gastrointestinal	GIH, GIM, GIL
Hematological	HEMEH, HEMVH, HEMM, HEML
Metabolic	METH, METM, METVL
Pregnancy	PRGCMP, PRGINC
Psychiatric	PSYH, PSYM, PSYML, PSYL
Substance Abuse	SUBL, SUBVL
Pulmonary	PULVH, PULH, PULM, PULL
Renal	RENEH, RENVH, RENM, RENL
Skeletal	SKCM, SKCL, SKCVL
Skin	SKNH, SKNL, SKNVL

(6) **Step 6. Determine age/gender category.**

(a) For each client, the agency selects the appropriate age/gender category. The 11 categories are listed in Table 4 in (b) of

this subsection. The categories for ages below five and above 65 are gender neutral.

(b) **Table 4. Age/Gender Categories**

Age	Gender
Age <1	
Age 1 to 4	
Age 5 to 14	Male
Age 5 to 14	Female
Age 15 to 24	Male
Age 15 to 24	Female
Age 25 to 44	Male
Age 25 to 44	Female
Age 45 to 64	Male
Age 45 to 64	Female
Age 65+	

(7) **Step 7. Apply risk weights.**

(a) The agency assigns each risk category and age/gender category a weight. The weight comes from either the model for clients who are age 17 and younger or from the model for clients age 18 and older.

(b) In each model there are three types of weights.

(i) Age/gender – Weights that correspond to the age/gender category of a client.

(ii) CDPS – Weights that correspond to 58 of the CDPS risk categories.

(iii) MRx – Weights that correspond to 45 of the MRx risk categories.

(c) **Table 5. Risk Score Weights**

Category Type	Category	Description	Weights for Children (age <18)	Weights for Adults (age 18+)
Age/Gender	Age <1	Clients of age less than 1	0.91261	0.00000
	Age 1 to 4	Clients age 1 to 4	0.31764	0.00000
	Age 5 to 14, Male	Male clients age 5 to 14	0.25834	0.00000
	Age 5 to 14, Female	Female clients age 5 to 14	0.26338	0.00000
	Age 15 to 24, Male	Male clients age 15 to 24	0.25662	-0.01629
	Age 15 to 24, Female	Female clients age 15 to 24	0.29685	0.03640
	Age 25 to 44, Male	Male clients age 25 to 44	0.00000	0.04374
	Age 25 to 44, Female	Female clients age 25 to 44	0.00000	0.06923
	Age 45 to 64, Male	Male clients age 45 to 64	0.00000	0.13321
	Age 45 to 64, Female	Female clients age 45 to 64	0.00000	0.06841
	Age 65+	Clients age 65 and older	0.00000	-0.05623
CDPS	CARVH	Cardiovascular, very high	0.84325	2.86702
	CARM	Cardiovascular, medium	0.33428	0.73492
	CARL	Cardiovascular, low	0.12835	0.24620
	CAREL	Cardiovascular, extra low	0.04307	0.06225
	PSYH	Psychiatric, high	0.40351	0.27085
	PSYM	Psychiatric, medium	0.23892	0.00000
	PSYML	Psychiatric, medium low	0.13796	0.00000
	PSYL	Psychiatric, low	0.07675	0.00000
	SKCM	Skeletal, medium	0.21071	0.42212

Category Type	Category	Description	Weights for Children (age <18)	Weights for Adults (age 18+)
	SKCL	Skeletal, low	0.08343	0.15467
	SKCVL	Skeletal, very low	0.06244	0.06773
	CNSH	Central Nervous System, high	0.80483	0.78090
	CNSM	Central Nervous System, medium	0.31945	0.40886
	CNSL	Central Nervous System, low	0.15106	0.18261
	PULVH	Pulmonary, very high	1.14056	4.01723
	PULH	Pulmonary, high	0.34356	0.39309
	PULM	Pulmonary, medium	0.35587	0.31774
	PULL	Pulmonary, low	0.11315	0.13017
	GIH	Gastro, high	0.65934	1.34924
	GIM	Gastro, medium	0.24699	0.24372
	GIL	Gastro, low	0.09767	0.05104
	DIA1H	Diabetes, type 1 high	0.27018	1.04302
	DIA1M	Diabetes, type 1 medium	0.27018	0.23620
	DIA2M	Diabetes, type 2 medium	0.13647	0.17581
	DIA2L	Diabetes, type 2 low	0.13647	0.09635
	SKNH	Skin, high	0.56322	0.37981
	SKNL	Skin, low	0.23664	0.45155
	SKNVL	Skin, very low	0.05697	0.02119
	RENEH	Renal, extra high	1.80489	3.41999
	RENVH	Renal, very high	0.59311	0.69251
	RENM	Renal, medium	0.28630	0.92846
	RENL	Renal, low	0.21048	0.17220
	SUBL	Substance Abuse, low	0.15170	0.16104
	SUBVL	Substance Abuse, very low	0.01794	0.08784
	CANVH	Cancer, very high	1.19700	2.80074
	CANH	Cancer, high	0.51985	0.97173
	CANM	Cancer, medium	0.22164	0.38022
	CANL	Cancer, low	0.10350	0.22625
	DDM	Developmental Disability, medium	0.50073	0.27818
	DDL	Developmental Disability, low	0.19696	0.05913
	GENEL	Genital, extra low	0.00790	0.01121
	METH	Metabolic, high	0.47167	0.47226
	METM	Metabolic, medium	0.26297	0.11310
	METVL	Metabolic, very low	0.11546	0.18678
	PRGCMP	Pregnancy, complete	0.00244	0.00000
	PRGINC	Pregnancy, incomplete	0.12631	0.51636
	EYEL	Eye, low	0.09919	0.13271
	EYEVL	Eye, very low	0.02835	0.00000
	CERL	Cerebrovascular, low	0.14294	0.00000
	AIDSH	AIDS, high	0.70597	0.47361
	INFH	Infectious, high	0.70597	0.79689
	HIVM	HIV, medium	0.26129	0.07937
	INFM	Infectious, medium	0.26129	0.79689
	INFL	Infectious, low	0.07784	0.05617
	HEMEH	Hematological, extra high	5.37808	12.71981

Category Type	Category	Description	Weights for Children (age <18)	Weights for Adults (age 18+)
	HEMVH	Hematological, very high	0.72873	3.08836
	HEMM	Hematological, medium	0.37824	0.63211
	HEML	Hematological, low	0.18676	0.25601
MRx	MRx1	Alcoholism	0.05982	0.01924
	MRx2	Alzheimer's	0.00000	0.08112
	MRx3	Anti-coagulants	0.34428	0.13523
	MRx4	Asthma/COPD	0.08758	0.05751
	MRx5	Attention Deficit	0.00000	0.00779
	MRx6	Burns	0.16633	0.00000
	MRx7	Cardiac	0.0906	0.06425
	MRx8	Cystic Fibrosis	0.50399	0.37265
	MRx9	Depression/Anxiety	0.06743	0.09436
	MRx10	Diabetes	0.1519	0.17046
	MRx11	EENT	0.00000	0.00072
	MRx12	ESRD/Renal	1.24598	1.20707
	MRx13	Folate Deficiency	0.17973	0.11899
	MRx14	CMV Retinitis	0.37762	0.00000
	MRx15	Gastric Acid Disorder	0.10082	0.15470
	MRx16	Glaucoma	0.04221	0.12971
	MRx17	Gout	0.00000	0.00000
	MRx18	Growth Hormone	0.9741	1.59521
	MRx19	Hemophilia/von Willebrands	13.56192	89.14461
	MRx20	Hepatitis	0.03018	0.00000
	MRx21	Herpes	0.0348	0.01725
	MRx22	HIV	0.65537	1.01178
	MRx23	Hyperlipidemia	0.00000	0.03791
	MRx24	Infections, high	1.38405	1.51663
	MRx25	Infections, medium	0.07462	0.06192
	MRx26	Infections, low	0.00000	0.00918
	MRx27	Inflammatory/Autoimmune	0.08075	0.20046
	MRx28	Insomnia	0.07093	0.06437
	MRx29	Iron Deficiency	0.13306	0.15054
	MRx30	Irrigating Solution	0.87573	0.16387
	MRx31	Liver Disease	0.45314	0.22681
	MRx32	Malignancies	0.36859	0.44200
	MRx33	Multiple Sclerosis/Paralysis	0.0345	0.04353
	MRx34	Nausea	0.18219	0.17120
	MRx35	Neurogenic Bladder	0.15282	0.07675
	MRx36	Osteoporosis/Pagets	0.00000	0.00000
	MRx37	Pain	0.0295	0.04151
	MRx38	Parkinsons/Tremor	0.17163	0.06257
	MRx39	Prenatal Care	0.00000	0.13192
	MRx40	Psychotic Illness/Bipolar	0.22819	0.20274
	MRx41	Replacement Solution	0.58622	1.49405
	MRx42	Seizure Disorders	0.23997	0.19837
	MRx43	Thyroid Disorder	0.03948	0.06326

Category Type	Category	Description	Weights for Children (age <18)	Weights for Adults (age 18+)
	MRx44	Transplant	0.37388	0.05810
	MRx45	Tuberculosis	0.20006	0.00000

(8) **Step 8. Sum risk weights to obtain the risk score.**

After obtaining the weights that correspond to a client's age/gender category and set of risk categories, the agency takes a sum of the values of all of the weights. This sum is the risk score for a client.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-17-166, § 182-557-0225, filed 8/24/22, effective 9/24/22; WSR 17-24-111, § 182-557-0225, filed 12/6/17, effective 1/6/18; WSR 15-17-065, § 182-557-0225, filed 8/14/15, effective 9/14/15.]

WAC 182-557-0300 Health home services—Confidentiality and data sharing. (1) Qualified health homes must comply with the confidentiality and data sharing requirements that apply to participants eligible under medicare and Title XIX medicaid programs and as specified in the health home contract.

(2) The agency and the department of social and health services (DSHS) share health care data with qualified health homes under the provisions of RCW 70.02.050 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(3) The agency requires qualified health homes to monitor and evaluate participant activities and report to the agency as required by the health home contract.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-065, § 182-557-0300, filed 8/14/15, effective 9/14/15. Statutory Authority: RCW 41.05.021 and 2011 c 316. WSR 13-12-002, § 182-557-0300, filed 5/22/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-557-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. WSR 07-20-048, § 388-557-0300, filed 9/26/07, effective 11/1/07.]

WAC 182-557-0350 Health home—Grievance and appeals. (1) Qualified health homes must have a grievances and appeals process in place that complies with the requirements of this section and must maintain records of all grievances and appeals.

(a) This section contains information about the grievance system for fee-for-service clients, including full dual eligible clients, for health home services. These participants must follow the process in chapter 182-526 WAC for appeals.

(b) Participants who are enrolled in an agency-contracted managed care organization must follow the process in WAC 182-538-110 to file a grievance or an appeal for health home services.

(2) **Grievance process.**

(a) Only a participant or the participant's authorized representative may file a grievance with the qualified health home orally or in writing. A health home care coordinator may not file a grievance for the participant unless the participant gives the health home care coordinator written consent to act on the participant's behalf.

(b) The qualified health home must:

(i) Accept, document, record, and process grievances that it receives from the participant, the participant's representative, or the agency;

(ii) Acknowledge receipt of each grievance, either orally or in writing, within two business days of receiving the grievance;

(iii) Assist the participant with all grievance processes;

(iv) Cooperate with any representative authorized in writing by the participant;

(v) Ensure that decision makers on grievances were not involved in the activity or decision being grieved, or any review of that activity or decision by qualified health home staff;

(vi) Consider all information submitted by the participant or the participant's authorized representative;

(vii) Investigate and resolve all grievances;

(viii) Complete the disposition of a grievance and notice to the affected parties as quickly as the participant's health condition requires, but no later than forty-five calendar days from receipt of the grievance;

(ix) Notify the participant, either orally or in writing, of the disposition of grievances within five business days of determination. Notification must be in writing if the grievance is related to a quality of care issue.

(3) **Appeal process.**

(a) The qualified health home must give the participant written notice of an action.

(b) The written notice must:

(i) State what action the qualified health home intends to take and the effective date of the action;

(ii) Explain the specific facts and reasons for the decision to take the intended action;

(iii) Explain the specific rule or rules that support the decision, or the specific change in federal or state law that requires the action;

(iv) Explain the participant's right to appeal the action according to chapter 182-526 WAC;

(v) State that the participant must request a hearing within ninety calendar days from the date that the notice of action is mailed.

(c) The qualified health home must send the written notice to the participant no later than ten days before the date of action. The written notice may be sent by the qualified health home no later than the date of the action it describes only if:

(i) The qualified health home has factual information confirming the death of a participant; or

(ii) The qualified health home receives a written statement signed by a participant that:

(A) The participant no longer wishes to receive health home services; or

(B) Provides information that requires termination or reduction of health home services and which indicates that the participant understands that supplying the information will result in health home services being ended or reduced.

(d) A health home care coordinator may not file an appeal for the participant.

(e) If the agency receives a request to appeal an action of the qualified health home, the agency will provide the qualified health home notice of the request.

(f) The agency will process the participant's appeal in accordance with chapter 182-526 WAC.

(g) Continued coverage. If a participant appeals an action by a qualified health home, the participant's health home services will continue consistent with WAC 182-504-0130.

(h) Reinstated coverage. If the agency ends or changes the participant's qualified health home coverage without advance notice, the agency will reinstate coverage consistent with WAC 182-504-0135.

(i) If the participant requests a hearing, the qualified health home must provide to the agency and the participant, upon request, and within three working days, all documentation related to the appeal.

(j) The qualified health home is an independent party and is responsible for its own representation in any administrative hearing, subsequent review process, and judicial proceedings.

(k) If a final order, as defined in WAC 182-526-0010, requires a qualified health home to provide the participant health home services that were not provided while the appeal was pending, the qualified health home must authorize or provide the participant those health home services promptly. A qualified health home cannot seek further review of a final order issued in a participant's administrative appeal of an action taken by the qualified health home.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-065, § 182-557-0350, filed 8/14/15, effective 9/14/15.]

WAC 182-557-0400 Health home—Payment. Only an agency-contracted qualified health home may bill and be paid for providing health home services described in this chapter. Billing requirements and payment methodology are described in the contract between the agency and the qualified health home.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-065, § 182-557-0400, filed 8/14/15, effective 9/14/15. Statutory Authority: RCW 41.05.021 and 2011 c 316. WSR 13-12-002, § 182-557-0400, filed 5/22/13, effective 7/1/13. WSR 11-14-075, recodified as § 182-557-0400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. WSR 07-20-048, § 388-557-0400, filed 9/26/07, effective 11/1/07.]

WAC 182-557-0500 Involuntary disenrollment from a health home. (1) **Involuntary disenrollment for health and safety concerns.** If a qualified health home or care coordinator believes there are unresolved health or safety concerns with a health home client, the medicaid agency reviews the health home's written request for involuntary disenrollment of the client from the health home program.

(a) Concerns about health and safety include, but are not limited to:

(i) Inappropriate or threatening behavior, such as inappropriate sexual or physical behavior;

(ii) Illegal or criminal activity;

(iii) Harassment; or

(iv) Environmental hazards, such as methamphetamine laboratories, dangerous animals, poor sanitation, or an unsafe home structure.

(b) The agency does not approve requests to end enrollment that are solely due to uncooperative or disruptive behavior resulting from a client's special needs, disability, or behavioral health condition, except when continued enrollment in the health home seriously impairs the health home's ability to furnish services to the client or other clients.

(c) Health homes requesting disenrollment must provide a client's assessment with any reasonable modifications attempted or made of policies, practices, procedures, or the provision of auxiliary aids or services, based on available evidence, in light of a client's special needs, disability, or behavioral health condition.

(d) A client's involuntary disenrollment is for one year, beginning on the first day of the month following the date on the notice of involuntary disenrollment.

(2) **Disenrollment request.** The agency grants a request from a qualified health home to involuntarily disenroll a client when the request is submitted to the agency in writing and includes documentation for the agency to determine that the criteria under subsection (1) of this section is met.

(3) **Client notification and appeal rights.** The agency notifies the qualified health home of the agency's decision within ten business days. If the request is approved, the agency sends a written notice of involuntary disenrollment to the client. The notice includes:

(a) The client's administrative hearing rights as described in chapter 182-526 WAC;

(b) The specific factual basis for disenrolling the client;

(c) The applicable provision under subsection (1) of this section, and any other applicable rule on which the disenrollment is based; and

(d) Any other information required by WAC 182-518-0005.

(4) **Reenrollment.** The agency may reenroll a client with a qualified health home within one year if:

(a) All of the concerns that led to the involuntary disenrollment are resolved; and

(b) The client continues to meet the health home eligibility criteria in this chapter.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-11-030, § 182-557-0500, filed 5/12/21, effective 6/12/21.]