

State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Washington

Summary: In 2011, Washington was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals*. As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Washington State Department of Social and Health Services and the Washington State Health Care Authority have submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further, discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., May 30, 2012. You may submit comments on this proposal to WA-MedicareMedicaidCoordination@cms.hhs.gov.



A Medicare and Medicaid Integration Project for Washington State

Submitted to the Centers for Medicare & Medicaid

APRIL 26, 2012

DESIGN PROPOSAL

HealthPathWashington (formerly Pathways to Health): A Medicare & Medicaid Integration Project

April 26, 2012

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The analyses upon which this publication is based were performed under Contract Number HHSM-500-2011-00043C, entitled, "State Demonstrations to Fully Integrate Care for Dual Eligible Individuals".

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A. Executive Summary

Washington (WA) is one of 15 states that received an 18-month planning grant from the Centers for Medicare and Medicaid Services (CMS) to develop a multi-phased design and implementation plan for innovative service delivery models that integrate care for individuals receiving services from both Medicare and Medicaid. The grant goals are to improve the care experience and health outcomes of individuals served under these programs, and decrease overall costs. This grant provides an opportunity for the State and CMS to design integrated care and a shared savings plan that would align incentives to ensure the right care, for the right person, at the right time.

Governance of the grant is shared between The Washington Department of Social and Health Services, Aging and Disability Services Administration (DSHS/ADSA) and The Health Care Authority (HCA). Together with stakeholders, the two agencies have collaborated extensively over the grant period to develop new strategies to improve health care, services and supports and their associated costs. The HCA is the Medicaid agency responsible for purchasing Medicaid medical services. ADSA is responsible for purchasing, program and service development for mental health, chemical dependency, long term services and supports and services to individuals with developmental disabilities. The project has been informed by a broad range of stakeholders who have participated in a wide variety of engagement activities throughout the past ten months.

The population of beneficiaries in WA who qualify for full Medicare and Medicaid benefits, often referred to as “dual eligible”, is approximately 115,000 as of June 2011. Approximately 65,000 are persons age 65 or above and 50,000 are persons with disabilities under the age of 65. Due to the eligibility criteria for these programs, these Individuals are by definition low-income with few financial resources. They represent the most expensive and at-risk population served by Medicare and Medicaid. Many, if not most, experience significant challenges caused by disability, mental illness and/or chemical dependence, which complicate delivery and payment of services.

In most cases, services for this population is paid for separately by the Medicare and Medicaid programs through a combination of financial models and delivery systems. Separate funding streams, service delivery systems, and a lack of focus on overall coordination, results in fragmented care that is difficult to navigate and lacks accountability necessary to ensure health outcomes are achieved. In addition, care that is not integrated results in cost shifting, and potentially avoidable high cost care in emergency rooms, hospitals and institutional settings. To address these challenges, interventions must be tailored to the unique needs of individuals and care coordination must be intensified for the segment of the population that would most benefit.

Integrating Medicare and Medicaid services means coordinating the delivery, financing, technology and human touches experienced by these beneficiaries. Confusion and fragmentation will be diminished by aligning payment, outcome expectations and services. This will improve the beneficiaries’ experience with service delivery, improve health outcomes and better control future costs.

This proposal describes the planning, stakeholder input, data analysis and parameters that guided the development of a strategic approach to realigning and integrating care through:

Strategy 1: Health Homes (HH) – managed fee for service financial model

Strategy 2: Full Financial Integration Capitation – three-way capitation financial model

Strategy 3: Modernized and Consolidated Service Delivery with Shared Outcomes and Aligned Financial Incentives – design plan financial model with capitation and fee for service

Table A-1: Features of Demonstration Proposal, Additional information available in appendix A

Target Population	Full benefit Medicare-Medicaid Enrollees (duals), all ages
Total Number of Full Duals	115,000 (June 2011); 65,000 aged 65 or above and 50,000 persons with disabilities under the age of 65 (June 2011).
Total Number of Beneficiaries Eligible for Demonstration	All full benefit Medicaid-Medicare enrollees (115,000 as of June 2011) will be eligible to participate in the demonstration.
Geographic Service Area	<ul style="list-style-type: none"> • Strategy 1: Health homes (HH) will be implemented statewide • Strategy 2: Full integration capitation model delivered through health plans will be available in counties where legislative criteria are met and health plans demonstrate readiness • Modernized and consolidated service delivery with shared outcomes and aligned financial incentives will be implemented in counties where full capitation is not available
Summary of Covered Benefits	<p><u>Strategy 1: managed fee for service—health homes for high cost/high risk duals (beginning January 2013)</u></p> <ul style="list-style-type: none"> • Comprehensive care management, using team-based strategies; • Care coordination and health promotion; • Comprehensive transitional care between care settings; • Individual and family support, which includes authorized representatives; • Referral to community and social support services, such as housing if relevant; • The use of web-based clinical decision support tool (PRISM) and other health information technology to link services, as feasible and appropriate. • All other Medicare and Medicaid services will be delivered consistent with a beneficiary’s choice of service delivery system and state Medicaid policy. <p><u>Strategy 2: Full financial integration capitated financial model purchased through health plan (beginning January 1, 2014):</u></p> <ul style="list-style-type: none"> • Medical Services provided under the Medicaid State Plan • Medicare Parts A, B, D • Mental Health Services • Chemical Dependency Services • Long Term Services and Supports • Beneficiaries with developmental disabilities will be included in this model, but services in their 1915(c) waivers will be carved out of the capitation <p><u>Strategy 3: Modernized and consolidated service delivery with shared outcomes and aligned financial incentives (beginning January 1, 2014):</u></p> <ul style="list-style-type: none"> • Medical services provided under the Medicaid State Plan (capitated) • Medicare Parts A, B, D (capitated) • Medicaid behavioral health (capitated through Prepaid Inpatient Health Plans) • Medicaid long term services and supports (fee for service) • Medicaid developmental disabilities Services (fee for service) • Medicaid chemical dependency (fee for service)
Financing Model	<p>Strategy 1: Health Homes (HH) – Managed fee for service</p> <p>Strategy 2: Full Financial Integration Capitation – Three-way capitation</p>

	Strategy 3: Modernized and consolidated service delivery with shared outcomes and aligned financial incentives – Design Plan Model with capitation and fee for service
Summary of Stakeholder Engagement/Input	<ul style="list-style-type: none"> • 4 Stakeholder Engagement Forums held Lacey, Everett, Yakima and Spokane— Total attendance 112 (Sept 2011) • 13 Beneficiary Focus Groups – total attendance 147 (Oct, Nov 2011, Jan 2012) • Provider Focus Groups (5) – total attendance 48 (Oct, Nov 2011) • Website Informational Page: October 2011 • 7 Key Informant Groups: July-August 2011, January 2012 • Multiple Informational Sessions: September 2011 –January 2012 • Design Plan 30-day public comment period (March 12-April 13, 2012) • 3 Public Webinars providing overview of draft design plan and asking public to comment (March 2012) • 13 in-person meetings with advocacy & provider groups to review proposal and encourage comment on draft design plan (March-April 2012) • First meeting of HealthPathWashington Advisory Team (April 2012) This standing advisory team is scheduled to meet at least 9 times in 2012 and 2013
Proposed Implementation Date(s)	<p>Strategy 1: Health Homes for High Cost/High Risk Duals January 2013</p> <p>Strategy 2: Full Financial integrated capitation model January 2014</p> <p>Strategy 3: Modernized system of care with partial capitation Partial fee for services with shared outcomes and aligned financial incentives January 2014</p>
Projected Enrollees (CY 2015 estimates)	Strategy 1: 21,000 Strategy 2: 27,000 Strategy 3: 58,000

B. Background

Washington State has a long history of innovation in its systems of service delivery. The Healthy Options (HO) program has been in existence since the 1990’s as a managed care approach to covering “moms and kids” under Medicaid. The Basic Health Plan (BHP) was created in 1987 as a vehicle for purchasing managed health care for the state’s uninsured low income residents not eligible for Medicaid. The state began testing financially integrated systems of care in 1995 with the Program for All Inclusive Care for the Elderly (PACE), followed by the Washington Medicaid Integration Partnership (WMIP) and the Medicare/Medicaid Integration Program (MMIP) in 2005. In 2011, HCA began planning for a joint procurement that would combine purchasing of medical coverage for individuals receiving services through HO, BHP and SSI (those who are blind or disabled). In addition to purchasing strategies, WA has adopted important quality and management strategies based upon evidence based practices that have improved care and created clinical controls to reduce unnecessary emergency room, pharmaceutical, hospitalization and institutional use. Examples include implementation of chronic care management interventions that are described in more detail within this document, narcotic reviews and multi-payer pilots.

WA was recently ranked as second in the nation in overall state level performance of its long term services and supports system based on a 2011 AARP national scorecard report. This has been achieved through a long established partnership between the state, Area Agencies on Aging (AAAs) and service providers that are committed to serving a population whose acuity has increased in every setting as the system was rebalanced from reliance primarily on nursing home care in the 1990’s to one where over 80% of the care is provided in home and community based service settings. One of the hallmarks of

WA's long term care system is beneficiary choice in both settings and providers. The majority of care is provided in-home and beneficiaries are able to employ qualified family and friends as paid personal care workers.

Since the 1990s, WA has delivered mental health services through a 1915(b) specialty managed care plan administered through the Regional Support Networks (RSNs). The plan began in 1993 as a Pre-paid Health Plan and then expanded to include in-patient psychiatric services in 1997, as a Pre-paid Inpatient Health Plan. The regional aspect of the delivery system allows for services to be tailored to local needs. Across the state, the RSNs direct their contracted mental health providers to actively engage mental health consumers with strengths-based assessments and recognize consumer voice and choice in the development of treatment plans. As part of WA's commitment to the recovery model of mental health treatment, the state and RSNs have expanded the use of peer support services from outpatient mental health services to hospital emergency departments, mental health crisis services, supported housing programs and other settings.

The chemical dependency system in WA delivers services primarily through fee for service contracts with residential treatment programs and county contracted outpatient assessment and treatment services. The state has a long tradition of innovation and, in partnership with local governments and others, is currently receiving federal grant funding for projects including; primary care - behavioral health integration, expanding systems of care, and demonstrations showing the efficacy of recovery support services such as housing and supportive employment in supporting long term recovery. The state has used linked data sources to show the importance of chemical dependency treatment in bending the health care cost curve.

Services to individuals with developmental and intellectual disabilities are primarily delivered in home and community based service settings. The most recent example of a strong state/community partnership resulted in 52 people transitioning from Francis Hadden Morgan Center, a residential habilitation institution, to a variety of community placements. Each individual received person-centered transition planning based upon their unique needs, including the need for active treatment. The comprehensive planning for medical, financial, environmental, physical transition and family support represented a valued collaboration between the State hospitals, community providers, counties, advocates and the Division of Developmental Disabilities and resulted in the closure of the institution. WA's individual supported employment program ranks first in the nation and is an example of the high priority the state places on community integration. The legislature recently passed a law that all individuals, for whom there is funding, must be offered at least a nine month opportunity to be supported in finding work in the community.

The current system of purchasing and service provision is sophisticated and reaches many but has been built in response to changing federal rules and payment criteria. Like many states, WA provides primary and acute care; mental health; chemical dependency; long-term services and supports; and a diverse range of supports for people with developmental disabilities through separate delivery and payment systems. As a result, there is a variety of fee for service and managed care programs. Although progress has been made, systems are fragmented, only loosely coordinated, and generally offer limited service, payment and administrative systems integration.

Integrating Medicare and Medicaid services means coordinating the delivery, financing, technology and human touches experienced by dual beneficiaries. Confusion and fragmentation will be diminished by aligning payment, outcome expectations and services. This will improve the beneficiaries' experience

with service delivery, improve health outcomes, decrease complexity and better control costs. Based upon the state's history of successful innovation and strong network of community based providers with experience serving complex populations, WA is well poised to take advantage of this unprecedented opportunity to integrate service delivery and create the ability for Medicare savings.

i. Overall Integrated Care Vision, Barriers to Address and Demonstration Rationale

Integrated Care Vision

Opportunities for better outcomes, system efficiencies, and cost containment lie in the purchase of increasingly coordinated and managed medical, mental health, chemical dependency and long-term services and supports. The models in this report present a path toward an overarching vision, shared by DSHS, HCA and stakeholders that an integrated system of effective services and supports must:

- Be based in organizations that are accountable for costs and outcomes
- Be delivered by teams that coordinate across professional disciplines including medical, mental health, chemical dependency, and long-term supports and services
- Provide person centered assessment, care planning and interventions
- Deliver services in a culturally competent manner and ensure access to translated materials and interpreter services
- Be provided by networks capable of meeting the full range of needs and that remain flexible to meet changing individual needs and populations over time
- Emphasize prevention, primary care and home and community based service approaches
- Provide strong consumer protections that ensure access to qualified providers
- Demonstrate principles of self-directed care, support of consumer choice and recovery
- Unite consumers and providers in eliminating use of unnecessary care
- Align financial incentives to impel integration of care

WA is committed to integrating the delivery and financing of medical, mental health, chemical dependency and long term services and supports for the Medicare/Medicaid dual eligible population. Broad stakeholder input has been sought during planning to ensure a process that is inclusive, transparent and responsive to the direct experience of beneficiaries, providers, health plans and advocates. More detail on stakeholder engagement can be found in section D of this proposal. WA proposes the following three strategies for integrating care:

1. **Implement health home (HH) services for all high cost/high risk dual beneficiaries beginning January 1, 2013.** Health home services provide the high touch care coordination necessary to bridge across the domains of service and specialization required by these beneficiaries. Health home functions will be supported by a nationally-recognized HIT application (PRISM) to support care coordination across Medicare, Medicaid and other sources;
2. **Implement a fully integrated financial model purchased through health plans beginning in January 1, 2014.** The model will be fully capitated with three-way contracting between the Centers for Medicare and Medicaid Services, Washington State and health plans. This strategy will be implemented where county agreement and health plan readiness exist;
3. **Modernize current service delivery system by implementing three-way contracting and capitation of Medicare payments and Medicaid medical payments coupled with the use of performance measures and incentive pools to align financial incentives** across medical, mental

health, chemical dependency, long term services and supports and developmental disability systems beginning in January 2014.

Barriers to Integration and How They Relate to the Current Financial and Delivery System
New Models are Slow to Ramp-up Impacting Evaluation and Sustainability

Beneficiary choice is a hallmark of the Medicare system and is also a fundamental principle of Medicaid services in WA. The models described in this proposal all rely upon beneficiaries making intentional decisions to try integrated approaches to service delivery. Past experience shows that enrollment in voluntary models are slow to ramp-up. Evaluation and sustainability rely on carefully designed enrollment and retention strategies. This poses significant challenges to this project and creates complexity in planning, outreach and communications.

Accountability for Cost, Service Delivery, and Outcomes is Fragmented:

The current system of purchasing and service provision has been built in response to distinct population needs and opportunities to expand reimbursement under Medicaid and Medicare using discrete federal and state authorities that have changed over time. The result is a complex set of specialized staff and providers and distinct roles for local government entities, labor and other interests that impact both the approach and speed of system reform needed to shift focus to integrated care.

Like many states, Washington provides services through separate delivery and payment systems. Each system has unique performance outcomes and goals that make sense within each sphere, but typically do not hold providers accountable for influencing overall public expenditures or overall health outcomes. That creates significant barriers in the face of mounting evidence that the greatest public expenditures and most preventable health outcomes are associated with individuals who have complex needs that cut across the disciplines represented by each of the current delivery silos.

Currently, payment is tied to the provision of distinct services, treatments or interventions and therefore is not oriented to prevention or performance based outcomes. Money saved in one silo or funding stream, due to the intervention by another, cannot easily be moved to incentivize the outcomes desired. As such, there are few incentives for the system to work together to comprehensively meet complex needs. The result is often uncoordinated service delivery, where beneficiaries express frustration in accessing necessary services and navigating across systems of care.

Without a comprehensive, beneficiary-centered orientation to care, it is difficult to identify whether beneficiaries are: 1) getting the care they need; 2) experiencing avoidable emergency room visits, hospitalizations and institutional stays; 3) knowledgeable about opportunities to improve health outcomes; 4) accessing preventative care and routine labs; or 5) experiencing gaps in care or service transitions. Getting this full view is complicated by separate Medicare and Medicaid funding streams where data systems are not aligned and cost shifting between fund sources is common.

Service Needs and Risk Factors Overlap:

The lack of coordination and overall accountability would not be a problem if individuals had singular needs that did not overlap and impact one another. Policy discussions frequently refer to individuals with particular service needs as if they are part of distinct groups—the “long-term care population,” the “mental health population,” etc. In reality, medical conditions and support needs for physical, cognitive, developmental disabilities, mental illness and chemical dependence frequently co-occur. In focus groups, beneficiaries stress that these needs are inter-related. For individuals who are high risk and dually eligible for Medicare and Medicaid, 91% have at least one additional risk factor and 31% have

more than one additional risk. Additional information on the overlapping needs can be found in Appendix F Targeting of Health Home Services.

The current medical system and the systems of support for people with needs related to physical, cognitive or developmental disabilities, mental health or chemical dependency challenges are not designed to address the complexity of individuals with multiple needs. Service planning does not create coordinated responses to address co-occurring needs, financing is not aligned to support comprehensive responses, and the current administrative structures have not been charged with the responsibility or given the authority to be held accountable for addressing such complexity. More than any other factor, correction of those shortfalls is the driving force behind the need to integrate service delivery.

Past Efforts to Integrate Services Provide Valuable Lessons that Informed the Design Proposal.

WA has operated health plan administered financially integrated programs of care for over 15 years. These projects include: 1) PACE (est. 1995) provides fully integrated Medicare and Medicaid services to frail elders in King County; 2) WMIP (est. 2005) provides fully integrated services to both Medicaid only and duals in Snohomish County; 3) MMIP (2005 – 2008) provided fully integrated services to dually eligible individuals in King and Pierce Counties; 4) Medical Services Program (est. 2007, formerly referred to as Disability Lifeline) integrates mental health and medical services statewide for individuals with disabilities eligible for General Assistance Unemployable services.

The WA experience with fully capitated integrated managed care service delivery models has shown promising results in key areas. Beneficiaries participating in integrated managed care tend to report that their care was better coordinated. Relative reductions in inpatient hospital admissions among participants in integrated managed care are consistently found. Experience has shown the need to focus on strengthening retention of high-risk individuals (including those with LTSS needs), screening and referral to substance abuse treatment, and provider network adequacy. Through these projects, much has been learned about integrated service delivery including: necessary contract requirements; accountability measures and monitoring requirements; and the capacity and expertise needed by accountable entities delivering these services. The state will take what has been learned through its direct experience, as well as the experience of other states, in integrating care through a single capitation and apply it in contracting with managed care organizations (MCO) to provide fully integrated care. See Appendix C: “Lessons Learned.”

In addition to experience integrating services through financial capitation, WA has also developed, implemented and evaluated services designed to improve the health of individuals with chronic conditions while working with those individuals to utilize health care resources more effectively. These models provide integration across silos of services through intensive care coordination and evidence based intent to treat protocols to support self management and behavior changes that result in improved health outcomes. Although these models do not utilize financially integrated systems of care, they have been successful at: 1) bridging systems of care; 2) increasing access to physicians and specialists; and 3) improving health outcomes.

These clinical efforts began with disease management activities, which focused on targeted disease states, rather than the overall health of the individual. Disease management programs were based largely on telephonic communication with only limited in-person visits. These programs did not demonstrate the desired results of improving health outcomes and reducing costs. Chronic Care Management (CCM) evolved from these programs to focus on the mental, physical and functional health of the individual as a whole. CCM programs are targeted to high-risk individuals with chronic conditions

(including mental health and chemical dependency treatment) to develop and improve self-management skills. These programs have demonstrated clients' improved ability to self-manage their health and have resulted in improved health care utilization. Entities that have piloted these CCM models include AAAs, FQHCs and CMHCs. HHs are the natural next evolution of WA's efforts to improve the management of chronic conditions.

ii. Description of the Medicare-Medicaid enrollee population (included and excluded).

The dual eligible population is primarily comprised of persons under the age of 65 who meet federal disability program criteria (46%), and persons above the age of 65 (53%). Although these two populations are both high cost, they have distinct service utilization patterns as shown in the State Fiscal Year (SFY) data presented in table 1 below. Relative to duals age 65 and over, individuals under age 65 are much more likely to use Medicaid-paid mental health services, services for individuals with developmental disabilities, or substance abuse treatment services. Although duals under age 65 use long-term services and supports (LTSS) at a relatively high rate (per member per month (PMPM) expenditures of \$400); duals ages 65 and older used LTSS much more intensively (PMPM expenditures of \$1,171). Selected Medicare-paid cost and utilization data for this population are reported in Appendix Q.

TABLE 1. Medicaid Health-Related Expenditures for Dual Eligible Beneficiaries, SFY2010

Beneficiaries –Under age 65	Clients Served		Dollars	
	TOTAL	% OF POP	TOTAL	PMPM
Long Term Services and Supports	12,748	21.4%	\$229,257,772	\$400.35
Alcohol and Substance Abuse	2,966	5.0%	\$6,387,926	\$11.16
Developmental Disabilities	9,925	16.6%	\$448,864,612	\$783.84
Mental Health (Excludes State Hospital)	18,530	31.1%	\$74027970	\$129.27
Unduplicated Annual Population	59,677			

Beneficiaries – Age 65 and Older	Clients Served		Dollars	
	TOTAL	% OF POP	TOTAL	PMPM
Long Term Services and Supports	43,586	58.3%	\$855,618,522	\$1,171.58
Alcohol and Substance Abuse	201	0.3%	\$513,554	\$0.70
Developmental Disabilities	978	1.3%	\$51,310,421	\$70.26
Mental Health (Excludes State Hospital)	8,005	10.7%	\$13,491,918	\$18.47
Unduplicated Annual Population	74,744			

Table 2 in Appendix D uses integrated Medicare and Medicaid pharmacy data to characterize the prevalence of major chronic disease conditions in the dual eligible population. Among duals ages 65 and older 74% receive cardiac medications; 45% for hyperlipidemia, 43% for gastric acid disorder; 27% for diabetes; and 23% for asthma/COPD. Use of medications to treat infections and pain are also common. Duals under age 65 show lower rates of heart disease, hyperlipidemia, gastric acid disorder, and diabetes, but show higher rates of asthma/COPD, infections and use of narcotics.

Mental health medications are among the most common drugs used by both dual populations. Among duals under age 65, antidepressants, anxiolytics, anticonvulsants and antipsychotics are all used with

relative high prevalence rates. Duals ages 65 and older use antidepressant and anti-anxiety medications at relatively high rates, and 13 percent were prescribed antipsychotic medications in SFY 2010. Use of antipsychotics in duals ages 65 and older is more likely to be related to the presence of dementia, rather than schizophrenia or mania/bipolar conditions that are far more prevalent among younger age duals. More than one in five duals ages 65 and older was diagnosed with dementia or a related condition.

The term “5/50” is often used to refer to the concentration of health care costs among a relatively small number of high-risk individuals – the 5 percent of the population who account for approximately 50 percent of expenditures. That duals represent a high-opportunity, high-cost population is indicated by the fact that approximately 40 percent of the dual eligible population in

WA State are at or above the level of risk that defines the “top 5 percent” of medical costs in the broader Medicaid population. If this view of risk were broadened to include LTSS, behavioral health and DD services, this comparison would be even starker.

WA has focused initial profiling efforts on those who appear at high risk of future medical expenditures because this population presents the greatest opportunity for health interventions to increase health outcomes and show a positive return on investment. This population is identified by risk algorithms based on disease conditions identified by diagnoses and medication use. The medical risk score is calibrated to WA State Medicaid Aged/Blind/Disabled costs patterns rather than using commercial population weights. The risk score is expressed as a ratio, with 1.0 equaling the average future expected healthcare costs for the reference (Supplemental Security Income) SSI-related population. A risk score of 1.5 means the individual is expected to incur 50 percent higher medical costs than the average WA SSI client. This is the risk threshold that has been used to define eligibility for the state’s promising high-touch CCM initiatives and will be used for as a basis for health home eligibility for duals and Medicaid only enrollees. More information can be found in Appendix D.

The table below provides projected January 2013 caseload levels in the dual eligible population, with information on projected utilization of LTSS and the prevalence of serious mental illness.

Forecasted January 2013 Caseload Composition	Overall Total Dual	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in community settings (in-home or residential)
Overall total	122,836	14,420	41,631
Individuals age 65+	69,629	12,507	31,358
Individuals under age 65	53,207	1,913	10,273
Individuals with serious mental illness	47,295	5,425	22,582

With regard to persons with developmental disabilities, the current system of supports reaches 63% of the 38,000 WA residents with a qualifying developmental disability. About 18,000 are under age eighteen and 20,000 are eighteen or older. About 14,000 people or 37% wait for services to be available. Of the people served approximately 24,000 live in the community, most with their families. Fewer than 900 people live in one of the five Residential Habilitation Centers (RHCs). In the next decade the number of WA residents with a developmental disability will increase to 51,000. The future system of supports for people with developmental disabilities must meet more of this significant and growing unmet need.

C. Care Model Overview

i. Proposed delivery system/programmatic elements including geographic service areas, enrollment methods and provider networks

Substantive and timely progress in developing innovative integrated care models that improve care for all individuals who rely on Medicare and Medicaid for critical health and social services requires a balance of strategies. There is broad stakeholder support for integrating care and using more than one strategy to do so. Stakeholders and state policy makers believe this multi-strategy approach will integrate care for the largest population possible including those who are in fee for service, those who choose to participate in managed care, those living in high density geographic population centers and those living in low-density counties.

Three strategies allow the state to test different models of integration which is necessary due to: 1) current statutory authorities that limit full financial integration; 2) the CMS requirement that managed care approaches be voluntary; 3) the geographic diversity and population distribution of duals; and 4) the need to respond to extensive stakeholder input. As detailed in section D, the state reached out to a wide array of beneficiaries, providers, health plans and advocates who provided valuable insight that helped to inform the strategies outlined in this proposal.

There were a number of themes in stakeholder feedback that provide context for the proposed integration strategies. These themes include: 1) medical and social services needs are inter-related and coordination and incentives need to be aligned across these domains; 2) care coordination is a key ingredient to effective care integration; 3) flexibility is necessary to allow for local variances based upon population need and provider network; and 4) change is both needed and feared. Additional feedback received during the draft design plan public comment period resulted in adjustments to the implementation timeline and revisions/additional clarification within each proposed strategy.

As indicated earlier, the current system as a whole has flaws. However, there are elements of service delivery that are high quality and are working well for beneficiaries. Stakeholders express fear that what is working will be broken, or the state's performance on key indicators such as employment and community based long term care will be eroded while the state is trying to improve the overall service delivery system. Stakeholders expressed considerable concern about the readiness of health plans operating in WA to provide the full array of mental health, chemical dependency, long term services and supports, and services to individuals with developmental disabilities. Stakeholders want to continue to test models of full financial integration applying lessons learned to date, but feel strongly that the state is not ready to "flip the switch" on managed care statewide.

Each of the proposed strategies will improve the care experience for eligible beneficiaries. The models place a priority on coordination of care and its impact on beneficiary outcomes by embedding health home services and care coordination in both fee for service and managed care arenas. In response to the need to better coordinate care across service domains, the state has developed the Predictive Risk Intelligence System (PRISM). It is actively in use to support care management interventions for high-risk Medicaid beneficiaries with chronic conditions. The tool combines three key innovations: 1) identification of clients most in need of comprehensive care coordination based on risk scores developed through predictive modeling; 2) integration of information from medical, social service, behavioral health and long term care payment and assessment data systems; and 3) an intuitive and accessible display of beneficiary health and demographic data from administrative data sources. It has proven to be an invaluable tool providing timely, actionable information to improve care and reduce costs. A data use agreement with CMS has allowed testing of the integration of Medicare and Medicaid

data. A PRISM prototype has been developed to provide the full view of Medicare and Medicaid services that will be used by care managers and health home providers under this demonstration in all three integration strategies to coordinate care across service domains, and where applicable, funding sources.

In each of the proposed integration strategies beneficiaries will have a care manager who is charged with overall care coordination and ensuring a person-centered and culturally competent approach to service provision. For high-cost high risk beneficiaries care coordination across service domains will be performed by qualified health home providers.

In focus groups, beneficiaries expressed frustration and difficulties in navigating care, duplicative time-consuming approaches to information sharing, and lack of coordination as a result of the fragmentation of care. The use of these integration strategies are expected to result in significant decreases in the issues beneficiaries identify as not working well under the current system.

The focus of each integration strategy will be to ensure CMS goals of service integration, including improving care from the beneficiary's perspective; alignment of financial incentives; strong performance expectations; and increased accountability for achievement of system-wide quality and cost-containment objectives.

Strategy 1: Implement health home services for high cost/high risk dual beneficiaries under Managed Fee for Service where beneficiaries do not have access to or opt-out of financially integrated capitation models (beginning January 1, 2013)

Intentional and intensive care coordination that crosses over service domains and risk factors is essential to improve the integration experience. It also provides the greatest opportunity for improving care and realizing cost savings. The need for effective care coordination was raised at every stakeholder engagement activity, including beneficiary, provider and advocacy groups. To adequately respond to the diversity of the population's needs, an array of options for the beneficiary's care coordination is needed. Care coordination will be most successful in engaging a beneficiary when it is provided locally by an entity that already has established care relationships.

Early evaluations of intensive care coordination models piloted by WA have shown that when comparing results for individuals in a treatment group to those in an abeyance group, Enrollees experience:

- Positive outcomes, even for the highest cost/highest risk individuals
- Lower mortality rates
- Better self-reported health outcomes as measured through participant surveys, including: overall health rating; improved patient activation measures; overall self-sufficiency; impact of pain and quality of life
- Nearly half of the enrollees achieved improvements in health condition, living environment or access to treatment as evidenced through record reviews
- Less emergency room visits, in-patient hospital stays necessitated through an emergency room visit, and decreased use of nursing homes

WA will implement HH services as a way of ensuring intensive person-centered care coordination to beneficiaries. A HH is not a place, but a set of services and functions provided by an entity that will be qualified by the state. A HH is responsible for the integration and coordination of primary, acute, mental health, chemical dependency and long-term care services and supports for *high cost/risk** persons with chronic illness across the lifespan. (See Appendix D for PRISM risk score and F for rationale for targeting of HH services.) A qualified HH is a network of community based providers that can include entities such

as primary care clinics, hospitals, health plans, community mental health centers, local government safety net providers, entities with long term care and independent living expertise or other providers with expertise in serving high cost/high risk beneficiaries. WA has revised its draft health home qualification process in response to stakeholder feedback and a second revised version is included as Appendix U. The state will propose a State Plan Amendment (SPA) under section 2703 of the Affordable Care Act to implement intensive care management through health homes beginning in January 2013.

Health home providers must demonstrate their ability to perform all requirements listed in the health home qualifications, Appendix U. A HH is the central point of contact working with the managed care or fee-for-service beneficiary to:

- Establish person-centered health action plan goals designed to improve health and health-related outcomes;
- Coordinate across the full continuum of health services (medical, mental health, substance use treatment , long-term services and supports and other social supports such as housing, and food assistance);
- Reduce avoidable health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and reduced use of institutional care, such as nursing homes, psychiatric hospitals and residential habilitation centers;
- Organize and facilitate the delivery of evidence-based/evidence informed health care services targeted to the individual;
- Interventions may change based upon the beneficiary age, cognitive limitations and required assistance;
- Arrange for timely post-institutional or facility discharge follow-up, including medication reconciliation and substance use treatment after-care program;
- Increase the beneficiary's confidence and skills to self-manage their health goals; and
- Work directly with entities or persons authorizing services to communicate the health action goals identified by the beneficiary. Authorizing and/or treating entities will assist by adjusting applicable service plans/treatment orders to include actions that would support achievement of health outcome goals.

Service delivery integration and effective HH coordination will be facilitated by a secure, web-based clinical decision support tool referred to as PRISM which combines claims, eligibility, assessment, risk identification and other Medicaid and Medicare sources organized by individual beneficiary. This technology, coupled with identification of risk factors, is not available through managed care plans, even the most technically proficient ones with Electronic Health Records (EHRs) In addition to being critical for coordinating care, it is important as a contract monitoring tool for quality and performance outcomes.

To accommodate the unique needs of the American Indian/Native population, the State will work with Tribal Governments to design a tribal centric health home

Individuals enrolled in the state's PACE program receive intensive care coordination through a multi-disciplinary team and will continue to receive their care coordination through the PACE provider. Enrollment to HH services will be made available to any eligible individual in the state whether served through a managed care organization or in fee-for-service. Eligibility is based upon presence of identified chronic condition(s), risk of a second chronic condition and either a predictive PRISM risk score of 1.5 or greater or additional criteria that will be developed in response to stakeholder feedback to identify high-opportunity populations for care management. These additional criteria are

model.

likely to include indicators related to medical and psychiatric re-hospitalization risk and care transitions from institutional settings (e.g., transitions from a nursing facility to a home or community setting).

Individuals receiving Medicaid medical services through managed care or Medicaid/Medicare services through a fully integrated capitated model will be assigned a qualified HH provider by the health plan. Outreach and enrollment for beneficiaries outside of managed care will be performed by qualified HH providers. The state will send lists of eligible beneficiaries to the health plan, or in the case of fee for service, to the lead entity of the qualified HH provider who will perform outreach and engagement activities. A beneficiary will elect whether or not to enroll in a HH and may change or discontinue HH services at any time.

HH services will be funded under the Managed Fee for Service financial alignment model described in the July 8, 2011 CMS State Medicaid Director letter. Sustaining this model for duals past the first eight quarters of enhanced federal match will require negotiation with CMS around options for Medicare funding either through mechanisms described in strategy 3, shared savings, a service fee or another approach that may be identified through federal/state negotiations.

Strategy 2: Implement full financially integrated model purchased through health plans (beginning January 1, 2014)

Full financially integrated service delivery through health plans has the potential to yield long-term benefits through improved financial flexibility, a single point of accountability over all services and financially aligned incentives. Public comments received on the draft design plan were supportive of the state's efforts to continue testing this integration strategy. Delaying implementation to 2014 will maximize the opportunity to have this strategy available in a greater geographic foot print than 2013 implementation would have achieved; and allow additional time for detailed implementation planning.

High touch HH services (consistent with the state's qualification process) will be embedded in health plan contract expectations. Strategy 2 will be implemented using a three-way contract between the State, CMS, and health plans in geographic areas meeting the legislative proviso requirements (see Appendix G). Services to be provided within the capitation include medical, mental health, chemical dependency and long term services and supports. Health plans will be required to allow beneficiary self-direction to select, hire, fire and supervise personal care workers, called Individual Providers (IPs). Health plans will also be required to provide the supports necessary for a beneficiary to self-direct their services including providing budget based authority for beneficiaries when possible.

With the exception of individuals residing in the state's Residential Habilitation Centers (RHC), individuals with developmental disabilities will be included in this model but services provided through the state's 1915(c) waivers for individuals with developmental disabilities will be carved out and provided by DSHS. These services will be coordinated between the health plan and the DSHS. The health plan contracts and the state's procedures will require coordination agreements and clearly articulate the expectation that services for this population will be shared between these entities with protocols and measurements to gauge whether or not this is happening effectively. The state is testing these types of coordination agreements with its roll-out of medical managed care in July 2012. The state has taken the approach of not including developmental disability 1915(c) services due to strong stakeholder sentiment. Stakeholders want individuals with developmental disabilities included in the state's medical

managed care strategies. However, stakeholders have expressed significant concern about health plan readiness to provide the rehabilitative and employment services provided under state and federal 1915(c) authorities. Stakeholders for individuals with developmental disabilities, including self-advocates and parents, are committed to working with the state to continue discussions about what competencies, outcomes and other factors would need to be present prior to determining whether a health plan could demonstrate readiness and expertise to deliver these services. The state is currently not able to serve all individuals with developmental disabilities who are eligible to receive 1915(c) services. Stakeholders would like to continue to explore whether managed care implementation would help the state deliver services to more individuals.

Consistent with existing state Medicaid policy, tribal members will not be passively enrolled in strategies 2 or 3. Tribal members will have option of voluntary enrollment.

Beneficiaries living in the counties where strategy 2 is offered will be given the opportunity to choose integrated service delivery. Individuals will receive information in October 2013 about available integrated options. Additional notice will be sent prior to enrollment to inform again of available options and the plan they will be enrolled in if no other action is taken. Information will be available in alternative formats and languages. The state is asking CMS to provide funding for an independent enrollment/options counseling function. This function would serve as an unbiased source of information to beneficiaries by providing outreach, enrollment and education services. If funded, the individual will be available to provide one-on-one assistance to beneficiaries who need additional help to make an informed decision. Beneficiaries who do not make a choice, will be passively enrolled to an identified health plan and be given the opportunity to opt-out after a 90-day retention period. During the 90-day retention period, the plans must ensure continuity of care. Health plans will be required to make no changes in providers, treatments, medications and no terminations or reductions in service delivery unless requested by the beneficiary. This period is needed to ensure care is not interrupted while the beneficiary and health plan establish a relationship and the beneficiary is provided with information about changes that would take place after the 90 day retention period. After the retention period, the beneficiary may disenroll at any time and will have all original choice options from which to choose. Individuals served in the state's PACE program, will be excluded from passive enrollment. PACE will be one of the integrated programs beneficiaries are informed of when the program is available in their service area. More information about consumer protections is available in section Dii of the design plan.

In beneficiary focus groups, the need for clear, transparent and unbiased information to inform decision making about integrated care options was identified. This was echoed during stakeholder engagement forums conducted in September, 2011 and in public comment on the draft plan. The state has contracted with a communications firm to assist in developing information and outreach strategies that can be used by the state and independent enrollment brokers (if funded by CMS) to inform beneficiaries about integrated care options. The state will also work with community organizations and Senior Health Information Benefits Advisors (SHIBA) to provide education, advice and information to beneficiaries with whom they work. During stakeholder engagement meetings the push and pull between beneficiary choice in voluntary models and the need to have sufficient enrollment in integrated models to test their effectiveness was discussed. The ability to choose whether or not to enroll in integrated care, a passive enrollment for those who do not make a choice and the ability to have a 90-day retention period for

those who are enrolled with a continuity of care guarantee provides a balanced approach to these issues.

The state will continue to determine financial eligibility for all Medicaid populations including duals. The state will continue to determine functional eligibility for Medicaid long term services and supports. To ensure standardized collection of clinical characteristics and the ability to monitor quality and effectiveness of health plan service delivery, the state will continue to use a standardized assessment for individuals receiving long term care and developmental disability services.

Core elements of the full financially integrated capitated health plan model:

- Three way contract for all services (CMS, State, health plan)
- Choice with passive enrollment and a 90-day retention period
- Tiered HH benefit with qualified community based providers for the high cost/high risk population
- Single point of contact and a coordinated plan of care
- Outcome measures and quality incentive pool
- Contract execution will be dependent upon demonstrated readiness and provider network that meets defined adequacy and quality standards (to be defined in state selection criteria and CMS criteria for Medicare standards)
- Secure web-based clinical decision support tool (PRISM)
- Risk adjusted rates

Implementation will be based upon agreement between the state and affected local governments and successful completion of a procurement process and a readiness review to ensure key integration elements (i.e. provider network adequacy, necessary consumer protections, care coordination and health home functions, ease of access, cultural competence, etc.) are in place for a January 1, 2014 start-up. The state will work with county governments, the advisory team and other stakeholders to develop state specific selection criteria and readiness review criteria for the new services that would be provided by health plans under this full financially capitated model. The selection and readiness review of plans will be jointly conducted by the CMS and the State of WA to ensure both Medicare and Medicaid requirements are met. For additional selection criteria refer to Appendix H.

Strategy 3: Modernize current service delivery system, implement three-way contracting and capitation of Medicare payments and Medicaid medical payments coupled with the use of performance measures and incentive pools to improve integration and financial alignment across medical, behavioral health, and long term services and supports systems (beginning January 1, 2014):

In geographic areas where full capitation integration health plans are not in place, we recommend steps to modernize and simplify the current systems of support. As noted in the barriers section, change is necessary to improve care coordination, better align financial incentives, and increase accountability for overall costs and health outcomes. This change will be accomplished through the integration of all Medicare-paid health services and Medicaid medical services under three-way contracting between the state, CMS and the health plans in 2014. This will effectively combine all medical care, along with Medicare-paid SNF services and Medicare-paid outpatient mental health services under a single contract for each beneficiary participating in this option. DSHS will work with stakeholders, contractors and interested parties in 2012 to: 1) determine statutory and system changes necessary to integrate care, simplify existing service delivery systems and reduce administrative structures; 2) identify shared outcomes; and 3) develop performance measures to align incentives toward achieving integration. The health plan integrating Medicare services with Medicaid medical services will be subject to quality

withholds tied to performance targets described elsewhere in this document. Financial incentives will also be built into existing contracts that will promote coordination and achievement of identified beneficiary outcomes that is lacking in the current delivery system.

The state uses a standardized assessment for beneficiaries receiving long term services and supports and services for individuals with developmental disabilities that embeds evidence-based screening and risk based protocols to support care coordination across service domains. These include: PHQ-9 depression screen, CAGE alcohol and drug screen, diagnosis, medications and medical treatments, and use of the minimum data set to determine need for activity of daily living assistance or changes in health status. In addition, nursing protocols are triggered to ensure in person or telephone consultation with an RN. Nursing protocols in the assessment are triggered based upon: complicated medication regimens; unstable or changing diagnosis; untreated pain management issues; nutritional status or weight issues; and risk of skin breakdown.

Strategy 3 improves integration and alignment of incentives through the following features:

- Provides medical care through a health plan with strong financial incentives to reduce inpatient medical admissions and avoidable ER/ED utilization;
- Integrates Medicare SNF services under the health plan creating strong financial incentive to reduce SNF entries and to reduce hospital readmissions from nursing facilities that restart Medicare-paid SNF payments at higher-than-Medicaid reimbursement rates;
- Builds health plan experience with SNF and community mental health providers directly through integration of these services in the health plan benefit;
- Builds health plan experience with the DD and home and community based long term service and supports system by requiring the health plan to contract with qualified providers in these systems for health home services when appropriate based on beneficiary choice;
- Creates incentives for the health plan to achieve quality metrics – including metrics tied to retention and engagement of high-risk clients with serious mental illness, substance use disorders, and/or significant functional impairments;
- Provides the health plans, mental health plans and long-term services and supports staff with access to the integrated patient health record through the PRISM application;
- Aligns contractual performance requirements and accountability between capitated medical, capitated Medicare mental health and nursing home, and fee-for-service Medicaid substance abuse treatment, long term care services and supports and services for individuals with developmental disabilities;
- Creates financial incentives to support the aligned contractual performance requirements and accountability.

Beneficiaries living in the counties where strategy 3 is in place, will be given the opportunity to choose integrated service delivery and if no choice is made will be passively enrolled to selected health plans and be given the opportunity to opt-out after a 90-day retention period in which the plan must ensure continuity of care. The beneficiary notification process in strategy 3 will mirror that in strategy 2 and will ensure the beneficiary protections outlined there and in section Dii.

This approach will demonstrate the extent to which CMS goals for duals could be achieved in a mixed managed-care and fee-for-service environment through promising health home service delivery models supported by innovative Health Information Technology (HIT) capability and the thoughtful design of financial structures to align incentives across medical, behavioral health, and long term services and

support systems. This strategy is different from the two financial models outlined by CMS in their July 8th State Medicaid Directors letter and implementation would begin in January 2014. This strategy provides a mechanism to continue health home services for duals when the enhanced federal match of 90% drops to regular match of 50% after the first eight quarters. CMS and the State would work jointly together to select health plans in 2013 and conduct detailed readiness review to ensure adequate provider networks, consumer protections and policies and procedures are in place prior to the enrollment of beneficiaries in January 2014.

ii. Benefits to be incorporated in all models include:

All services paid for by Medicare and Medicaid under fee for service or existing managed care plans are included in all three strategies. Medicare services include Parts A, B and D (primary and specialty medical care, rehabilitation, hospitals, hospice, home health and pharmaceuticals). CMS will issue guidance for three-way contracting that includes requirements under Medicare parts A, B and D. Medicaid services are listed below and additional information for three-way contracting will be detailed in state specific selection criteria that stakeholders will be given an opportunity to comment on. The RFP is tentatively scheduled for release in early November 2012:

For beneficiaries enrolled in strategies 2 or 3, the Medicaid medical services listed below will be delivered by health plans. For those who have opted out of strategies 2 or 3 or live in geographic areas where strategies 2 or 3 are not available, these services will be provided through fee for service.

Services Include:

<ul style="list-style-type: none"> • Physicians Visits • Emergency Medical Care • Maternity care • Limited Mental health services • Limited Treatment for chemical or alcohol dependence • Reproductive health and family planning 	<ul style="list-style-type: none"> • All necessary dental and vision care for children • Limited dental and vision care for adults • Prescription medications • Transportation to and from medical appointments, when necessary • An interpreter for medical appointments for individuals who do not speak English (arranged through your provider)
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For beneficiaries enrolled in strategy 2, these Medicaid mental health services will be delivered by health plans. If not enrolled in strategy 2, these will be delivered through the Regional Support Network delivery network.

Outpatient Services Include:

<ul style="list-style-type: none"> • Brief Intervention Treatment • Crisis Services & involuntary treatment • Day Support • Family Treatment • Freestanding Evaluation & Treatment • Group Treatment • High Intensity Treatment • Individual Treatment • Intake Evaluation 	<ul style="list-style-type: none"> • Medication Management • Medication Monitoring • Peer Support • Psychological Assessment • Rehabilitation Case Management • Special Population Evaluation • Stabilization • Therapeutic Psycho-education • Mental Health provided in Residential Settings
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Inpatient Services Include:

<ul style="list-style-type: none"> • Community Inpatient Psychiatric Services • State Psychiatric Hospital Services 	<ul style="list-style-type: none"> • Children’s Long-term Inpatient Program (CLIP)
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For beneficiaries enrolled in strategy 2, these chemical dependency services will be delivered by health plans. If not enrolled in strategy 2, these will be delivered through the fee-for service delivery

network.

Outpatient Services Include:

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| <ul style="list-style-type: none"> • Case Management • Chemical Dependency Assessment • Expanded Chemical Dependency Assessment • Intake Processing | <ul style="list-style-type: none"> • Individual Therapy • Group Therapy • Opiate Substitution Treatment |
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Residential Services Include:

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| <ul style="list-style-type: none"> • Youth Inpatient Treatment Level I Secure • Youth Inpatient Treatment Level II Secure • Youth Recovery House Level II • Youth Detoxification Stabilization (subacute) • Youth Detoxification Stabilization (acute) • Women without children Long Term Residential Treatment • Pregnant and Parenting Women with Children Long Term Residential Treatment | <ul style="list-style-type: none"> • Sub-acute Detoxification • Acute Detoxification • Screening, Brief Intervention and Referral to Treatment • Adult Intensive Inpatient Treatment • Long Term Adult Residential Treatment • Adult Recovery House • Involuntary Treatment • Co-occurring Disorder (COD) Residential Treatment |
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For beneficiaries with functional impairments due to developmental, cognitive or physical disabilities enrolled in strategy 2 these Medicaid long-term services and supports will be delivered by health plans. If not enrolled in strategy 2, these will be delivered through the fee for service delivery network.

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| <ul style="list-style-type: none"> • Case Management (currently paid as an administrative function, not a service) • Environmental Modifications • Personal Care (provided by Individual Provider, licensed home care agency, Adult Family Home or Boarding Home) • Nursing Facility Care • Self-Directed Care of skilled treatments as per 74.39 RCW • Home Health Aide • Adult Day Care • Adult Day Health • Specialized Medical Equipment and Supplies | <ul style="list-style-type: none"> • Skilled Nursing • Private Duty Nursing • Personal Emergency Response System including medication reminders • Nurse Delegation • Caregiver Recipient Training Service including evidence based/informed programs for depression and chronic disease mgmt • Budget based waiver services with financial consultation • Enrollee Participation in Cost of Care • Transportation • Home Delivered Meals |
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For beneficiaries enrolled in strategies 1, 2 or 3 these Medicaid 1915(c) developmental disability services will be provided by DSHS. All other services for beneficiaries in strategy 2 will be provided by health plans.

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| <ul style="list-style-type: none"> • Case Management (currently paid as an administrative function, not a service) • Behavior Management & Consultation • Community Guide • Emergency Assistance | <ul style="list-style-type: none"> • Employment and Day Program Services • Environmental Accessibility Adaptations • Mental Health Stabilization Services • Residential Habilitation • Community Transition |
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For beneficiaries enrolled in strategy 2, these Medicaid services offered under Washington's Money Follows the Person Demonstration Program (Roads to Community Living) will be delivered by health plans. If not enrolled in strategy 2, these services will be available through the fee for service delivery

network.

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| <ul style="list-style-type: none"> • Community Choice Guide • Community Choice Housing Specialist • Informal Caregiver Support Services • Challenging Behavior • Life Skills | <ul style="list-style-type: none"> • Professional Therapy • Transitional Mental Health and Substance Abuse Services • Service Animals |
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iii. Description of whether the program will add new supplemental benefits and/or other ancillary/supportive services (e.g. housing, non-emergency transportation, etc) or modify existing services.

The state together with its actuary will evaluate the feasibility of requiring health plans to provide new supplemental benefits and/or other ancillary/supportive services during the development of state specific selection criteria (scheduled for Aug-October 2012). If the state does not require additional benefits, plans will be encouraged to provide supplemental benefits and/or other ancillary support services. Offering expanded benefits has proven important as beneficiaries make choices about voluntary enrollment into managed care plans. During focus groups beneficiaries expressed time and time again how difficult it can be to get critical needs met on limited incomes. The ability to access supplemental services that might otherwise be purchased out of pocket was viewed as a very important factor by beneficiaries in making a choice to enroll in integrated plans.

HHs for the high cost/high risk beneficiaries that provide intensive care coordination across all service domains is a new service that is not currently available in the state’s Medicaid program nor is it paid for by Medicare. Plans will be required to provide this service to enrollees who meet the high cost/risk criteria and to comply with the state health homes qualification process.

iv. Discussion of how evidence based practices will be employed as part of the overall care model.

Throughout the design phase, WA has explored the value of integrating evidence based and informed practices into the strategies. A clear result from stakeholder engagement activities was that they have an expectation that evidence based or evidence informed promising practices will be incorporated to support the highest health outcomes and beneficiary activation possible. Many evidence based practices are already commonplace and have standardized use in the existing service delivery systems, such as: depression, chemical dependence and suicide screens, Chronic Disease Self Management Program (an approved benefit in the COPES LTSS waiver), Coleman and Naylor’s Care Transitions models and many protocols for the treatment and prevention of chronic conditions. DSHS jointly developed the “Living Well with Chronic Conditions in Washington State” website. <http://livingwell.doh.wa.gov/about-us> It is a website for providers, potential providers, leaders, trainers and participants to learn about healthy aging, self management programs and evidence based classes that are available throughout the state. The state has also developed standards for completion of health risk assessments and health action plans that utilize evidence based tools and protocols in the provision of HH services.

A comprehensive health assessment will be conducted within 30 days of enrollment using evidence based/informed practices where available. The assessment identifies chronic conditions, severity factors and gaps in care, the beneficiary’s activation level and opportunities for potentially avoidable emergency room, inpatient hospital and institutional use.

v. As applicable, description of how the proposed model fits with:

(a) current Medicaid waivers and/or State plan services available to this population

WA uses authority under the Medicaid state plan and federal waivers to receive federal match to support the delivery of medical, mental health, chemical dependency, long term services and supports and services for individuals with developmental disabilities. DSHS and HCA are reviewing current state plan and waivers to determine where administrative simplification and efficiencies can be achieved and to identify revisions that may be necessary to implement health reform activities including implementation of integration strategies. Where multiple waivers can be combined to promote efficiency and/or flexibilities, the state will work with CMS to do so. As an example, two of the state's 1915 (c) long term care waivers are being collapsed into the larger COPES 1915 (c) waiver and the Division of Developmental Disabilities is exploring whether to combine two 1915 (c) waivers into one.

Strategy 1: Beneficiaries will be eligible to receive current Medicaid State Plan, 1915(b), 1915(c), 1115 services and Roads to Community Living Services based upon eligibility criteria for those services.

Strategy 2: Health plans will be required to cover all services currently available under the state's Medicaid State Plan, 1915(b), 1915(c) waivers and Roads to community living to eligible beneficiaries. 1915(c) waiver services provided under ADOSA's Division of Developmental Disabilities will be excluded from health plan coverage.

Strategy 3: Beneficiaries will be eligible to receive current Medicaid State Plan, 1915(b), 1915(c), 1115 services and Roads to Community Living Services based upon eligibility criteria for those services.

(b) Existing managed long-term care programs

WMIP is a voluntary managed care pilot project in Snohomish County. It is designed to improve care for disabled Medicaid clients who are 21 years of age or older by coordinating services that in the past have been provided through separate treatment systems. WMIP began providing care for clients in January 2005. The benefit package includes medical care, substance abuse treatment, mental health treatment (fully phased-in October 2005), and long-term care services (added October 2006).

(c) Existing specialty behavioral health plans

Mental health services in WA are administered by Regional Service Networks (RSNs). These networks contract with licensed community mental health providers to supply mental health services. RSNs coordinate crisis response, community support, residential, and resource management services. Funding is provided from the state to the local RSNs for consumers who are Medicaid eligible through capitated Prepaid Inpatient Health Plans. Limited services are available to those who are non-Medicaid eligible as general state funds allow.

(d) Integrated programs via Medicare Advantage Special Needs Plans (SNPs) or PACE programs

Currently the Medicaid agency holds four information exchange contracts with Medicare Advantage Special Needs Plans to support their operation in WA. Through their experience with the provision of increased care coordination for dual eligibles, our expectation is they will align with and enhance the proposed duals innovation model. Several managed care plans that are apparent successful bidders to provide Medicaid coverage as of July 1, 2012 offer Medicare Advantage SNPs. Health Plans are interested in participating in three-way contracts under strategy 2 must submit a non-binding letter of intent to CMS in early 2013.

PACE provides the full scope of long-term care, medical, mental health, and drug and alcohol treatment services under one service package and capitated payment per member per month. PACE has been available in a limited number of zip codes in King County since 1995 and is operated by Providence ElderPlace in Seattle. Total expenditures in FY10 were \$8,401,930, with average monthly census of approximately 344.

(e) Other State payment/delivery efforts underway (e.g. bundled payments, multi-payer initiatives, etc)

The proposed duals innovation model takes advantage of many health reform efforts underway in the state. In particular it leverages progress made towards fully integrated care in which service delivery, financing and administrative systems are increasingly less fragmented and accountability for improved health outcomes and reduced costs are clearer. The cumulative effect of these efforts, in conjunction with the proposed duals innovation model, is to accelerate the move away from inefficient health care purchasing practices to improved and sustainable access, quality, patient experience, population health, and affordability of coverage and care. Key health reform and program development efforts that inform and enhance the proposed duals innovation model include:

Expansion of Managed Care to individuals receiving medical services under the Medicaid State Plan

The Healthy Options program currently provides a fully capitated, managed care program serving approximately 700,000 Temporary Assistance to Needy Families (TANF), TANF related Children's Health Insurance Program (CHIP) clients, which is about 60% of WA's total Medicaid/CHIP population. Basic health serves approximately 40,000 low income clients. HCA will add approximately 120,000 individuals who are eligible for Supplemental Security Income (SSI) who are blind and disabled to Medicaid medical managed care in July 2012.

- vi. Other CMS payment/delivery initiatives or demonstrations (e.g. health home, accountable care organizations, multi-payer advanced primary care practice demonstrations, demonstration to reduce preventable hospitalizations among nursing home residents, etc)**

The Dual Innovation Design Plan will include core elements that link with other Affordable Care Act (ACA) and Washington Health Innovations projects including:

- a. Integrated services under WA's multiple home and community-based (HCBS) waivers into a combined benefit package;
- b. Building capacity in organized health systems to deliver HCBS, and test integration/coordination of HCBS with organized health systems;
- c. Developing innovative payment methods for supports providers through bundled and capitation payments for example;
- d. Health Technology Assessment
- e. Health Benefits (Insurance) Exchange
- f. Electronic Health Records Incentive Program
- g. Identifying areas where additional federal approval would increase flexibility and maximize the sustainability of programs for duals into the future;
- h. Including health home and other supplemental benefits, building on WA's work to date on health homes including health home services permitted in ACA Section 1945(h)(4).

The 2011 Legislative Session, through enactment of House Bill 1738, moved the single Medicaid agency from DSHS to the HCA. It also directed DSHS and the HCA to propose preliminary recommendations regarding the role of the HCA in purchasing DSHS provided mental health, chemical dependency and long term care services including services for persons with developmental disabilities.

WA House Bill 1738 calls for a planning process in 2012 to identify the role of the HCA in the State's purchasing of the programs that remain within DSHS. The goal is to use the full purchasing power of the

State to get the greatest value for its money and allow other agencies to focus more intently on their core missions. It further directs the DSHS and the HCA to consider options for effectively coordinating the purchase and delivery of care for those populations served by DSHS after seeking input from a broad range of stakeholders.

D. Stakeholder Engagement and Beneficiary Protections

i. Discussion of how the state engaged internal and external stakeholders during the design phase and incorporated input into its demonstration proposal.

Engagement with individuals, organizations, professional associations and government entities that receive, provide, administer or advocate for health and social services, particularly those funded under Medicaid and Medicare is a critical component of the design plan development. During initial planning, WA developed a strategic and inclusive conceptual framework to guide and direct the state's work with stakeholders. (Appendix I) In addition, WA utilized a stakeholder matrix to help identify a broad array of interested parties; and assist in targeting and prioritizing efforts given the short planning timeframe. Stakeholders were invited to participate through a number of methods including: interviews, forums, presentations, focus groups and webinars. Individuals and organizations were also asked to submit written comment and feedback on the draft design plan and did so using a variety of communication methods including surveys, letters, email and in-person meetings. Throughout the stakeholder process, the state shared approaches and sought comments from beneficiaries, their families, advocacy groups, providers, impacted organizations and entities, government entities and other key informants.

This ongoing dialogue was invaluable in shaping the integration strategies contained in the proposal as well as identifying operational and implementation issues that are not contained in this high-level design proposal. These detailed comments which include the need for more specificity about state specific selection criteria, consumer protections, contract language, readiness review, provider network quality and adequacy and on-going quality and monitoring will be used to shape implementation planning efforts. The state will continue work with stakeholders and other interested and impacted parties as work on the project moves from the design to the implementation planning phase. A complete listing of entities involved in engagement activities to date can be found in Appendix J.

Additionally, the American Indian/Native population was engaged in a parallel process with the state to discuss the unique needs of tribal members with a recognition that Federally Recognized Tribes operate and deliver services based upon treaty elements with the Federal government that may differ from standard Medicaid and/or Medicare regulations. Key to discussions were the design of tribal centric models that reduce fragmentation, simplify access, improve outcomes, reduce avoidable costs and provide culturally competent services. Meetings, both in-person and via video conference, were hosted by the Indian Policy Advisory Committee (IPAC), the Indian Health Services Board meeting (IHS) and the Regional Tribal Coordinating Council. Throughout the process tribal representatives encouraged face to face discussions to continue prior to Tribal Consultation and the state is looking forward to continued work with the tribes around health homes and integration strategies.

An external website was developed in the fall of 2011. It describes the project and provides a place where documents were posted after stakeholder engagement activities were concluded. The site address and link were shared in stakeholder forums, subsequent email distributions to interested parties, involved stakeholders and in public webinars to encourage participation in providing comment on the draft design plan. The website can be found at <http://www.adsa.dshs.wa.gov/duals>

There were a number of themes in stakeholder feedback provided during the design planning process that provide context for the proposed integration strategies. These themes include: 1) medical and social services needs are inter-related and coordination and incentives need to be aligned across these domains; 2) care coordination is a key ingredient to effective care integration; 3) flexibility is necessary to allow for local variances based upon population need and provider network; and 4) change is both needed and feared. Although the current system as a whole has flaws, there are elements of service delivery that are high quality and are working well for beneficiaries. Stakeholders expressed fear that what is working will be broken or the state's performance on key indicators such as employment and community based long term care will be eroded while the state is trying to improve the overall service delivery system. Stakeholders expressed that changes be made in a way that uses all due deliberate speed – but in a logical and reasonable fashion.

The design plan was posted for public comment on April 12, 2012. The state held three webinars to provide an overview of the design plan and encourage review and comment by the public and other interested parties. Announcement of the public comment period and webinars was broadly distributed including notification of the press and posting by the state's code reviser. The state received written comments from over 60 organizations and individuals. The state also posted a brief survey on the website so that individuals could quickly provide responses in lieu of, or in addition to, submitting more formal written comment.

In April 2012, the state created the HealthPathWashington Advisory Team (HAT). The purpose is to inform DSHS and the HCA as the two agencies work to implement the integration strategies identified in this document. The team is made up of participants who have expertise in serving individuals who are eligible for both Medicare and Medicaid services including serving individuals with special needs, those experiencing health disparities, social and geographic isolation and limited English language skills. Team participants represent the broad range of expertise in medical, long term services and supports, developmental disabilities, mental health, chemical dependency, health information technology, national integration strategies, tribal service delivery, medical home collaborative and care transitions – all are necessary for the successful implementation of this project. There are many implementation details and deliverables still to be developed and the HAT will be utilized to provide feedback on draft documents and materials as the state moves forward. A list of HAT participants can be found in Appendix K.

A more detailed description and overview of stakeholder and engagement activities that have been conducted through the design planning process is contained in Appendix L.

ii. **Description of protections (e.g. continuity of care, grievances and appeals processes, etc) that are being established, modified, or maintained to ensure improved beneficiary experience and access to high quality health and supportive services necessary to meet the beneficiary's needs.**

WA State recognizes and embraces the need for strong consumer protections, an issue raised by a wide range of individuals and groups in the engagement activities and in public comment. In the design and implementation of integration strategies WA is committed to building on the foundation of current consumer protections. Enrollment choices will be clearly described and well communicated and mindful of continuity of care issues crucial to beneficiary wellbeing. On an ongoing basis WA will offer services that reflect consumer voice, input, and choice. Stakeholders will be given opportunities for input on how to develop and use program decision materials that are integrated, accessible in a variety of formats and languages, and respectful of a range of cognitive abilities. WA will work with beneficiaries and their advocates to provide information in the ways they prefer to access information. Program standards will

be shared with beneficiaries and those who support them. WA will require health plans to create responsive, quality provider networks, access standards, and well informed coordinated care transitions. Beneficiary protections will include respect for beneficiary privacy. WA will provide beneficiaries with information about available decision support that is independent of MCO's. The integrated appeal and grievance process for beneficiaries will include the most beneficiary responsive protections in current Medicare and Medicaid appeal and grievance programs. Additional detail related to consumer protections will be developed during implementation planning with input from the HAT.

Continuity of Care

WA respects beneficiary and stakeholder concern about continuity of care. To inform decisions, WA will provide beneficiaries with information about their upcoming choices and the implications of those choices during the enrollment period. Available information will be shared with beneficiaries, using available data systems, to alert them with available information to help support their decisions. Materials will inform that during the initial 90 day period, those beneficiaries who participate and whose providers are not part of the plan network can continue to see their established providers and complete any ongoing courses of treatment. Beneficiaries will be provided information about their choices including information that, at the end of 90 days, they will have full portability if they choose to opt out. Implementation planning materials will be designed to provide beneficiaries information to make informed decisions to engage in a plan that includes their current providers, if that is their choice.

Network Adequacy and Provider Access

WA's beneficiaries will have access to strong provider networks offering licensed primary care, specialist providers and community based supports with experience serving dual beneficiaries in the full array of covered services with diverse cultural, language and cognitive considerations. Standards will be in place to address how long it takes to get care, how far beneficiaries travel to get care, and to reinforce that they have a voice in decision making about their care. These standards will be routinely communicated with beneficiaries.

Enrollment Assistance

WA is working with CMS to provide one set of clear, current, understandable materials that assist beneficiaries to make initial enrollment decisions and any additional enrollment or disenrollment decisions. WA is requesting funding from CMS to support an independent enrollment broker function. This would provide a resource person outside of health plans to provide assistance to beneficiaries. Enrollment brokers would be unbiased, not be invested in a particular outcome, and equipped to help beneficiaries understand and explain both integrated and other service delivery options. There will also be written materials and assistance showing enrollment protocols, choices and options for opting out. Outreach and education activities will be responsive to cultural, language, and special needs of beneficiaries to ensure beneficiary choice and voice.

Integrated Grievance and Appeal Process

WA will work with CMS and use the state rule-making process to develop a fully integrated Medicare and Medicaid grievance and appeal process. That process will incorporate the most beneficiary-friendly elements of Medicare and Medicaid. Key elements of the integrated approach will include single notices for the two programs, continuation of benefits pending appeal, the option for in-person appeals, and timelines that are the most advantageous to beneficiaries. The existing Medicaid and Medicare processes and the CMS preferred alternatives with the HCA Appeals Office have been reviewed. Subsequent work with CMS is anticipated and will enable a truly integrated beneficiary favorable

process to reduce confusion and complexity for beneficiaries. A review of House Bill 2523, recently passed by the 2012 WA Legislature (Appendix M), is underway as it may have implications for the appeals process.

Rights and Responsibilities

WA recognizes that it is crucial for beneficiaries to maintain all their available rights and responsibilities, have easy access to an explanation of those rights, and avenues for exercising them. The HealthPathWashington project will ensure the current rights and responsibilities of beneficiaries under existing federal and state programs, the ACA, and the Patient Bill of Rights are not adversely impacted. A description of rights and responsibilities and how to exercise them will be provided to beneficiaries through integrated materials.

Beneficiary Support

WA is committed to providing strong beneficiary support building on current organizational resources available to beneficiaries and natural community supports. Case management staff within the DSHS /ADSA will work with beneficiaries and their families to determine eligibility, assess initial needs and reevaluate ongoing needs and services. The Washington State Office of the Insurance Commissioner (OIC) is lead for ensuring compliance with the Patient Bill of Rights (Appendix M). The OIC's Statewide Health Insurance Benefits Advisors (SHIBA) staff provides beneficiaries with some assistance in accessing their care, understanding, exercising their rights and responsibilities, and appealing adverse decisions made by health plans (Appendix M). Staff is available to support beneficiaries and their families in health coverage issues. They provide advice, information, referral, and direct assistance and representation in dealing with WA plans and providers, as well as DSHS and HCA.

Assistance through existing state resources, case management staff, and HH providers will assist beneficiaries to address issues and resolve problems such as the following:

- Understanding benefits, coverage or access rules and procedures, and participant rights and responsibilities
- Exercising rights and responsibilities
- Accessing covered benefits
- Addressing providers who balance bill
- Understanding Washington's Patient Bill of Rights
- Challenging plan denial, reduction or termination of service decisions
- Raising and resolving quality of care and quality of life issues
- Ensuring the right to privacy, consumer direction and decision-making

Plans will be required to notify beneficiaries that program support and assistance is available to help with enrollment materials, notices of grievance and appeal procedures, and all written notices of denial, reduction, or termination (change) of a service. These notifications will be developed through a process that includes stakeholder review to assure they are comprehensive, clear and understandable.

Integrated Consumer Information

WA will provide one set of informative integrated consumer materials. These materials will be responsive to cultural, language, and special assistance needs of beneficiaries. Marketing and beneficiary notices will be comprehensive and flow in a logical manner to promote ease of comprehension and beneficiary participation and protect beneficiary voice and choice.

During stakeholder engagement activities, individuals who receive, authorize, provide and advocate for services helped to develop the core elements and consumer protections that are essential in an effective service delivery system. The perspectives of these diverse groups, together with lessons

learned from implementation of state and local service delivery systems and from other states, all helped to inform the critical consumer protections WA will require of health plans and providers.

Additional information can be found at

<http://www.adsa.dshs.wa.gov/duals/documents/Duals%20Stakeholder%20Engagement%20Meetings%20September%202011%20Summary.pdf>

vii. Description of the State’s plans for continuing to gather and incorporate stakeholder feedback on an ongoing basis during implementation and duration of the demonstration, including how the State will inform beneficiaries (and their representatives) of the changes related to this initiative. Discuss how information will be provided in languages other than English and in alternative formats for individuals with disabilities.

As indicated above, the state has created an on-going advisory team (HAT) that is scheduled to meet at least 8 times over the next 22 months to continue to inform the project’s implementation. To make certain that all engaged participants and interested parties – as well as the general public – are able to stay informed about the state’s **HealthPathWashington** program, the communications system for this project is multi-pronged and based on a set of foundational communications tools and key messages.

WA recognizes that a broad array of outreach and enrollment efforts will be important to success – the audiences that need to be engaged are hard-to-reach groups with diverse cultural and linguistic differences – all important and relevant factors from a communications perspective.

HealthPathWashington also recognizes that one-on-one support to help participants through the enrollment process will be important, as will engaging existing advocacy organizations to help with the communications and outreach with their constituent base.

Engaging beneficiaries and hearing their feedback is critical to the project’s success. The Communications Plan (Appendix N) includes the tools needed for focused outreach to all target audiences, as well as the tactics and processes that will allow gathering of data and feedback – and to adjust program initiatives in response to the data and feedback that is received.

A detailed Communications Timeline provides an initial 23-month schedule for the communications tools and activities that cover February 2012 through January 2014. (Appendix O)

E. Financing and Payment

Description of proposed State-level payment reforms, including whether State is pursuing either/both of the financial alignment models outlined in the July 8, 2011 State Medicaid Director Letter (https://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).

The development of the proposed financial models were guided by Governor Gregoire’s Health Reform goals, informed through work with stakeholders, regular conversations with CMS and their technical assistance contractors, analysis of the current service delivery system strengths and weaknesses and population profiling of the duals population.

Strategy 1: Health Homes (HH)

Beginning January 2013, a HH service for duals who meet the state high risk/high cost criteria will be implemented (pending approval of a section 2703 health home state plan amendment). The state will qualify HHs based upon developed standards that demonstrate integration through coordination across service domains (mental health, chemical dependency, long term care services and support and physical health). Health homes will be paid on a PMPM basis for each month an enrolled beneficiary receives one of the six qualifying HH services. In response to stakeholder feedback and consistent with clinical experience learned to date, WA will develop at least two payment tiers of HH services that will be linked to higher and lower intensity care coordination levels. HH services would be available under managed

care and fee for service payment methods. Outside of strategy 2, the payment structure of medical, mental health, chemical dependency and long term services and supports in 2013 would remain fee-for-service for both Medicare and Medicaid (except for the managed care Medicaid mental health system), with shared savings calculated after year end according to the managed fee-for-service option proposed by CMS. As mentioned in the Care Model section, this intervention is based upon CCM models in operation in WA over the past seven years. Early evaluation of these models have shown increased health outcomes, patient activation and reduced costs in avoidable institutional stays, emergency room usage and in-patient hospital stays.

Strategy 2: Full Financial Capitation through Health Plans

This strategy will follow the structure of the CMS proposed integrated full-risk capitation model through three-way contracting. Rates for duals will be developed based on baseline spending in both programs, historical trend factors, claims lag factors, program changes if any and anticipated savings. As a demonstration program, the State proposes the following payment reform details:

- Aggregate savings will be shared between the federal and state partners, recognizing that expenditures in Medicaid reduce expenditures in Medicare. For example, reductions in Medicare nursing home stays and hospital readmissions will result in increases in Medicaid paid nursing home days.
- Medicaid payment rates may be risk-adjusted for geographic area, age group, gender, program type, diagnosis group, and /or nursing home use, as determined after actuarial review. Past experience with passive enrollment and partial integrated capitation showed selective opt-outs, where higher risk individuals opted out at higher rates than lower risk individuals.
- A quality incentive pool will be created by a withhold from the capitation rate.
- An additional health home service for duals who meet the State high risk, high need criteria (approximately 40% of duals) will be added to the capitation benefit, upon federal approval of a 2703 state plan amendment.

There are a number of reasons WA is proposing full financial capitation in addition to other integration strategies including strong stakeholder feedback expressing concerns about the readiness of health plans to meet long term care and behavioral health needs; unintended adverse impacts on current systems if the state moves too quickly to managed care; the rural nature of WA; whether adequate managed care coverage will be available; and the desire to have other models for beneficiaries that opt out of a full financial integration.

Strategy 3: Modernize current service delivery system, implement three-way contracting and capitation of Medicare payments and Medicaid medical payments coupled with the use of performance measures and incentive pools to improve integration and financial alignment across medical, behavioral health, and long term services and supports systems (beginning January 1, 2014):

Beginning January 2014, a three-way managed care contract is proposed with 1) Medicaid capitating medical services only and 2) Medicare fully capitating all Medicare services. Participating health plans would be required to develop networks that could be qualified HHs or purchase HH services through a qualified provider. The state will establish a qualification process and qualify all HH providers. The plan together with the HH will be responsible for integrating the delivery of Medicaid medical, mental health, chemical dependency and long term care services and support services, with Medicaid contractual requirements for quality performance measures. Shared outcomes and financial incentives will be developed through performance based contracting methods.

Strategies 1 and 2 face significant challenges. Few geographic areas are likely to be ready to implement fully integrated capitated managed care (strategy 2) within the 3-year timeline for this project. With

regard to strategy 1, the ability to support HH investments for duals in the balance of the state depends on CMS providing Medicare funding to support HH payments after the end of the enhanced Medicaid match available through the 2703 SPA. Strategy 3 has key strengths that overcome these limitations:

- Integration of the Medicare medical, SNF and outpatient mental health benefit with the Medicaid medical benefit provides a mechanism for funding HH services through the health plan capitation payment. This provides a vehicle for longer-term sustainability of funding for HH services by avoiding the misalignment of HH service costs and the associated savings that accrue primarily to Medicare.
 - Compared to Strategy 1, Strategy 3 aligns key financial incentives within the health plan. In particular, the health plan has the incentive to improve patient health outcomes to reduce Medicare-paid inpatient hospitalizations – especially hospitalizations from a nursing facility setting that are likely to restart Medicare-paid SNF payments when the patient is readmitted to the nursing facility following hospital discharge.
 - Strategy 3 creates an environment that increases the viability of further delivery system integration. The health plan will contract with community mental health system providers who currently bill Medicare for outpatient services, and therefore will gain experience with the provider network that is the backbone of the current Medicaid RSN system. The health plan will contract with the nursing facilities that make up the vast majority of facilities that contract with the Medicaid program. In addition, the health plan will be contractually required to use long-term care providers, when appropriate, to provide HH services for duals who are receiving HCB LTSS.
 - These strategies are responsive to community stakeholder input, to focus on integration of service delivery in areas where full financial integration is not currently possible.
- i. **Discussion of how payments will be made to both health plans (if applicable) and providers, including proposed payment types (e.g., full-risk capitation, partial cap, administrative PMPM); financial incentives; risk sharing arrangements; etc. as applicable.**

Strategy 1 Health home services will be paid on a PMPM basis, for those high-risk clients who have agreed to actively participate and with evidence of at least one HH –related contact in the month. For individuals enrolled in managed care, the PMPM will be in the capitation and paid based upon encounter data. For individuals enrolled in fee for service, the PMPM will be a service fee. Enrollment in the HH will be managed centrally by the HCA in coordination with the health plan where applicable. Enrollment serves as prospective notice of coverage of HH services to the provider, beneficiary and health care delivery system. Payment will be based on retrospectively processing a health home claim through the Medicaid Management Information System (ProviderOne) for an enrolled beneficiary. HH payments will be made to the state-qualified HH, which may be a health plan, community collaborative or a provider group. HH payments do not contain explicit financial incentives, but do contain explicit performance expectations that will be identified in the contracts.

Strategy 2 Full Financial Integrated Capitation – In keeping with the policies on integrated capitation, a full-risk capitation payment will be made to the health plan. A quality withhold paid out based on performance results creates a financial incentive to provide cost-effective health care services while meeting quality performance targets.

Strategy 3 2014 Modernized System of Care- Payments will be a mix of capitated and fee-for-service payments, with a shared incentive pool derived from a withhold from capitation and/or the fee-for-service rate structure. Pay for Performance contractual performance expectations additionally support and coordinate efforts across service delivery systems.

F. Expected Outcomes*

- i. **Description of the ability of the State to monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive high quality care and for the purposes of the evaluation.**

The state has advanced analytic capability to monitor, collect and track the following Medicaid and Medicare data which form the basis for key quality and cost outcome measures:

- **Health service utilization:** all hospital admissions (broken down by scheduled admits and those through the ER); primary care avoidable hospital admissions ; psychiatric inpatient admissions; 30-day re-hospitalizations, emergency room visits (in total and broken down by avoidable type); nursing home placements (including shifts between Medicare and Medicaid skill nursing); physician visits; narcotic use (prescriptions, number of unique prescribing physicians, number of prescribed pills); antipsychotic use; access to CD treatment; access to mental health treatment
- **Medical expenditures:** total and broken down by inpatient acute; outpatient emergency room; physician; nursing home; home and community based services
- **Morbidity/mortality outcomes:** death rate; indicator of injury
- **Social service impact outcomes:** homelessness; Washington State Patrol arrests/charges
- Eligibility and provider detail

Key Performance Metrics

The proposed quality performance metrics listed in Appendix P address the key performance measurement domains of beneficiary engagement, appropriate service utilization and access to care. The state may propose changes to this set of metrics as new measurement standards emerge, as implementation work with the HAT continues or as analyses of integrated Medicare and Medicaid data progresses. Additional topics will be addressed in the program evaluation are more fully described in the evaluation section. Measures derived from health risk assessments require additional infrastructure resources to construct a common collection tool. Resources for conducting evaluation and client surveys to capture client experience as described in the evaluation section also require additional resources. The majority of key performance measures will be derived from claims and managed care encounter data. The state will also require plans participating in the fully integrated capitated managed care model to monitor and provide supplemental performance metric data for their enrollees. Similarly, plans participating in HHs and strategy 3 will be required contractually to monitor and report supplemental performance metrics for measures that are consistent with the service benefit package for which they are responsible. Key performance outcome measures related to quality and cost including their definitions can be found in Appendix P.

ii. Evaluation Design

The evaluation of the project will consist of the following elements, assuming additional funding for evaluation and access to Medicare encounter data:

1. Plan-Specific Implementation and Quality Monitoring.

Regional community meetings with managed care plans will be convened before, during and after implementation to coordinate local development of networks, identify areas for improvement and provide feedback on state monitoring results. Before implementation, plans and health homes will be reviewed for readiness to perform their contracted duties. Assignment of beneficiaries will be dependent on proof of readiness. During implementation, program staff will be monitoring access, enrollment and complaints on a continuous basis. Monthly phone conferences will be held with

capitated plans to identify issues, quality activities and action plans. An in-depth, on-site review will be conducted by state and federal staff on an annual basis. Results of the scoring of plan contract requirements and the required External Quality Review report including self-reports of HEDIS quality measures will be made available on an annual basis by plan, beginning in the second year of the project.

2. Implementation Process Description.

Descriptive comparison between the proposal and actual implementation by county and population group will be done. Areas will include budgeted versus actual retention of assigned beneficiaries, with a description of retention strategies; active engagement of high risk duals in health home/care management; significant modifications from original design and lessons learned. This will be completed in the second year of the project.

3. Pre/Post Cost and Utilization Evaluation with Comparison Group.

The relative changes in utilization, cost and outcomes for the target population from a baseline period to a post-implementation period against the same changes experienced by a non-target comparison group (a difference-in-differences analysis) is recommended. This design accommodates unequal baseline values and controls for effects of time alone (such as regression to the mean).

Given that integrated capitation will only be available to beneficiaries in selected counties, and assuming enrollment will not be mandatory, the evaluation design will focus on two levels: an intent-to-treat design (county level) and a sub-analysis of those who participated in the integration program.

- The county level analysis will compare the overall impact of the duals project on the counties as a whole versus like counties where the program was not implemented. This approach is also useful in explaining the impacts of a policy decision to offer an integrated capitation option to dual eligibles.
- The first cohort of duals who maintained enrollment in integrated capitation will be tracked. A systematic non-random risk selection of beneficiaries into the fee-for-service environment is assumed, requiring a matched comparison group built from like clients in non-targeted areas matched on risk score, age, gender, and other factors.

Given claims processing and data compilation lags, this portion of the evaluation would be completed in the third year of the project.

4. Client Survey.

A sample of high-risk dual beneficiaries will receive a telephone survey at several points in the project. Ideally there will be three comparison arms – those who opted out, those who participated and those who did not have the option to participate, roughly -300 in each arm. Topics will include reasons for participation or non-participation, self-assessed health status and function, satisfaction with primary care and health home provider, perceptions of access to care (getting care quickly, getting needed care), and knowledge of available services. The survey will require additional resources, including a survey completion incentive for an expected response rate of over 75% (based on prior experience). Will cover questions and clients not covered by CAHPS surveys required of plans.

iii. List potential improvement targets for measures such as potentially avoidable hospitalizations, 30-day readmission rates, etc.

Formal improvement targets for dual eligibles have not yet been established, as our focus in the short time that we have had Medicare data has been on developing a “proof of concept” prototype PRISM

application for duals and identifying high-risk dual beneficiaries using integrated Medicare and Medicaid data. Preliminary investigation suggests:

- High-risk duals who meet the PRISM risk score criterion of 1.5 or above have average PMPM Medicare expenditures of more than \$2,000 PMPM, including more than \$1,100 in Medicare-paid inpatient and skilled nursing facility costs (Adding Medicaid-paid nursing facility costs would add substantially to this total.) See further discussion in Appendix Q.
- The potential for Medicare savings lies primarily in reductions in hospital admissions and use of Medicare-paid skilled nursing facility services. Analysis of integrated Medicare and Medicaid data for Washington State duals in SFY 2010 shows that:
 - About 75% of duals admitted to a hospital directly from a Medicaid-paid skilled nursing facility stay are subsequently discharged from the hospital directly to a nursing facility stay. More than half of the time, these subsequent nursing facility stays are paid for by Medicare at a higher cost than the prior Medicaid nursing facility stay.
 - Inpatient hospital readmission rates are relatively high for duals who have been previously admitted to the hospital from a Medicare-paid skilled nursing facility stay. Among Elder duals admitted to the hospital from a Medicare-paid SNF stay, 90-day readmission rates are 38%. Among comparable disabled duals, 90-day readmission rates are 56%. Although more analysis is required to set specific improvement targets, these findings point to inpatient and SNF utilization as potentially important sources of Medicare savings.
- We estimate that a reduction of approximately 17 percent in Medicare inpatient and skilled nursing facility expenditures (e.g. through a reduction in avoidable admissions and readmissions) would be necessary for health home services for high-risk clients to “break even.” Savings calculations presented in Appendix Q assume a 20 percent reduction in Medicare inpatient and skilled nursing facility expenditures for high-risk clients engaged in health home services, which is consistent with estimates derived from evaluation of WA State’s Chronic Care Management pilots.

iv. Discussion of the expected impact of the proposed demonstration on Medicare and Medicaid costs, including specific mention of any effect on cost-shifting occurring today between the two programs and detailed financial projections over the next three years for Medicare, Medicaid, and total combined expenditures, including estimates of how much savings are anticipated.

WA already has statewide medical practice patterns which result in low hospital admission rates per 1,000 compared to the rest of the country, as well as having one of the most mature and extensive long term care community support service networks nationally, which results in lower skilled nursing home placements compared to other states.

However, the demonstration that WA proposes can still reasonably save Medicare and Medicaid additional costs, with pragmatic recognition that some of the changes needed to create and sustain cost savings will need to mature over time. Even if the change is less than statistically significant initially, past piloting of care coordination and service integration points to increased value of what is purchased, considering decreased morbidity rates and shifts in spending to more appropriate utilization of health services. A key determinate of the success of sustainable cost savings will be the willingness of the eligible population to participate in the integrated options available, provider willingness to accept change and innovation at the community level to support integrated service delivery.

More information about projected Medicare savings and cost-shifting can be found in Appendix Q.

G. Infrastructure and Implementation

- i. **Description of State infrastructure/capacity to implement and oversee the proposed demonstration. States should address the following: staffing, expected use of contractors, and capacity to receive and analyze Medicare data.**

WA is well poised to plan for implementation of an integrated approach to delivering care to duals. The Governor's vision to transform the delivery of health care includes specific reference to planning initiatives that target delivery system reform for duals, including steps that align with the phases of this proposal. WA has a demonstrated commitment to use data to drive decision making and routinely invests in a predictive modeling application (PRISM) to ensure success with correctly identifying, coordinating and managing care for dual beneficiaries.

Both the HCA and DSHS have extensive experience in implementing large systems change projects that require collaboration with providers, community groups, and state and local government entities. Both agencies are experienced in health promotion, consumer engagement, program development and have applied evidence-based methods to improve beneficiary participation.

Supporting and enhancing this demonstration project will be the availability of the robust data and evaluation resources, including the DSHS Research and Data Analysis Division (RDA), to inform design, implementation and operation of evaluation activities. This ensures ongoing linkages with national and state-based evaluation activities. Additionally, WA has the advantage of the PRISM system which is utilized to identify clients most in need of comprehensive care coordination based on risk scores developed through the predictive model. PRISM draws from Medicaid and Medicare payment systems, including managed care encounter data and the extensive DSHS assessment used for long term services and supports and developmental disabilities to create comprehensive profiles and cost analysis.

Integrating care for people who are dually eligible requires close coordination and joint decision-making between the DSHS and HCA. Through close ties to other health homes-related endeavors, the dual eligibles project will also coordinate with HCA and Department of Health (DOH), as well as other HCA-lead activities that forward the development of WA's HH strategy. The overall governance structure is designed to assure this coordination. See Appendix R.

Key State Staff: We anticipate continuing our joint agency sponsorship led by Doug Porter, HCA Medicaid Director and Robin Arnold-Williams, Secretary of DSHS. Day to day sponsorship will be delegated to Preston Cody, Assistant Director (HCA) and MaryAnne Lindeblad, Assistant Secretary (DSHS/ADSA). Duals Integration Project Managers, Bea Rector (DSHS/ADSA) and Kathy Pickens-Rucker (HCA) will continue to manage the day-to-day planning, implementation and stakeholder engagement activities. David Mancuso and Beverly Court (DSHS/RDA) will continue to lead the data, analytics, clinical decision support tool implementation and evaluation portions of the project. Key staff will be supported through a Project Steering Committee that will include representatives from DSHA, HCA and the Governor's office.

Work to integrate service delivery and evidence based practices is supported by many HCA and DSHS efforts including HHs, procurement of medical services into managed care, electronic health record development, pay for performance contracting, Money Follows the Person demonstration grant, and overall work with the populations served. DSHS and HCA have worked closely with CMS to gain access to the full set of Medicare data including parts A, B and D. The state has demonstrated its ability to receive, store and do high level data analytics at both the population and individual beneficiary level.

External Consultants: WA will likely rely on contractual relationships, existing or new with multiple entities for portions of the integrated care demonstration for which state resources or are not available.

Potential consultants may include: Milliman; Mercer; Covington; Christian & Barton; Navigant; Insignia; Gilmore; Organizational Resource Group; Rialto Communications; Coleman and Naylor. Additionally, contracts with Insignia Health for Patient Activation Measurement assessment may be instituted for training to ensure fidelity to models.

ii. Identification of any Medicaid and/or Medicare rules that would need to be waived to implement the approach. CMS is available to assist States in this analysis as necessary.

The state and CMS are working together to align the administrative processes that currently differ between Medicare and Medicaid such as grievance procedures. CMS issued guidance to states about this process of administrative simplification. The state is committed to work with CMS should waivers be required as this proposal is reviewed or implementation is contingent on waiver approval. The state is asking for the ability to passively enroll beneficiaries in the full financial integration model with a 90-day retention period where the plan will need to follow continuity of care requirements.

It will be important in the implementation preparation period to synchronize the incentive instruments used by Medicaid and Medicare. The state would also like to expand the use of incentive payment structures. Examples include focusing on nursing home use and re-hospitalization from nursing homes, use of long term care support services and increasing referrals to substance use treatment.

iii. Description of plans to expand to other populations and/or service areas if the model is focused on a subset of dual eligibles or is less than statewide.

Strategy 2 is the only model that will begin in limited geographic areas and carve out some services for individuals with developmental disabilities. Strategies 1 and 3 are anticipated to cover all full benefit duals in areas of the state where strategy 2 is not available.

Strategy 1 and 3 (health homes and system modernization) operating in the rest of the state will provide an opportunity to demonstrate the feasibility of integrating care, improving quality, and containing costs in service delivery contexts where fully integrated capitation may not be feasible. This three strategy integration approach will demonstrate the extent to which CMS goals for duals can be achieved in a mixed managed-care and fee-for-service environment through promising health home service delivery models supported by innovative HIT capability and the thoughtful design of financial structures to align incentives across medical, mental health, chemical dependency and long term services and supports systems.

iv. Initial description of the overall implementation strategy and anticipated timeline, including the activities associated with building the infrastructure necessary to implement the proposed demonstration. States should identify key tasks, milestones, and responsible parties, etc. (See attached Word template) This needs to include stakeholder feedback, etc

The WA project team is responsible for all implementation activities. Stakeholder engagement will be conducted throughout the planning, implementation and evaluation phases of the project. See Appendix S.

H. Feasibility and Sustainability

i. Identification of potential barriers/challenges and/or future State actions that could impact the State's ability to successfully implement proposal and strategies for addressing them.

- County legislative authority approval of terms for implementation of strategy 2
- For strategy 1 which establishes health home services without introducing fully or partially capitated managed care, sustainability in year 3 of the demonstration project requires CMS to provide

ongoing support for health home services for duals through continuation of the enhanced match available under the 2703 SPA, a Medicare-funded service payment, or comparable mechanisms.

- Uncertainty surrounding measurement of statistically significant savings in the managed fee-for-service approach
- Voluntary enrollment could significantly impact the cost savings potential of the project and overall sustainability

ii. Description of any remaining statutory and/or regulatory changes needed within the State in order to move forward with implementation.

The State will be working with stakeholders, providers, legislators and CMS to determine statutory changes necessary to modernize DSHS system of care, reduce administrative structures, etc.

iii. Description of any new state funding commitments or contracting processes necessary before full implementation can begin.

The state does not expect the need for any new state funding commitments in the beginning years of this demonstration project. The state will explore options with CMS related to sustaining health home services for duals in the third year of the demonstration.

The state has developed a timeline (see item G, section iv) of contracting processes necessary in all three strategies to begin full implementation.

iv. Discussion of the scalability of the proposed model and its replicability in other settings/States.

The HealthPathWashington proposal consists of three integration strategies all of which are scalable and replicable within the state. They could also be successful integration strategies for use by other states. The approach allows measured progress toward the goal of increasingly integrated care, recognizes the flexibility needed due to the geographic diversity of the state, moves the state forward in achieving the Governor's health reform priorities, and achieves the integration goals outlined by CMS. For individuals with complex care needs currently served under Medicaid and Medicare it will improve the experience beneficiaries have in accessing and navigating care, improve health outcomes and build methods of shared accountability.

v. Letters of Support – See Appendix X

I. Requested Implementation Support from CMS

WA is committed to integrating care for the individuals we serve including those eligible for both Medicare and Medicaid. Current resources are fully invested in ensuring choice and quality as we move the SSI blind and disabled populations into managed care statewide beginning in July 2012 and developing the infrastructure and provider network necessary to offer health home services to high cost/high risk Medicaid clients. Integrating payment, administrative processes such as enrollment, grievances, education and outreach, technology and human touches experienced by dual eligible beneficiaries entails the state performing functions it does not currently have the systems and staff to conduct. WA is proposing to create an integrated PRISM application that contains both Medicaid and Medicare claims data and is proposing many transformative changes that impact the entire service delivery system which requires additional staffing and contracting resources. Significant changes are also needed to the Medicaid Management Information System (ProviderOne) system to meet the standards and conditions outlined for the demonstration. Appendix W is a detailed budget for which the State is requesting CMS funding.

J. Additional Information Requested from CMS (not applicable)

K. Interaction with other HHS/CMS Initiatives

State agencies are positioned to leverage activities supported by the CMS Partnership for Patients in the implementation of this grant. The WA State Hospital Association (WSHA) was awarded funds to support twelve quality measures in WA State, including the reduction of hospital readmissions by 20% between 2010 and 2013. WSHA's statewide Partnership initiative, "Smooth Transitions," will develop shared work flows and communication strategies to improve transitions between hospital, homes and nursing homes.

Governor Gregoire's Interagency Council on Health Disparities (the Health Disparities Council) was established by the Legislature in 2006. The Council has 17 members; a chair appointed by the Governor; representatives of 14 state agencies, boards and commissions; and 2 members of the public. The Legislature directed the Council to prioritize health conditions and social determinants of health and identify five topics for the action plan. The Council went through a detailed prioritization process and selected the following five priorities for the first version of its plan: health insurance coverage, health care workforce diversity, obesity, diabetes, and education. The council requested and received a presentation about the duals integration project. HCA and DSHS are committed to continued coordination with the Council to reduce health disparities for individuals who are eligible for both Medicare and Medicaid.

The Department of Health works with ADSA to support the goals of the Million Hearts Campaign through funding awarded by the Centers for Disease Control Community Transformation grants program. The department is expanding training and technical assistance to primary care providers in the "ABCS" of clinical prevention (aspirin therapy, blood pressure control, cholesterol control, and smoking cessation). An initial focus for this five-year initiative is on training and support for key medical providers for Medicaid and Dual eligible populations, including community health centers and other safety net primary care providers.

Appendix A: Strategy Matrix

Target Population: Full benefit Medicare-Medicaid enrollees (115,000), all ages



HealthPath
Washington

- Design Plan Milestones:**
- State posts draft design plan for public comment (March 12-April 13)
 - State Submits Duals Design Plan to CMS (April 26)
 - CMS posts final design plan for 30-day public comment
 - State and CMS negotiate Memorandum of Understanding for Implementation (June-September)

TOPIC	STRATEGY 1: Health Home Services	STRATEGY 2: Full Capitation through Health Plans	STRATEGY 3: Modernized consolidated service delivery with shared outcomes and aligned financial incentives
Geographic Service Area	Statewide (could be phased geographically)	Available in counties where legislative criteria are met and health plans demonstrate readiness	In counties where full capitation is not available
Enrollment	<ul style="list-style-type: none"> • Voluntary • Approximately 45,000 eligible duals (some will be served in strategy 2, 3 or fee for service) 	<ul style="list-style-type: none"> • Voluntary • Single or multi-county areas meeting design plan criteria 	<ul style="list-style-type: none"> • Those not enrolled in strategy 2 • Enrollment in Medicare/Medicaid Medical capitation voluntary
Summary of Covered Benefits	<ul style="list-style-type: none"> • Comprehensive care management, using team-based strategies; • Care coordination and health promotion; • Comprehensive transitional care between care settings; • Individual and family support, which includes authorized representatives; • Referral to community and social support services, such as housing if relevant; • The use of web-based clinical decision support tool (PRISM) and other health information technology to link services, as feasible and appropriate. • All other Medicaid and Medicare Services available through managed care or fee for service 	<ul style="list-style-type: none"> • Medical Services provided under the Medicaid State Plan • Medicare Parts A, B, D • Mental Health Services • Chemical Dependency Services • Long Term Services and Supports • Beneficiaries with developmental disabilities will be included in this model, but services in their 1915(c) waivers will be carved out of the capitation 	<ul style="list-style-type: none"> • Medical services provided under the Medicaid State Plan (capitated) • Medicare Parts A, B, D (capitated) • Medicaid behavioral health (capitated through Prepaid Inpatient Health Plans) • Medicaid long term services and supports (fee for service) • Medicaid developmental disabilities Services (fee for service) • Medicaid chemical dependency (fee for service)

TOPIC	STRATEGY 1: Health Home Services	STRATEGY 2: Full Capitation through Health Plans	STRATEGY 3: Modernized consolidated service delivery with shared outcomes and aligned financial incentives
Financing Model	Managed fee for service	Three-way capitation	Design plan model with capitation and fee for service
Proposed Implementation Date	January 1, 2013	January 1, 2014	January 1, 2014
Key Benchmark Dates:	<ul style="list-style-type: none"> • Draft qualifications document public comment period (March 23-April 13) • Financial modeling (May-June) • Finalize qualification requirements (May) • Release application and instructions (June) • Submit 2703 SPA (Sept after CMS MOU for duals is final) • Qualify/contract for health homes (summer-fall) • Training and technical assistance (fall-winter) • Implement health homes January 2013 (may look at geographic roll-out contingent upon location of qualified health homes) 	<ul style="list-style-type: none"> • County legislative approval (August-Sept 2012) • RFP development (Sept-Oct 2012) • RFP issued for Medicare and Medicaid integrated services (Nov 2012) • Health Plans submit letter of intent (Nov 2012) • Health plan applications due (Feb-March 2013) • Apparently successful bidder identified (July 2013) • Readiness review (Aug-Sept 2013) • Contracts signed (Sept 2013) • Enrollment begins (Oct 2013) • Coverage begins (Jan 2014) 	<ul style="list-style-type: none"> • Identification of barriers to integration (thru Dec 2012) • Potential for agency request legislation (Fall 2012) • Recommended changes to structures, contracts, etc. (Fall/winter 2012) • RFP development for Medicare and Medicaid medical (Sept-Oct 2012) • RFP issued for Medicare and Medicaid integrated services (Nov 2012) • Health Plans submit letter of intent (Nov 2012) • Health plan applications due (Feb-March 2013) • Apparently successful bidder identified (July 2013) • Readiness review (Aug-Sept 2013) • Contracts signed (Sept 2013) • Enrollment begins (Oct 2013) • Coverage begins (Jan 2014)

Appendix B: County Medicaid Eligibility by Dual Status

County representation of dually eligible persons varies dramatically. It is further reason to move with a multiple model implementation in order to allow local level systems to adapt infrastructure.

Medicaid Eligibility by Dual Status, Age Group and County
December-2010

	Age < 55			Age >= 55		
	non-Dual	Dual	Total	non-Dual	Dual	Total
Missing County	53	0	53	6	0	6
Adams	5,831	71	5,902	46	233	279
Asotin	3,532	231	3,763	106	352	458
Benton	28,662	861	29,523	591	1,586	2,177
Chelan	13,830	394	14,224	309	941	1,250
Clallam	9,665	487	10,152	426	826	1,252
Clark	61,696	1,984	63,680	1,541	4,549	6,090
Columbia	617	39	656	23	96	119
Cowlitz	19,776	793	20,569	713	1,237	1,950
Douglas	6,313	148	6,461	91	331	422
Ferry	1,425	79	1,504	97	109	206
Franklin	19,930	293	20,223	293	817	1,110
Garfield	254	12	266	12	46	58
Grant	21,811	506	22,317	445	1,229	1,674
Grays Harbor	13,247	637	13,884	576	1,162	1,738
Idaho	63	2	65	0	0	0
Island	6,290	244	6,534	189	497	686
Jefferson	2,996	139	3,135	167	300	467
King	184,520	7,504	192,024	9,473	23,722	33,195
Kitsap	26,013	1,370	27,383	960	2,344	3,304
Kittitas	4,389	152	4,541	115	300	415
Klickitat	3,511	147	3,658	162	233	395
Lewis	14,356	677	15,033	490	1,172	1,662
Lincoln	1,268	45	1,313	40	103	143
Mason	9,218	399	9,617	394	606	1,000
Okanogan	9,335	303	9,638	361	779	1,140
Oregon	70	1	71	3	5	8
Other	174	1	175	3	8	11
Pacific	3,138	178	3,316	184	381	565
Pend Oreille	2,367	108	2,475	149	198	347
Pierce	112,254	4,591	116,845	3,675	8,546	12,221
San Juan	1,088	33	1,121	45	87	132
Skagit	19,526	615	20,141	614	1,242	1,856
Skamania	1,376	43	1,419	60	101	161
Snohomish	79,184	2,852	82,036	2,700	7,186	9,886
Spokane	77,001	3,743	80,744	2,486	5,847	8,333
Stevens	7,947	327	8,274	312	651	963
Thurston	29,072	1,502	30,574	940	2,223	3,163
Wahkiakum	505	23	528	24	48	72
Walla Walla	9,047	364	9,411	221	850	1,071
Washington Other	5	0	5	0	0	0
Whatcom	24,910	1,187	26,097	916	2,141	3,057
Whitman	3,121	152	3,273	86	316	402
Yakima	67,001	1,581	68,582	1,307	3,990	5,297
STATEWIDE	906,387	34,818	941,205	31,351	77,390	108,741
STATEWIDE DUAL-ELIGIBLE		34,818			77,390	112,208

Appendix C: Lessons Learned from earlier Integrated/Capitated Models of Care

Lessons learned in operating fully financially integrated capitated programs: Washington Medicaid Integration Project (Snohomish County), Medicaid Medicare Integration Project (King and Pierce Counties), Disability Lifeline (statewide), and other states

WA State has been operating financially integrated programs of care for over ten years. Through these projects, much has been learned about integrated service delivery, necessary contract requirements, accountability measures and monitoring requirements, and the capacity and expertise needed by accountable entities that deliver these services. The state will take what has been learned through its direct experience as well as the experience of other states in integrating care through a single capitation and apply it in contracting with managed care organizations (MCO) to provide fully integrated care.

- a. ***Develop standards for care management and coordination designed to be responsive to diversity in population complexity and needs of target populations:*** The state has developed health home criteria and contract language requirements for care coordination and health home services for individuals with special health care needs to address this lesson.
- b. ***Ensure that those clients who need assistance in coordinating their care are screened, have a comprehensive integrated plan of care and that the plan of care is monitored on a routine basis:*** The state has developed standards for completion of health risk assessments and health action plans that utilize evidence based tools and protocols. The managed care organization will be required to develop an integrated health plan of care for individuals who receive medical and at least one other service delivered through the managed care organization such as behavioral health and long term services and supports.
- c. ***Integrate service delivery at the community level, rather than at the MCO level, to meet the needs of individuals with complex needs:*** Health home standards have been developed with the intent of creating community based integrated care teams at the service delivery level. Strategies will be developed and implemented that ensure confidentiality requirements will be met through contract language and training activities.
- d. ***A solid care transition program is essential to program success:*** The state has developed care transitions standards as part of health home qualifications and contract language to ensure effective care transitions.
- e. ***Integrated programs need sufficient enrollment to allow for evaluation and sustainability.*** Auto-enrollment including lock-in should be used with appropriate consumer protections to provide time for enrollees to make fully informed decisions. CMS is now willing to allow passive enrollment into integrated managed care and WA will pursue a 90-day retention period during which the enrollee must stay enrolled in the managed care organization and the MCO must ensure continuity of care.
- f. ***Capitation rate cells need to be blended and risk adjusted to capture the full set of services provided by the managed care organization.*** The state should pay a single rate for individuals with or without a disability and for those living in an institution or a community-based setting. This gives the managed care entity incentives to provide services in the community and reduces administrative complexity.
- g. ***Benchmarks must be established to know whether community based care options are being offered and prioritized for enrollees.*** The state will create measurements and contract expectations to ensure that enrollees are provided with community based options and to compare utilization

patterns between managed care and fee for service, where available. Contract requirements will ensure enrollees are able to self-direct their care when appropriate including the ability to hire/fire Individual Providers.

- h. ***The managed care entity must be at full risk for the continuum of services provided to a population. The ability to shift risk or incentive institutional care must be minimized.*** The MCO will be at full risk for nursing home, psychiatric hospitalizations and residential treatment for mental health and chemical dependency services.
- i. ***MCOs must have an active relocation and diversion program to ensure enrollees can move from institutional care to community based settings.*** This will be a contract expectation and measures will be developed.
- j. ***The state must have the administrative capacity to hold plans accountable to contract expectations and outcomes.*** This will be part of the state's readiness review criteria.
- k. ***Contracts must include incentives and withholds/penalties that will be used to ensure performance of the managed care organizations.*** The state has developed performance based contracts for MCOs and will continue to use carrots and sticks in contracting practices with MCOs.
- l. ***Enrollment should not be limited to a particular age group or eligibility group:*** Some services will be carved out to allow time to work with stakeholders and managed care organizations to determine whether additional services should be carved in over time.
- m. ***Integration must be a high priority at both the federal and state levels:*** CMS has created the Duals Coordination Office to serve as a focal point for integrating care for individuals who are dually eligible. The Coordination office has some legislative mandated authority within Medicare to support innovation. WA's dual innovation grant is jointly governed by the Health Care Authority and the Department of Social and Health Services. Both agencies are committed to improving integration for individuals who receive services from both Medicare and Medicaid.
- n. ***States must design their programs to demonstrate access, quality, satisfaction and cost effectiveness:*** Contracts will contain key goal statements, with corresponding process, quality and cost outcome measures identified at the program, MCO, provider group and consumer level. The evaluation of the demonstration project will be broader than the key elements as identified in the contract, including areas which are of policy importance, such as impact on homelessness.
- o. ***There must be mechanisms to share savings between the federal and state governments.*** The state is not in a position of subsidizing or front-funding Medicare in this demonstration, but will work with CMS to devise reasonable mechanisms for sharing savings.
- p. ***Administrative requirements must be streamlined between Medicare and Medicaid:*** CMS and the state are committed to developing a single set of administrative requirements for integrated Medicare/Medicaid programs. CMS has issued guidance for states and MCOs outlining how streamlining will occur.
- q. ***Enrollment process must be automated to the extent possible:*** The state will work to automate and reduce administrative burden associated with enrollment, disenrollment, payment, etc.
- r. ***Integrated Care must be supported by the community in which these programs are developed:*** The state will work with communities involved to implement integrated managed care programs consistent with budget proviso language.

- s. ***Enrollees must have access to critical provider networks:*** The state is committed to a thorough readiness review and will not enroll participants unless and until the managed care organization demonstrates an adequate provider network. Sufficient resources for evaluation and enrollee satisfaction need to be available for objective assessment of the success and lessons learned from the demonstration. Contracts with managed care plans need to clearly identify in one section the key performance goals, measures related to those goals, and the reporting requirements for each of the key measures, rather than having goals, measures and reporting dispersed without connection throughout the contract.

Appendix D: The PRISM Risk Scoring Algorithm and Duals Population Risk Profile

PRISM risk scores are derived from the diagnosis-based Chronic Illness and Disability Payment System¹ (CDPS) and pharmacy-based Medicaid-Rx² risk models developed by Rick Kronick and Todd Gilmer at the University of California at San Diego. These risk models were developed specifically for Medicaid populations, are freely licensed for non-commercial uses, and have been shown in a series of actuarial studies to perform well relative to commercially available alternatives. The software necessary to implement these risk models is freely available for download from UC San Diego, including the core files that group diagnoses and national drug codes into risk groups.³

PRISM uses a prospective hybrid risk model that combines the risk categories that comprise the CDPS and Medicaid-Rx models. The prospective risk score is a measure of expected future medical costs on a per-member-per-month (PMPM) basis, relative to the average for the population used for calibration. Prior service data are used to forecast the client's relative PMPM expenditures over the following 12-month period. A score of 1.5 indicates the client is expected to have medical expenditures over the following 12 months that are 50 percent higher than the population average on a per member per month basis.

Risk weights will be developed specifically for dual eligibles using four years of integrated Medicaid data and Medicare National Claims History data. Population-specific recalibration of risk weights is critical to producing accurate predictive risk models. Tools calibrated to commercial populations have been found to be much less accurate in predictive high-risk clients in Medicaid populations.

The tables that follow provide a detailed listing of the risk categories that comprise the CDPS and Medicaid-Rx models, along with the prevalence of these risk factors derived from integrated Medicare and Medicaid medical and behavioral health claims and encounter data. Prevalence data are presented for Disabled and Elder full-benefit duals in SFY 2010. All clients with at least one coverage month in SFY 2010 are included in the analysis.

Note that the CDPS model uses hierarchical unduplication within disease categories. This means that a patient is counted only once per disease category if they are diagnosed with multiple "levels" of a disease condition. For example, a patient who is diagnosed with both congestive heart failure and hypertension is flagged only in the "cardiovascular medium" category for purposes of risk scoring and in the tables in this appendix.

All disease conditions that build toward the CDPS risk groups have a statistically significant association with future health care costs. The use of descriptive labels such as "high", "medium" or "low" is meant to signify the relative magnitude of the association of the condition group to future costs, and is not meant to diminish the clinical importance of the conditions that are grouped into a "low" risk group. Also note that the sample diagnoses and drug descriptions do not necessarily represent an exhaustive listing of the risk group.

In a separate appendix we provide data showing the effectiveness of CDPS and Medicaid-Rx risk scores in identifying clients who are at highest risk of experiencing poor health outcomes associated with high inpatient and ER/ED utilization. Research has shown that targeting high-risk patients is a key element of effective care management interventions, and risk scores provide a powerful tool in this regard.⁴

¹ For more information about the CDPS, see Kronick R, Gilmer T, Dreyfus T, et al. Improving health-based payment for Medicaid beneficiaries: CDPS. *Health Care Fin Rev* 2000; 21:29-64.

² For more information about the Medicaid-Rx system, see Gilmer T, Kronick R, Fishman P, et al. The Medicaid Rx Model: Pharmacy-based risk adjustment for public programs. *Med Care* 2001; 39:1188-1202.

³ CDPS and Medicaid-Rx tools are available for download at: <http://cdps.ucsd.edu/>

⁴ For example, Mathematica's evaluation of the Medicare Coordinated Care Demonstration emphasizes the key role of targeting in effective care management interventions. The March 2011 report is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Schore_Fourth_Eval_MCCD_March_2011.pdf

Profile of persons with at least 1 month of Dual Medicaid/Medicare enrollment in FY 2010

Derived from integrated Medicare and Medicaid medical and behavioral health claims and encounter data

TABLE 1. Diagnoses

BY CDPS DISEASE GROUP	SAMPLE DIAGNOSES	ELDERS		DISABLED	
		Total #	Percent	Total #	Percent
Cancer, very high	Pancreatic cancer, secondary malignant neoplasms	1,537	2.1%	601	1.0%
Cancer, high	Lung cancer, ovarian cancer	1,997	2.7%	1,018	1.7%
Cancer, medium	Mouth, breast or brain cancer, malignant melanoma	935	1.2%	445	0.7%
Cancer, low	Colon, cervical, or prostate cancer, carcinomas in situ	3,835	5.1%	1,247	2.1%
Cardiovascular, very high	Heart transplant status/complications	702	0.9%	1,120	1.9%
Cardiovascular, medium	Congestive heart failure, cardiomyopathy	16,893	22.5%	4,741	7.9%
Cardiovascular, low	Endocardial disease, myocardial infarction, angina	18,819	25.1%	7,912	13.3%
Cardiovascular, extra low	Hypertension	20,538	27.4%	13,480	22.6%
Cerebrovascular, low	Intracerebral hemorrhage, precerebral occlusion	7,963	10.6%	2,497	4.2%
CNS, high	Quadriplegia, amyotrophic lateral sclerosis	536	0.7%	1,422	2.4%
CNS, medium	Paraplegia, muscular dystrophy, multiple sclerosis	1,698	2.3%	3,671	6.2%
CNS, low	Epilepsy, Parkinson's disease, cerebral palsy, migrane	17,128	22.9%	12,034	20.2%
DD, medium	Severe or profound mental retardation	155	0.2%	783	1.3%
DD, low	Mild or moderate mental retardation, Down's syndrome	349	0.5%	2,256	3.8%
Diabetes, type 1 high	Type 1 diabetes with renal manifestations/coma	208	0.3%	535	0.9%
Diabetes, type 1 medium	Type 1 diabetes without complications	2,309	3.1%	2,282	3.8%
Diabetes, type 2 medium	Type 2 or unspecified diabetes with complications	5,643	7.5%	2,820	4.7%
Diabetes, type 2 low	Type 2 or unspecified diabetes w/out complications	19,007	25.4%	9,260	15.5%
Eye, low	Retinal detachment, choroidal disorders	1,307	1.7%	735	1.2%
Eye, very low	Cataract, glaucoma, congenital eye anomaly	18,698	24.9%	5,937	9.9%
Genital, extra low	Uterine and pelvic inflammatory disease, endometriosis	6,166	8.2%	3,268	5.5%
Gastro, high	Peritonitis, hepatic coma, liver transplant	1,418	1.9%	1,354	2.3%
Gastro, medium	Regional enteritis and ulcerative colitis, enterostomy	3,366	4.5%	4,016	6.7%
Gastro, low	Ulcer, hernia, GI hemorrhage, intestinal infectious disease	17,814	23.8%	11,744	19.7%
Hematological, extra high	Hemophilia	34	0.0%	40	0.1%
Hematological, very high	Hemoglobin-S sickle-cell disease	0	0.0%	20	0.0%
Hematological, medium	Other hereditary hemolytic anemias, aplastic anemia	1,355	1.8%	1,367	2.3%
Hematological, low	Other white blood cell disorders, other coagulation defects	3,106	4.1%	1,980	3.3%
AIDS, high	AIDS, pneumocystis pneumonia, cryptococcosis	113	0.2%	1,047	1.8%
Infectious, high	Staphylococcal or pseudomonas septicemia	105	0.1%	129	0.2%
HIV, medium	Asymptomatic HIV infection	361	0.5%	313	0.5%
Infectious, medium	Other septicemia, pulmonary or disseminated candida	4,131	5.5%	2,384	4.0%
Infectious, low	Poliomyelitis, oral candida, herpes zoster	2,699	3.6%	3,984	6.7%
Metabolic, high	Panhypopituitarism, pituitary dwarfism	1,460	1.9%	1,813	3.0%
Metabolic, medium	Kwashiorkor, merasmus, and other malnutrition, parathyroid	9,693	12.9%	6,058	10.2%
Metabolic, very low	Other pituitary disorders, gout	3,969	5.3%	1,610	2.7%
Psychiatric, high	Schizophrenia	5,417	7.2%	9,755	16.3%
Psychiatric, medium	Bipolar affective disorder	1,845	2.5%	4,616	7.7%
Psychiatric, medium low	Recurrent major depressive disorder	5,956	7.9%	9,820	16.5%
Psychiatric, low	Other depression, panic disorder, phobic disorder	13,832	18.5%	6,410	10.7%
Pulmonary, very high	Cystic fibrosis, lung transplant, tracheostomy status	1,751	2.3%	1,010	1.7%
Pulmonary, high	Respiratory arrest or failure, primary pulmonary hypertension	667	0.9%	295	0.5%
Pulmonary, medium	Other bacterial pneumonias, chronic obstructive asthma	11,108	14.8%	5,569	9.3%
Pulmonary, low	Viral pneumonias, chronic bronchitis, asthma, COPD	13,729	18.3%	11,206	18.8%
Renal, extra high	Infection due to peritoneal dialysis catheter	854	1.1%	1,513	2.5%
Renal, very high	Chronic renal failure, kidney transplant status/complications	9,533	12.7%	2,767	4.6%
Renal, medium	Acute renal failure, chronic nephritis, urinary incontinence	536	0.7%	597	1.0%
Renal, low	Kidney infection, kidney stones, hematuria, urethral stricture	17,344	23.1%	8,777	14.7%
Skeletal, medium	Chronic osteomyelitis, aseptic necrosis of bone	7,580	10.1%	6,045	10.1%
Skeletal, low	Rheumatoid arthritis, osteomyelitis, systemic lupus	15,434	20.6%	9,312	15.6%
Skeletal, very low	Osteoporosis, musculoskeletal anomalies	4,742	6.3%	4,834	8.1%
Skin, high	Decubitus ulcer	3,641	4.9%	1,646	2.8%
Skin, low	Other chronic ulcer of skin	2,670	3.6%	1,780	3.0%
Skin, very low	Cellulitis, burn, lupus erythematosus	7,367	9.8%	8,228	13.8%
Substance abuse, low	Drug abuse, dependence, or psychosis	941	1.3%	5,019	8.4%
Substance abuse, very low	Alcohol abuse, dependence, or psychosis	1,476	2.0%	3,622	6.1%
TOTAL BENEFICIARIES		74,944		59,677	

HOW TO INTERPRET THIS TABLE: Chronic disease conditions were identified by applying the Chronic Illness and Disability Payments System (CDPS) to clients' fee-for-service medical claims in FY 2005. Counts are hierarchically unduplicated within the disease group. For example, a client with diagnoses of schizophrenia and depression will be counted only once in the "Psychiatric, high" category. Thus, percentages can be added within a disease category (e.g., Psychiatric) to produce the unduplicated percentage of clients in that disease category. Clients with diagnoses in multiple categories (e.g., Cardiovascular and Psychiatric) will be counted once in each broad category represented in their medical claims diagnoses. For more information about the CDPS, see Kronick R, Gilmer T, Dreyfus T, et al. Improving health-based payment for Medicaid beneficiaries: CDPS. Health Care Fin Rev 2000; 21:29-64.

Profile of persons with at least 1 month of Dual Medicaid/Medicare enrollment in FY 2010

Derived from integrated Medicare and Medicaid medical and behavioral health claims and encounter data

TABLE 2. Prescriptions

BY MEDICAID-Rx PHARMACY GROUP	SUMMARY DRUG DESCRIPTIONS	ELDERS		DISABLED	
		Total #	Percent	Total #	Percent
Alcoholism	Disulfiram	21	0.0%	149	0.2%
Alzheimers	Tacrine	7,720	10.3%	523	0.9%
Anti-coagulants	Heparins	7,543	10.1%	2,885	4.8%
Asthma/COPD	Inhaled glucocorticoids, bronchodilators	17,568	23.4%	15,342	25.7%
Attention Deficit	Methylphenidate, CNS stimulants	407	0.5%	1,973	3.3%
Burns	Silver Sulfadiazine	1,089	1.5%	801	1.3%
Cardiac	Ace inhibitors, beta blockers, nitrates, digitalis, vasodilators	55,194	73.6%	26,882	45.0%
Cystic Fibrosis	Pancrelipase	849	1.1%	448	0.8%
Depression / Anxiety	Antidepressants, antianxiety	33,126	44.2%	33,594	56.3%
Diabetes	Insulin, sulfonylureas	19,995	26.7%	11,064	18.5%
EENT	Anti-infectives for EENT related conditions	17,572	23.4%	11,898	19.9%
ESRD / Renal	Erythropoietin, Calcitriol	2,044	2.7%	1,816	3.0%
Folate Deficiency	Folic acid	2,377	3.2%	1,546	2.6%
Gallstones	Ursodiol	47	0.1%	132	0.2%
Gastric Acid Disorder	Cimetidine	32,064	42.8%	21,659	36.3%
Glaucoma	Carbonic anhydrase inhibitors	5,631	7.5%	1,239	2.1%
Gout	Colchicine, Allopurinol	3,808	5.1%	1,202	2.0%
Growth Hormone	Growth hormones	12	0.0%	23	0.0%
Hemophilia/von Willebrands	Factor IX concentrates	0	0.0%	12	0.0%
Hepatitis	Interferon beta	69	0.1%	164	0.3%
Herpes	Acyclovir	1,569	2.1%	2,346	3.9%
HIV	Antiretrovirals	98	0.1%	939	1.6%
Hyperlipidemia	Antihyperlipidemics	34,037	45.4%	17,232	28.9%
Infections, high	Aminoglycosides	747	1.0%	670	1.1%
Infections, medium	Vancomycin, Fluoroquinolones	23,747	31.7%	17,482	29.3%
Infections, low	Cephalosporins, Erythromycins	27,913	37.2%	24,808	41.6%
Inflammatory /Autoimmune	Glucocorticosteroids	10,101	13.5%	8,948	15.0%
Insomnia	Sedatives, Hypnotics	6,369	8.5%	7,784	13.0%
Iron Deficiency	Iron	5,159	6.9%	2,901	4.9%
Irrigating solution	Sodium chloride	304	0.4%	250	0.4%
Liver Disease	Lactulose	916	1.2%	572	1.0%
Malignancies	Antineoplastics	2,476	3.3%	1,181	2.0%
Multiple Sclerosis / Paralysis	Baclofen	6,450	8.6%	13,695	22.9%
Nausea	Antiemetics	8,843	11.8%	7,431	12.5%
Neurogenic bladder	Oxybutin	6,120	8.2%	3,426	5.7%
Osteoporosis / Pagets	Etidronate/calcium regulators	11,256	15.0%	2,540	4.3%
Pain	Narcotics	32,879	43.9%	30,479	51.1%
Parkinsons / Tremor	Benzotropine, Trihexyphenidyl	4,427	5.9%	4,729	7.9%
PCP Pneumonia	Pentamidine, Atovaquone	485	0.6%	849	1.4%
Psychotic Illness / Bipolar	Antipsychotics, lithium	9,917	13.2%	16,285	27.3%
Replacement solution	Potassium chloride	1,572	2.1%	1,064	1.8%
Siezure disorders	Anticonvulsants	12,493	16.7%	18,959	31.8%
Thyroid Disorder	Thyroid hormones	13,535	18.1%	7,965	13.3%
Transplant	Immunosuppressive agents	228	0.3%	591	1.0%
Tuberculosis	Rifampin	211	0.3%	207	0.3%
		74,944		59,677	

HOW TO INTERPRET THIS TABLE: Pharmacy groups were identified by applying the Medicaid-Rx system to clients' fee-for-service medical claims in FY 2005. Clients with prescriptions in multiple categories (e.g., Pain and Depression/Anxiety) will be counted in both categories. For more information about the Medicaid-Rx system, see Gilmer T, Kronick R, Fishman P, et al. The Medicaid Rx Model: Pharmacy-based risk adjustment for public programs. Med Care 2001; 39:1188-1202.

Appendix E: Dual Eligible High Risk Beneficiaries by County (June 2010)

	Not High Risk	High Risk	Total	High Risk Percent of Total
Adams	197	131	328	40%
Asotin	347	253	600	42%
Benton	1,545	1,004	2,549	39%
Chelan	870	482	1,352	36%
Clallam	886	446	1,332	33%
Clark	4,172	2,295	6,467	35%
Columbia	84	66	150	44%
Cowlitz	1,230	778	2,008	39%
Douglas	343	182	525	35%
Ferry	138	58	196	30%
Franklin	710	396	1,106	36%
Garfield	19	30	49	61%
Grant	1,070	617	1,687	37%
Grays Harbor	1,033	720	1,753	41%
Island	511	269	780	34%
Jefferson	300	157	457	34%
King	21,502	9,613	31,115	31%
Kitsap	2,370	1,411	3,781	37%
Kittitas	293	151	444	34%
Klickitat	260	118	378	31%
Lewis	1,110	710	1,820	39%
Lincoln	77	79	156	51%
Mason	647	364	1,011	36%
Okanogan	704	354	1,058	33%
Pacific	347	212	559	38%
Pend Oreille	207	114	321	36%
Pierce	8,269	5,100	13,369	38%
San Juan	99	27	126	21%
Skagit	1,220	597	1,817	33%
Skamania	113	47	160	29%
Snohomish	6,694	3,447	10,141	34%
Spokane	6,013	3,639	9,652	38%
Stevens	626	343	969	35%
Thurston	2,494	1,283	3,777	34%
Wahkiakum	52	27	79	34%
Walla Walla	781	473	1,254	38%
Whatcom	2,235	1,170	3,405	34%
Whitman	259	224	483	46%
Yakima	3,668	1,900	5,568	34%
Missing	276	107	383	28%
STATEWIDE	73,771	39,394	113,165	35%

Appendix F: Targeting Health Home Services for High Risk Patients

This appendix discusses the importance of targeting high-touch health home services to high-risk patients. This strategy is informed by state's experience with care management interventions in aged and disabled populations, and by the national literature in this area.

Proposed approach to targeting eligibility for health home services. Our approach is to target eligibility for health home services to clients who meet criteria that indicate they are at significant risk of experiencing poor health outcomes that are associated with hospitalization or use of other costly health care services. A key component of the targeting model is the use of PRISM risk scores with their demonstrated ability to identify clients who are at risk of adverse and costly future health outcomes. The PRISM risk model will be calibrated specifically for dual eligibles based on integrated Medicare and Medicaid health services data. Population-specific recalibration of risk weights is important for producing accurate predictive risk models. Tools calibrated to commercial populations have been found to be much less accurate in identifying high-risk clients in Medicaid populations. The PRISM risk scoring algorithm is derived from the CDPS and Medicaid-Rx tools developed by Rick Kronick and Todd Gilmer at the University of California at San Diego, and described in more detail in a separate appendix.⁵ As we recalibrate the PRISM risk scoring algorithm to dual eligibles, we will explore additional criteria to identify high-opportunity populations for care management. These criteria are likely to include indicators related to medical and psychiatric rehospitalization risk and care transitions from institutional settings (e.g., transitions from a nursing facility to a home or community setting). Along with PRISM risk scores, identification of these additional criteria will also be accessible to health home providers and contracted health plans through the PRISM application. We anticipate that provision will be made for engaging clients in health home services prior to that information becoming available through claims or encounters processed through PRISM, when exigent circumstances emerge such as a hospitalization or transition from a nursing facility to the community.

Lessons Learned from the Medicare Care Coordination Demonstrations. The critical importance of targeting care management interventions toward high-risk, high-opportunity clients is a key finding from Mathematica's evaluation of the Medicare Care Coordination Demonstrations:

"To summarize, neither program met CMS's objectives of cost neutrality or net savings for all of its enrollees during the full six-and-a-half year period examined for this report (April 2002 through September 2008), but the findings were more positive for a subgroup of enrollees at greater risk of hospitalization and high costs."⁶

In other words, the Medicare Care Coordination Demonstrations failed to achieve cost neutrality in part due to failure to adequately target high-risk, high-opportunity populations.

Lessons learned from Washington State's experience. WA State's Chronic Care Management pilots illustrate the potential for health home services targeted to high-risk clients to achieve promising impacts on hospital and nursing facility utilization, mortality, and costs.⁷ These pilots have used a PRISM risk score of 1.5 or above to set the lower limit for eligibility. Unlike the evaluation of the Medicare Care Coordination Demonstrations, these pilots have shown modest net cost savings, along with other key indicators of improved client health outcomes and satisfaction with participation in the program. Given

⁵ For more information about the CDPS, see Kronick R, Gilmer T, Dreyfus T, et al. Improving health-based payment for Medicaid beneficiaries: CDPS. *Health Care Fin Rev* 2000; 21:29-64. For more information about the Medicaid-Rx system, see Gilmer T, Kronick R, Fishman P, et al. The Medicaid Rx Model: Pharmacy-based risk adjustment for public programs. *Med Care* 2001; 39:1188-1202.

⁶ See Jennifer Schore, J et al. Fourth Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration. The March 2011 report is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads//Schore_Fourth_Eval_MCCD_March_2011.pdf

⁷ Mancuso, D and Court, B. *Chronic Care Management Pilots Show Early Promise*. Report to the Medicaid Purchasing Administration, November 2009. Available at: <http://publications.rda.dshs.wa.gov/1396/>

the margin of net savings observed in the care management intervention, lowering the risk threshold for eligibility for health home services would increase the risk that these services will not be found to be cost effective, and therefore would increase the risk that these services would not be sustainable beyond the life of the demonstration project. Identification of additional eligibility criteria will allow individuals at risk of poor health outcomes due to ER usage, hospital admissions/readmissions and transitions from institutional facilities access to health home services for individuals that may not meet the 1.5 PRISM risk score. This will prevent an adverse incentive to allow conditions to deteriorate in order to qualify for needed high touch care coordination if only the risk score criterion is used. The data below illustrate why targeting is critical. The key potential areas of impact of health home services are reductions in unplanned hospital admissions and use of skilled nursing facility services. The table illustrates how the existing PRISM adult risk model (currently calibrated to Medicaid-only SSI recipients) is able to identify from the broader dual eligible population a high-risk subset that is at far greater risk of experiencing inpatient admissions or nursing facility stays. Elderly duals who meet the PRISM risk score criterion of 1.5 or above have average PMPM Medicare expenditures of more than \$2,000 PMPM, including more than \$1,100 in Medicare-paid inpatient and skilled nursing facility costs (Adding Medicaid-paid nursing facility costs would add substantially to this total.) In contrast, lower-risk dual elders have total PMPM Medicare expenditures of only \$334, and combined inpatient and skilled nursing expenditures of only \$86 PMPM. The non-elderly disabled population shows the same degree of extreme stratification in the cost areas that are likely to be impacted by health home interventions.

Table 1. Medicare expenditures on full-benefit duals eligibles in Washington State, SFY 2010

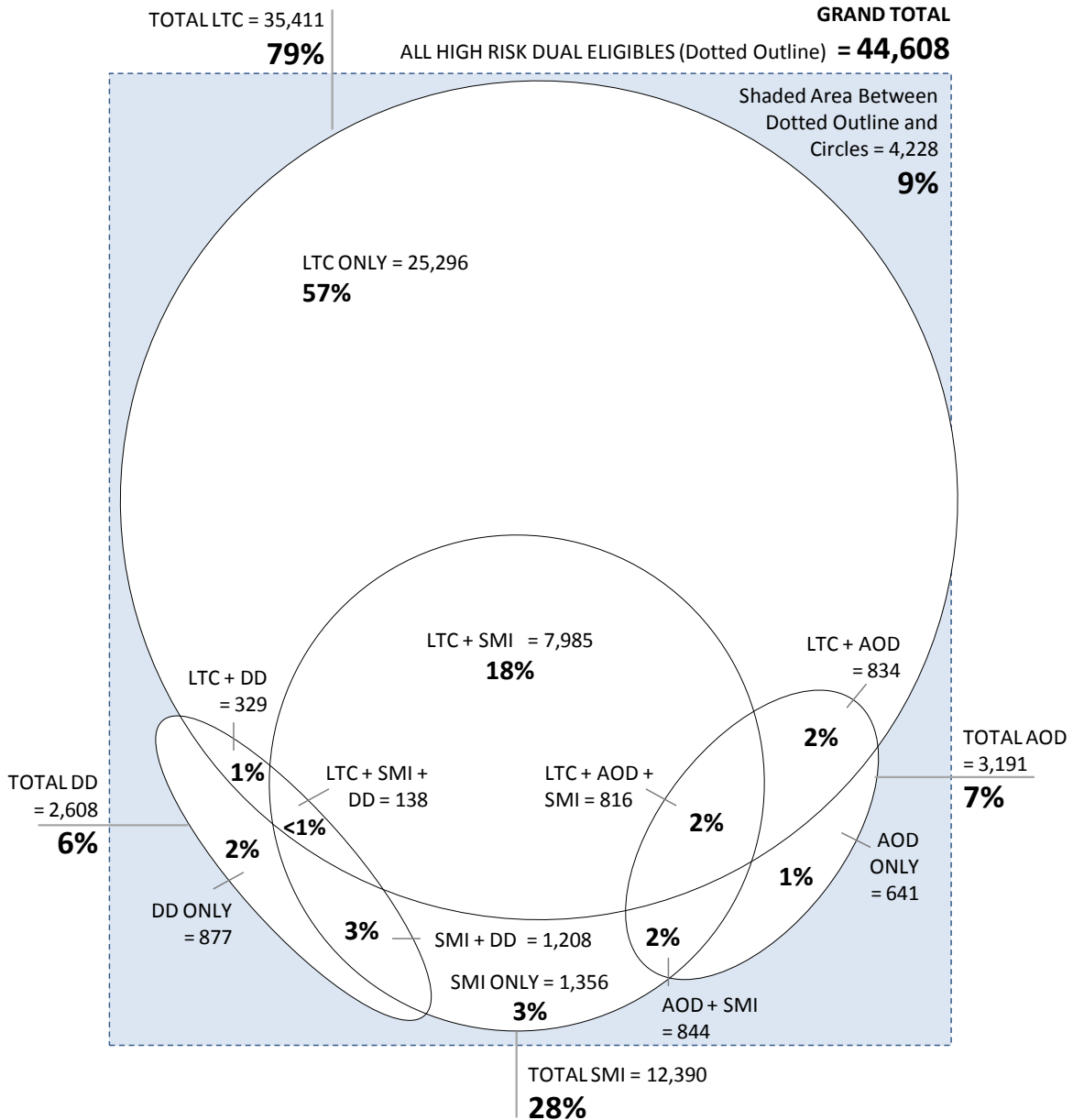
	Medicare Costs Per Member Per Month (PMPM), SFY 2010			
	Excludes Medicaid Expenditures			
	Elders		Disabled	
	Low Risk PRISM Score < 1.5	High Risk PRISM Score >= 1.5	Low Risk PRISM Score < 1.5	High Risk PRISM Score >= 1.5
Total PMPM	\$334	\$2,023	\$357	\$2,371
Inpatient PMPM	\$59	\$809	\$70	\$960
SNF PMPM	\$27	\$339	\$7	\$153
Covered Lives	46,241	28,703	39,560	20,117

This illustrates the reality that extending a high-touch care management intervention to low-risk clients is unlikely to be cost effective because avoidable costs are already so low in this segment of the population. The use of risk models to identify a subset of patients most at risk of experiencing the costly and potentially avoidable adverse health outcomes is therefore essential to our intervention strategies. Note that these data do not yet reflect the re-calibration of PRISM risk weights to the dual eligible population or the potential extension of health home eligibility to include additional criteria related specifically to rehospitalization risk and care transitions. Collectively, these enhancements are likely to lead to even more effective targeting of health home services towards clients most at risk. This will further increase the likelihood that the interventions undertaken through this demonstration project will be found to be cost effective, and therefore the likelihood that these services could be sustained beyond the life of the demonstration project.

The Venn diagram below describes the degree to which the high-risk duals targeted for health home engagement have needs in the areas of long-term services and supports, mental health, substance abuse, and services for the developmentally disabled. The Venn diagram makes the fundamental point that although our current risk scoring algorithm is calibrated primarily to costs that occur in the medical arena, our risk models identify high-risk patients with extensive needs in these other health service areas. This finding points to the importance of involvement of community-based providers of long-term

services and supports, mental health services, substance abuse treatment services, and services for the developmentally disabled in the care management of a majority of the high-risk dual eligible clients.

**Service need and risk factor overlaps among HIGH RISK DUAL ELIGIBLE Aged or Disabled clients
SFY 2009**



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Outcomes Database, January 2012

NOTE: This diagram shows **almost** all the groups with overlapping risk factors. 56 people in the total population of 44,608 persons are not shown on the diagram (though they are included in the group subtotals), because they have combinations of risk factors represented in circles at opposite ends of the diagram. These are the 56 people with both developmental disabilities (DD) and alcohol/drug (AOD) need flags.

Appendix G: Legislative Budget Provisos 2012 Session

In the 2012 session, the WA State Legislature passed Third Engrossed Substitute House Bill 2127 (Operating Budget). In that budget bill is the authority for the state to implement strategy 1 and 2 of the duals design plan. It is anticipated that the Governor will sign the bill making it law on approximately May 2, 2012.

Sec. 213. FOR THE STATE HEALTH CARE AUTHORITY

(50) Within the amounts appropriated in this section, the health care authority and the department of social and health services shall implement the state option to provide health homes for enrollees with chronic conditions under section 2703 of the federal affordable care act. The total state match for enrollees who are dually-eligible for both medicare and medicaid and not enrolled in managed care shall be no more than the net savings to the state from the enhanced match rate for its medicaid-only managed care enrollees under section 2703.

Sec. 201 FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(3)(a) The health care authority and the department are authorized to develop an integrated health care program designed to slow the progression of illness and disability and better manage Medicaid expenditures for the aged and disabled population. Under ((this)) the Washington medicaid integration partnership (WMIP) and the medicare integrated care project (MICP), the health care authority and the department may combine and transfer such medicaid funds appropriated under sections 204, 206, 208, and 213 of this act as may be necessary to finance a unified health care plan for the WMIP and the MICP program enrollment. The WMIP pilot projects shall not exceed a daily enrollment of 6,000 persons, nor expand beyond one county during the 2011-2013 fiscal biennium. The amount of funding assigned from each program may not exceed the average per capita cost assumed in this act for individuals covered by that program, actuarially adjusted for the health condition of persons enrolled, times the number of clients enrolled. In implementing the WMIP and the MICP, the health care authority and the department may: (i) Withhold from calculations of "available resources" as set forth in RCW 71.24.025 a sum equal to the capitated rate for enrolled individuals; and (ii) employ capitation financing and risk-sharing arrangements in collaboration with health care service contractors licensed by the office of the insurance commissioner and qualified to participate in both the medicaid and medicare programs. The health care authority and the department shall conduct an evaluation of the WMIP by October 15, 2012, and of the MICP measuring changes in participant health outcomes, changes in patterns of service utilization, participant satisfaction, participant access to services, and the state fiscal impact.

(b) Effective January 1, 2013, if WA has been selected to participate in phase two of the federal demonstration project for persons dually-eligible for both medicare and medicaid, the department and the authority may initiate the MICP. Participation in the project shall be limited to persons who are eligible for both medicare and medicaid and to counties in which the county legislative authority has agreed to the terms and conditions under which it will operate. The purpose of the project shall be to demonstrate and evaluate ways to improve care while reducing state expenditures for persons enrolled both in medicare and medicaid. To that end, prior to initiating the project, the department and the authority shall assure that state expenditures shall be no greater on either a per person or total basis than the state would otherwise incur. Individuals who are solely eligible for medicaid may also participate if their participation is agreed to by the health care authority, the department, and the county legislative authority.

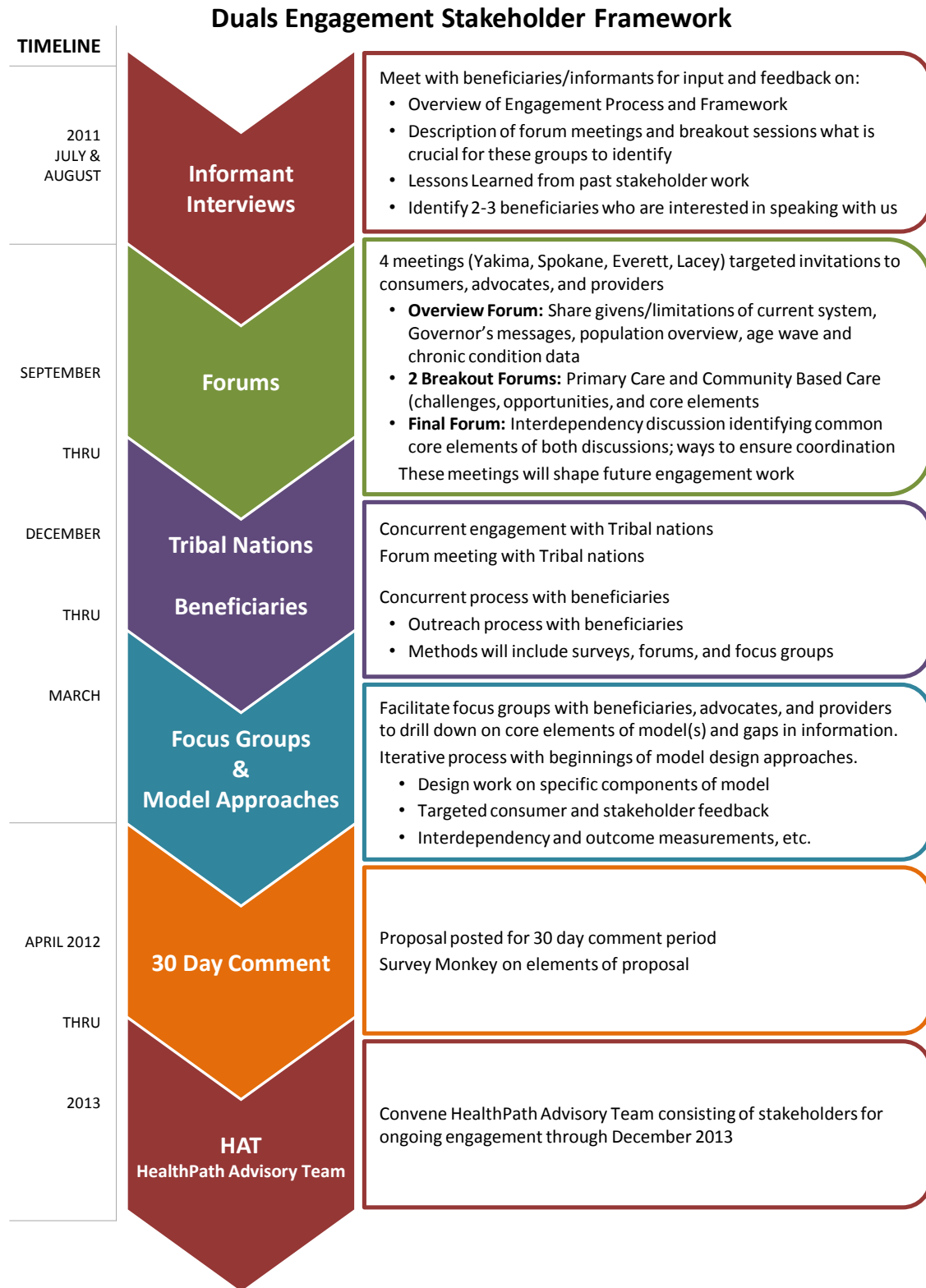
Appendix H: County selection for strategy 2

State specific selection criteria for Medicaid requirements will be issued in approximately November 2012. The document(s) will include detailed requirements including qualifications, demonstrated experience serving the population, description of network adequacy and quality requirements for all services and the model of care. Medicare requirements will be developed by CMS and Medicaid requirements will be developed by the state with an opportunity for stakeholders to provide feedback.

In addition to the detailed procurement requirements, the following will be required:

- Agreement by the county legislative authority.
- Submission of a Notice of Intent to Apply to CMS by deadline they publish;
- Commitment to three-year demonstration contract;
- An ability to begin implementation of full financial integration capitated service delivery in January 2014;
- Local support for integrating medical care, long term services and supports and behavioral health funding and services as follows:
 - Agreement by entities to work collaboratively together to achieve goals of service integration, improved health outcomes, and decreased use of avoidable institutional care;
 - Agreement by contracted entities to provide unbiased information that will support full beneficiary choice in selecting among available services and providers, this is referred to as “conflict free case management”;
- Demonstrate an understanding and commitment to self-management and recovery principles that ensures participant direction is incorporated into the model.
- Demonstrated commitment to person-centered practices that greatly improve the consumer’s experience, health, self -direction and community participation;
- Demonstrated experience in serving dual eligible population;
- Ability to provide culturally appropriate service delivery;
- Commitment to an on-going local stakeholder process including health plans, county based human services providers, community programs, other service providers and interested stakeholders in the implementation and operations of the demonstration project;
- Enrollment is made available to any eligible individual in the county or multi-county area;
- Health Plan is an apparently successful bidder in the completion of a procurement process which will include adequate provider networks, demonstrated readiness to provide mental health, chemical dependency and long term services and supports and meet the diverse needs of the duals population.

Appendix I: Stakeholder Framework



PURPOSE: To inform and engage internal and external feedback to incorporate on an ongoing basis.

July 26, 2011

Appendix J: List of Participants in Engagement Activities



The development of WA State’s design plan involved engaging many beneficiaries, stakeholder groups and government entities. Engagement took place between the months of July 2011 and April 2012. Activities included: Key informant interviews, forums, focus groups, attending standing government community, provider, association and advisory meetings, public webinars, a 30-day comment period and creation of an Advisory Team to help inform ongoing integration activities. The list below includes entities that were involved in any of the engagement activities and is based upon sign-in sheets and documentation of meetings attended.

Beneficiaries

- Over 150 beneficiaries participated in engagement activities. Due to confidentiality, the names of beneficiaries are not listed in the public report.

Advocacy Groups

- AARP
- AARP member (Retired Family Physician)
- Aging Caucus
- ARC of Snohomish County
- ARC of Spokane
- ARC of Washington
- Community Transformation Partnership
- Developmental Disabilities Community Advocacy Coalition
- Developmental Disabilities Parent Coalitions
- Disability Rights Washington
- King County Mental Health Advisory Board
- King County Parent Coalition
- Long Term Care Ombudsman
- Medicaid Expansion Health Home and Chronic Disease Stakeholder Collaborative
- Mental Health Action
- National Association of Mental Illness- Eastside
- National Alliance on Mental Illness – Washington Chapter
- Northwest Health Law Advocates
- Northwest Justice Project
- Senior Citizens Lobby
- State Health Insurance Benefits Advisors
- Traumatic Brain Injury Council
- Washington State Council on Aging
- Washington State Developmental Disabilities Council

Professional Associations/Organizations

- Aging Services of Washington
- Association of Addiction Providers

- Association of Centers for Independent Living
- Association of County Human Services
- Association of Washington Public Hospital Districts
- Association of Washington State Health Care Plans
- Centers for Independent Living
- Community Employment Alliance
- Community Mental Health Provider Council
- Community Protection Providers Association
- Community Residential Services Association
- Home Care Association of Washington
- Pacific Association for Medical Equipment
- PhARMA
- Regional Support Networks of Washington State
- Rural Health Care Association of Washington
- Rural Health Clinic Association of Washington
- SEIU Health Care 775NW
- Washington Home Care Coalition
- Washington Academy of Family Physicians
- Washington Adult Day Services Association
- Washington Association of Area Agencies on Aging
- Washington Association of Community and Migrant Health Centers
- Washington Association of Counties
- Washington Association of Independent Outpatient Programs
- Washington Dental Association
- Washington Health Care Association
- Washington Rural Health Association
- Washington State Association for the Treatment of Opioid Dependence
- Washington State Association of Local Public Health Officials
- Washington State Psychological Association
- Washington State Hospital Association
- Washington State Medical Association
- Washington State Residential Care Council

Community Providers/Contractors

- Asian Counseling and Referral Service
- Beacon
- Behavioral Health Prevention Providers
- Capitol Clubhouse
- Christian Healthcare Center
- Community Employment Alliance
- Comprehensive Mental Health
- Criminal Justice Treatment Account Panel
- Evergreen Club, Spokane Mental Health
- Family Home Care and Hospice
- Frontier Behavioral Health
- Full Life Care

- Garden Village Nursing Facility, Memorial Hospital
- Greater Columbia Behavioral Health
- Independent Services Corporation
- Interfaith Community Health Clinic
- Lake Chelan Community Hospital
- Lutheran Retirement Community
- Living Care Centers
- Medicaid Expansion Leadership Group
- Migrant Health Clinic
- Northwest Kidney Centers
- OneHealthPort
- OptumHealth Pierce County Regional Support Network
- PACE, Providence Health System
- Planned Parenthood Northwest
- Republic Hospital
- Sea Mar
- St Joseph Medical Center
- Vancouver Fire Department
- Warm Beach
- Wenatchee Valley Medical Center
- Yakima Valley Hospital
- Yakima Neighborhood Services

Health Plans

- Amerigroup
- Centene
- Columbia United Providers
- Community Health Plan of Washington
- Coordinated Care
- Group Health Cooperative
- Humana
- Kaiser Foundation Health Plan
- Molina Health Care of Washington
- Regence Blue Shield
- United Healthcare
- Well Point

Health Systems

- Qualis Health
- Multi Care
- Providence
- Whatcom Health Care Alliance
- CHOICE Regional Health Network

Governments/Government Agencies

- American Indian Health Commission of Washington State

- Benton County Human Services
- Department of Health
- Department of Social and Health Services
- Health Care Authority (Medicaid Agency)
- Indian Policy Advisory Committee
- King County Department of Community and Human Services
- Northwest Portland Area Indian Health Board
- Peninsula RSN
- Port Gamble S'Klallam Tribe
- Public Health Seattle and King County
- Public Health and Social Services, Thurston County
- Snohomish Health District
- Spokane County, Community Services , Housing and Community Development Department
- Spokane Regional Support Network
- Washington State Legislature
- Washington Governor's Office
- Washington State Department of Veterans Affairs
- Veterans Administration
- Yakama Nation
- Yakima County Human Services

Appendix K: Designated Advisory Team Participants

HealthPathWashington Advisory Team (HAT)

Purpose: To inform the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA), as the two agencies work to integrate Medicare and Medicaid delivery, financing, technology and human touches experienced by beneficiaries in Washington State who are eligible for both programs.

Organization

AARP
The ARC of Washington State
Service Employees International Union (SEIU)
Individual with National Expertise in Integrated Care
OneHealthPort (Health Information Technology)
Association of Washington State Health Plans

Washington State Association of Local Public Health Officials
Washington Department of Health
Association of County Human Services
Regional Support Network (RSN)
Area Agencies on Aging (AAA)
Community Mental Health Provider Council

Washington Health Care Association
Aging Services Washington

Washington Parent Coalitions

State Council on Aging
Governor's Policy Office
Disability Rights Washington
Washington State Association for the Treatment of Opioid Dependence
Mental Health Action
PACE/Providence Health
Qualis Health
Washington State Medical Association
Developmental Disabilities Council
Beneficiary
Washington State American Indian Health Commission
Port Gamble S'Klallam Tribe
Washington State Hospital Association
Washington Association of Community & Migrant Health Centers

Beneficiary
Beneficiary

Participant

Ingrid J. McDonald
Sue Elliot
Misha Werschkul
Alice Lind
Rick Rubin
Sydney Zvara
Betsy Jones (4.19.12)
Gary Goldbaum, MD, MPH
Anne Shields
Rashi Gupta
Anders Edgerton
Roy Walker
Ann Christian
Gregory Robinson (4.19.12)
Rich Miller
Del Murphy
Paul Montgomery (4.19.12)
Cindy Christianson
Joanne O'Neill (4.19.12)
Marie Raschko-Sokol
Jonathan Seib
David Lord
Ron Jackson, MSW, LICSW
Helen Nilon
Susan Tuller
Selena Bolotin
Katie Kolan
Ed Holden
Aaron Wolfman
Marilyn M. Scott
Edward Fox
Chelene Whiteaker
Mary Looker
Juno Whittaker (4.19.12)
Corinna Fale
TBD

Appendix L: Description of Engagement Activities Conducted to Date:

Key Informant and Informational Meetings (summer and fall 2011)

To begin framing the issues and potential responses from a variety of perspectives, key informants and groups were initially interviewed or participated in informational presentations during the summer and fall of 2011. These included representatives of beneficiaries, provider, staff and advocacy groups at the state and local level representing Mental Health, Chemical Dependency, Aging, Developmental Disabilities, Long Term Care and Labor.

Input on considerations for Native Americans was and is being solicited through presentations and conversations with the American Indian Health Commission (AIHC) and the Indian Policy Advisory Committee for ADSA.

Engagement Forums (fall 2011)

Stakeholder Engagement Forums were held in September 2011 in Lacey, Everett, Yakima and Spokane. In response to invitations to beneficiaries, their families, advocates and providers the forums had 112 participants. Those sessions were iterative and provided attendees the opportunity to discuss and provide input on the key components of an integrated system and consumer protections. As the forums evolved, performance and evaluation measures were explored.

Participants representing a wide array of interests emphasized in the break-out sessions that individual beneficiaries within the duals population have different needs, and that the needs of specific individuals are likely to increase or decrease over a period of time. They noted that any system needs to recognize these differences, allocate limited resources accordingly, and be responsive to individuals transitioning between services and supports as needs vary. For example – while multidisciplinary teams were seen as a key tool for coordination and decision making, participants indicated that not all dual beneficiaries would need such a team. Additional information on the outcomes of these forums can be found at <http://www.adsa.dshs.wa.gov/duals/documents/Duals%20Stakeholder%20Engagement%20Meetings%20September%202011%20Summary.pdf>

Beneficiary Focus Groups (fall 2011 and January 2012)

In October and November 2011, meetings were held with a total of 135 beneficiaries who receive services from both Medicare and Medicaid to discuss their experience in accessing, navigating and receiving services paid for by these two fund sources. Participating beneficiaries represented diverse characteristics across age, ethnicity, race, disability and rural and urban settings. Beneficiaries participating included those who have experienced issues related to homelessness, mental health and recovery, substance abuse, multiple chronic conditions or disabilities and they received a broad array of services. Groups were held throughout the state in both urban and rural locations. Participants were asked to discuss from their perspective what works well in the delivery of their services, what doesn't work well, who they go to when they need help, and what the state can do differently to help them access services. While individual backgrounds and experiences varied and were recognized, there were several common themes that emerged in these discussions.

Beneficiaries shared that the lack of available providers and the short time allotted for provider visits, as well as the lack of coordination between providers, contributed to challenges in navigating the system. These challenges are magnified when having to navigate multiple systems. Many beneficiaries report difficulty in keeping track of the array of workers in each of the service systems they deal with and confusion over the roles and responsibilities of providers/staff within each of these systems. Several reported giving up on the system and only attempting to access care when it is urgent or a crisis. In addition, a number of beneficiaries expressed concern over the inflexibility of the delivery system,

specifically in the responsiveness to health variability and a recognition that people's needs vary and shift and that a "one size" approach to care does not address these needs.

Two follow-up beneficiary focus groups, with representatives from fall focus groups, were held in January 2012. We sought input from beneficiaries on elements of the models including their perspectives on coordinated care, capitated care and language used in outreach and communication. A summary of the beneficiary focus groups can be found at <http://www.adsa.dshs.wa.gov/duals/documents/Duals%20Beneficiary%20Summary.pdf>

Provider Focus Groups (fall 2011)

These groups were held in Seattle, Yakima, Bellingham, Wenatchee and Spokane. They included providers of services for those with aging, mental health, developmental disabilities and chemical dependency issues. There were 48 participants from health centers, hospitals, nursing homes and private, state and local governments. Focus group participants were asked for their input on improving coordination of care, reducing fragmentation, and improving accountability. Combined and individual summaries of these provider focus groups can be found at <http://www.adsa.dshs.wa.gov/duals/stakeholder.htm>

Focus Group with Paid In-home Caregivers

The focus group with individual provider and agency personal care workers and care focused on the role of paid personal care workers in supporting and improving client health outcomes. Due to the daily nature of personal care and the type of services performed, paid caregivers, particularly those with long-term relationships with beneficiaries, are uniquely positioned to support beneficiary health and behavior change goals.

Key Informant Groups Follow-up (January-February 2012)

In January two meetings were held in Olympia with individuals from organizations representing services for aging, mental health, developmental disabilities, chemical dependency, hospital and nursing home associations and labor. These meetings were designed to get feedback on evolving models and to facilitate discussion on key issues or implementation considerations.

In the first meeting key informants were presented with a high level presentation on the proposed models and provided valuable feedback and input that informed contents of the draft design plan. It was determined that it was crucial for these key informants to engage their constituencies in further discussion and so a follow up meeting was scheduled.

Informational Sessions

In addition to the structured focus groups with key informants and beneficiaries, the state capitalized on numerous informational meetings held with our constituents and captured key areas of concern and considerations. Specifically, there is concern that we are faced with providing services for clients with complex and multiple needs in a system that is multifaceted, difficult to navigate and limited in collaboration and coordination. In addition, there is limited information for referral and the lack of a centralized system to facilitate coordination.

30-day Public Comment Period

Public notice of the 30-day public comment period was distributed via email, media, the state's code revisers office and three public webinars. Three public webinars were held to provide an overview of the draft proposal, answer questions about the proposal and to encourage public comment. Information about the webinars as well as the power point presentation used for the meetings can be found at <http://www.adsa.dshs.wa.gov/duals/webinars.htm>. During the public comment period, the state also

reached out to critical stakeholder groups and scheduled meetings with approximately 13 different groups as well as legislative staff. The purpose of these meetings was to answer questions related to the draft and to hear the perspective of these groups on: 1) elements that are critical for support of the proposal; 2) elements that are barriers to support of the proposal; and 3) general feedback to help inform potential revisions to the draft. To assist individuals and groups to better understand the differences and similarities of the state's three strategy approach, a matrix (Appendix A) was created and used during these meetings.

The state received over 200 pages of written comment from over sixty organizations and individuals. The comments received were thoughtful and have informed many of the changes made in the final design plan. In the nine working days between receipt of the comments and submission of the final plan, comments were organized into categories including: 1) general statements for which no change to the draft was requested; 2) questions that the state will work to answer with additional input from stakeholders as more detailed implementation steps are taken; 3) additional clarification and specification considerations for implementation; 4) considerations related to the communications plan; 5) considerations for the consumer protections section; and 6) considerations for changes to the final design plan.

Written comments received during the 30-day public comment period will be posted on the state's website within the next month.

HealthPathWashington Advisory Team (HAT)

In April 2012, the state created the HealthPathWashington Advisory Team (HAT). The first meeting of the HAT took place on April 19, 2012. The purpose of the team is to inform DSHS and the HCA as the two agencies work to implement the integration strategies identified in this document. The team is made up of participants who have expertise in serving individuals who are eligible for both Medicare and Medicaid services with expertise in serving individuals with special needs, those experiencing health disparities, social and geographic isolation and limited English language skills. Team participants represent the broad range of medical, long term services and supports, developmental disabilities, mental health, chemical dependency including experts on health information technology, national integration strategies, tribal service delivery, medical home collaborative and care transitions implementation. There are many implementation details and deliverables that are necessary to successfully implement this demonstration project and the HAT will be utilized to provide feedback on draft documents and materials as the state moves forward. The state's website will be revised to include information about the HAT including participants and agendas/hand-outs used during the meetings.

Appendix M: Consumer Protections

- **Washington State 2012 Legislation - House Bill 2523**
<http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202012/2523.SL.pdf>
- **Washington State Patient Bill of Rights**
http://www.insurance.wa.gov/consumers/health/bill_of_rights.shtml
- **Office of the Insurance Commissioner e-mail regarding Consumer Advocacy**
The Consumer Advocacy Program at the Office of the Insurance Commissioner works with consumers when they have problems with their health insurance. The OIC has a hotline (800 562-6900) consumers can call and eight health analysts on staff to answer questions and investigate complaints. The Program answers 90,000 calls a year and investigates approximately 5,700 complaints. There is extensive information on the web site (www.insurance.wa.gov) about health insurance and an online application where consumers can file complaints against insurers and track our work on their complaints 24/7. Here's the link to the online complaint information: <http://www.insurance.wa.gov/consumers/complaints.shtml>
- When consumers file complaints against insurers, OIC analysts forward them onto the carriers for their responses. Once they have received all the information they need, they evaluate the carrier's handling of the consumer's concern to make sure the company is following the terms of their contract and legal requirements. If not, the company is required to correct their conduct and take care of the consumer's concern. They are also often required to go back to correct any wrong actions against any other consumers who may have been impacted by their errors. Illegal activity is then reported to the OIC enforcement division where further corrective action, including fines, can be imposed.
- The OIC compliance analysts are experts on health insurance law, both on the federal and state level, including filing health plan appeals. The appeals guide was created as part of a 2011 Consumer Assistance grant from HHS using funding made available under federal health care reform. THE OIC helps consumers understand the appeals process and their legal rights. The OIC does a tremendous amount of work with consumers in general, advising them of their legal rights.
- The OIC also has an extensive network of referral resources to send consumers to for any help the OIC cannot provide. The OIC's Consumer Protection Division, which includes both the Consumer Advocacy Program and SHIBA, is the official ombudsman under ACA for consumer assistance in WA State. The Consumer Advocacy Program is a key component of the OIC services to those needing help dealing with their health plans and information regarding their options for shopping for health coverage. • wainsurance.blogspot.com • Twitter: [@WAinsuranceblog](https://twitter.com/WAinsuranceblog) • [Facebook.com/WSOIC](https://www.facebook.com/WSOIC)
 - **Protecting insurance consumers**
Insurance Consumer Hotline 1.800.562.6900

Appendix N: Communication Plan



A System for Communicating to and Engaging People Who are Covered by Medicare & Medicaid in Washington state

Overview

Institutional, cultural and multi-pronged communications challenges face each State that is working to improve the care and health of beneficiaries, while simultaneously innovating, streamlining and coordinating Medicare and Medicaid. While effective outreach and consistent communications will not guarantee program or enrollment success, a program that meets its strategic and enrollment objectives must include a strong system for communicating, engaging and incorporating feedback from a broad swath of beneficiaries, providers, advocates, opinion leaders and policy makers. This communications system takes into consideration the noteworthy cultural and linguistic distinctions among the dual beneficiaries in Washington State.

To make certain that all engaged participants and interested parties – as well as the general public – are able to stay informed about WA state’s **HealthPathWashington** program, the communications system for this project is multi-pronged and based on a set of foundational communications tools and key messages. HealthPathWashington’s communications plan is being coordinated between the Washington State Health Care Authority (HCA), Department of Social & Health Services (DSHS), and Rialto Communications. Rialto has extensive experience at defining and stamping an identity on companies, products and projects in WA State’s health care community. The team members will work closely to ensure we meet the project’s objectives in a methodical, timely and cost-effective manner.

We recognize that a broad array of outreach and enrollment efforts will be important to success – the audiences that we are seeking to engage are hard-to-reach groups from a communications perspective. We believe HealthPathWashington also recognizes that one-on-one support to help participants through the enrollment process will be important, as will engaging existing advocacy organizations to help with the communications and outreach with their constituent base.

The multi-pronged tools and deliverables of the project communications and engagement deliverables include work being conducted in three distinct phases:

- Stage 1: the current grant application phase (through early-April 2012)
- Stage 2: the pre-grant announcement phase (estimated April-June 2012)
- Stage 3: the grant implementation phase (July 2012 and beyond).

More specifically, the attached Communications Timeline provides an initial 23-month schedule for the communications tools and activities that cover February 2012 through January 2014.

Feedback. Beneficiary Engagement. Surveys. Please note that all three stages in WA’s project work are geared toward an appropriate investment of time and resources to actively engage a broad scope of individuals and organizations that are impacted by the innovation envisioned in the WA version of the State Demonstrations. Meetings held across the Evergreen State since mid-2011 have laid the groundwork for creating HealthPathWashington’s Board of Engagement – which is being implemented during the next few months as part of our plan’s Stage 2 scope of work. The Board of Engagement and the feedback from individuals will be augmented by surveys and/or focus group discussions. Online and telephone surveys with beneficiaries will be conducted so that we are able to measure initial baseline metrics of engaged audiences as well as ongoing views once project implementation is underway.

The Communications Plan includes the tools needed for focused outreach to all of our target audiences, as well as the tactics and processes that will allow us to gather data and feedback – and to adjust our program initiatives in response to the data and feedback that is received.

HealthPathWashington’s ramp-up of marketing and implementation activities will require concerted efforts to educate stakeholders, providers and beneficiaries throughout the project. This will include public education and engagement, as well as technical assistance and customer support to beneficiaries, advocacy organizations and health plans. In addition, we have taken care to ensure that additional focus is placed in three key areas that will improve our opportunities for success:

- a) April through September 2012 – County Government Outreach:** During the anticipated timeframe of our proposal’s evaluation by CMS, WA state will be reaching out to a number of county governments and their elected officials (perhaps totaling five to ten counties) to achieve legislative endorsement or resolve in support of our *Strategy Two: Full Capitation through Health Plans*.
- b) September 2012 through December 2013 – Strategy One:** During open enrollment later this year, and throughout the first year of implementation, HealthPathWashington’s *Strategy One: Health Home Services*, will be a significant point of emphasis for our communications and outreach activities.
- c) September 2013 through December 2014 – Strategies Two & Three:** Under our proposal’s timeline, Strategies Two and Three (Full Capitation through Health Plans, and Modernized Consolidated Service Deliver, respectively) will be emphasized during open enrollment during the 3rd and 4th quarters of 2013, and through the first year of implementation.

Some of the critical aspects of the Communications Plan include:

1. The creation and ongoing use of foundational communications materials is the first step. As with any communications effort that establishes a project vision that can be easily understood, a series of basic materials offer everyone an organized platform for common messaging. Foundational materials that are already being used and others that will likely be created during the pre-grant announcement phase include the following:

- ✓ Key Messages
 - ✓ Project Communications Plan & Timeline
 - ✓ Project Name
 - ✓ Fact Sheet
 - Project Terminology One-Pager
 - Project Organizational Diagram
 - ✓ HealthPathWashington Advisory Team Roster
 - ✓ Communications and HAT Engagement Schedule
- (✓) = Now available. (☐) = Coming soon.

2. The project’s name. To provide a memorable ‘handle’ that will be well received by all engaged audiences, the WA program considered dozens of names, descriptors and available website domains. Providing a distinct identity for the integration of Medicare and Medicaid in the Evergreen State takes into consideration the wide range of services that is provided to dually eligible participants, while keeping an eye toward the prospective and broader integration of many other Medicare and Medicaid programs – not just those that cover the ‘duals population’. This approach is consistent with legislation (HB 1738) passed by the State Legislature during 2011.

During the grant application phase we explored more than three-dozen project names that would meet a number of criteria including the following characteristics: Appearance, distinctiveness, depth, energy, positioning, sound, and competitiveness.

HealthPathWashington – along with the availability and potential use of .com and .org domain extensions – provides a visual and geographic context that will be augmented with a project logo and usage guide. For future communications that will need to compete for the attention of consumers who are inundated daily with hundreds of advertising themes/concepts, this is an important tool for public outreach and education that will serve us well.

3. The establishment and maintenance of a website. The project website, located at www.aasa.dshs.wa.gov/duals/, will be used for posting project documentation and will also be our focal point for keeping stakeholders and the public up-to-date with HealthPathWashington announcements. If appropriate, the site can be developed as a standalone online tool for public information, ongoing feedback, online surveys, as well as being a secure site for any transactional purposes.

4. Ongoing communication and public education. Consistent communication with participants is central to keeping the engaged parties aware of the program’s scope as well as the strategies being implemented. These communications will entail announcing HealthPathWashington, reaching out to and engaging individuals to consider participation, coordinating ongoing communications (e.g. in response to feedback or policy decisions by CMS or the State, and generally communicating program details in a methodical and timely manner. When needed to reach specific audiences, some of HealthPathWashington’s materials may be translated into languages other than English, and always will be sensitive to the different cultural backgrounds of beneficiaries and advocacy organizations.

5. Ongoing media monitoring. The monitoring of public statements, news stories, and perhaps enterprise-specific newsletters (e.g. advocacy organizations, insurers, providers, etc.) will help HealthPathWashington understand – beyond the immediate participant engagement responses – the tenor of what is being stated publicly. This component may include periodic updates and summary documents that will be provided to the HealthPathWashington Advisory Team (HAT) as well as the Stakeholder Engagement Workgroup over the course of the project.

6. Strategic re-connect & review meetings. The communications team has created a formalized “strategic re-connect and review” schedule that will make certain that the communications tactics and tools are aligned with HealthPathWashington Washington Advisory Team. This officially organized quarterly meeting is included on the communications timeline to make certain that effective, timely and appropriate project communications and feedback discussion occurs – and that education tools and tactics are responsive to the project needs. Participants of this meeting should include the communications team members from DSHS, HCA and Rialto, as well as the project directors.

7. Project design. The communications and engagement consulting team will develop a project ‘look and feel’ so that the project can be easily identified. This will include developing a logo or visual mark for HealthPathWashington that is used on all online or printed educational materials. If needed, the mark will incorporate the logos of DSHS and HCA, so that participants and others recognize the ‘authority’ of the state agencies behind the project. Over time, the materials’ familial look will be supported with methodical messaging and explanations that provide easy to understand, non-jargon-filled descriptions for our intended audiences.

8. Public outreach: focus and tools. As HealthPathWashington’s details are finalized with CMS, the communications team will be able to more definitively spell out the precise outreach materials/tools that will be needed to drive a strong communications effort. The communications materials will strive to answer some of the following questions:

- What is HealthPathWashington all about?
- Who qualifies and how can qualified people participate?
- How do I choose a plan that is right for me and how do I enroll?
- What are the incentives, features and benefits for participation?
- What happens if I enroll and then determine that it is not what I need or want?
- How does this project fit with Federal and State health care reform efforts?

Among the documents, materials or tools that will be created, we will consider many of the items from the following menu that would be compiled into our project communications tool kit:

- Fact Sheets
- Direct mail or direct e-mail (HTML)
- Posters
- Newsletters
- Flyers
- Website content
- Brochure
- On hold messaging
- Scripts for surveys
- Robo calls
- News releases
- Print, electronic & outdoor advertising
- Bylined articles

9. **Flexibility.** Finally, the communications system allows for methodical implementation as well as changes to meet the unexpected – whether because of good news or not-so-good news. We should be well prepared to handle news media inquiries and respond in an informed manner with a steady hand. This preparation might include questions about the project, methodologies, or processes. For both positive and negative stories, we will work hand-in-hand with HCA and DSHS to make decisions about the value or need to respond – or perhaps use selected quotes from these stories as illustrative vignettes in outreach efforts.

10. Coordination with the HealthPathWashington Advisory Team (HAT). The state agencies with shared governance of HealthPathWashington have already created an advisory team that will meet on a regular basis throughout the next 24 months. The purpose of the HAT is to inform the Department of Social & Health Services (DSHS) and the Health Care Authority (HCA) as the two agencies work to integrate the delivery, financing, technology and human touches experienced by beneficiaries in WA State who are eligible for both Medicare and Medicaid.

The communications plan will work with the HAT to make certain that educational and outreach materials are useful, relatively easy to understand, and that they are used to communicate to the right audiences in the most efficient manner.

A membership list of the HAT is provide in the proposal’s appendix.

Conclusion

The communications approach for HealthPathWashington must help de-mystify or simplify what can be highly complex systems and processes. The complexity is compounded when simultaneously coordinating and streamlining Medicare and Medicaid systems and processes; even more so when the cultures and languages of beneficiaries are diverse and broad. Purely focusing on public education and communications prior to or during open enrollment will be necessary, but as the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured stated, *“preparing for (health care reform) will entail a significant organizational and cultural shift.”*

Achieving this organizational and cultural shift requires leadership, resolve, and consistent and compelling communications.

Appendix O. Communication Timeline

2012 HealthPathWashington: Communications Timeline	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Stage 1: Grant Application Phase												
Initial Planning Session												
Strategic Brief & Key Messages												
Naming, Fact Sheets, etc.												
Communications Plan												
Logo or Project Design												
Public Comment												
Stage 2: Pre-Grant Decision Phase												
Logo or Project Design Style Guide												
Website: Strategic Direction and Concepts												
Website: Development & Launch* (OPTIONAL)								LAUNCH				
PowerPoint & Letterhead Template												
Advisory Team (HAT): ID, Appoint, Hold Kick-Off												
Stage 3: Community Outreach and Education												
Identify opportunities / audiences												
Stakeholder Periodic Meetings		AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED
Outreach Toolkit												
Quarterly Newsletter					IF NEEDED	POSSIBLY						
Coordinated Campaign: Posters, direct mail, brochure, fact										OPEN ENROLLMENT	OPEN ENROLLMENT	OPEN ENROLLMENT
Surveys: Feedback & Improvement Process								AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED
Paid Media: Advertising- online, print, outdoor, broadcast (OPTIONAL)									OPTIONAL	OPTIONAL	OPTIONAL	
Earned Media: publications												
Additional outreach for Strategy 1												
Outreach to County Governments for Strategy 2												
Additional outreach for Strategy 3												
Advocacy: Partnering with business, organizations, etc.												
Stage 4: Marketing Materials												
Outreach Toolkit												
Fact Sheet / Backgrounder												
Direct Mail												
Brochure												
Poster												
Website: Updating and Enhancement				AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED
Internal Strategic Re-Connect & Review Meetings												
Website Development & Launch												
Site architecture and wire frames												
Design development & content creation												
Design implementation												
Programming & implementation of the site												
Training on CMS solution												
Website maintenance				UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE
Additional web capabilities / interactive qualities												
Target Audiences												
Providers, Provider Orgs, Professional Assoc. & County Governments												
Insurers, Health Plans												
Public Policy Decision-Makers												
State, County, Local & Federal Decision-Makers												
Opinion Leaders												
Advocacy Organizations												
Beneficiaries & Participants												
Tribes and Tribal Leaders												
Note: Open Enrollment (approximately Oct. 1 - Dec. 31)												

2013 HealthPath Washington: Communications Timeline	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Stage 1: Grant Application Phase	COMPLETION											
Initial Planning Session												
Strategic Brief & Key Messages												
Naming, Fact Sheet, etc.												
Communications Plan												
Logo or Project Design												
Public Comment												
Stage 2: Pre-Grant Decision Phase	COMPLETION											
Logo or Project Design Style Guide												
Website: Strategic Direction and Concepts												
Website: Development & Launch* (OPTIONAL)												
PowerPoint & Letterhead Template												
Advisory Team (HAT): ID, Appointment, Hold Kick-Off												
Stage 3: Community Outreach and Education												
Identify opportunities / audiences	UPDATE											
Advisory Team (HAT): Periodic Meetings												
Outreach Toolkit	UPDATE	UPDATE										
Quarterly Newsletter												
Coordinated Campaign: Posters, direct mail, brochure, fact sheets, community meetings, statement staffers, etc.										OPEN ENROLLMENT	OPEN ENROLLMENT	OPEN ENROLLMENT
Surveys: Feedback & Improvement Process	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED
Paid Media: Advertising - online, print, outdoor, broadcast (OPTIONAL)										OPTIONAL	OPTIONAL	OPTIONAL
Earned Media: public relations												
Additional outreach for Strategy 1												
Additional outreach for Strategy 2												
Additional outreach for Strategy 3												
Advocacy: Partnering with businesses, organizations, etc.												
Stage 4: Marketing Materials												
Outreach Toolkit	UPDATE											
Fact Sheet / Backgrounder	UPDATE											
Direct Mail	UPDATE											
Brochure	UPDATE											
Poster	UPDATE											
Website	UPDATE											
Internal Strategic Re-Connect & Review Meeting												
*Website Development & Launch	COMPLETION											
Site architecture and wireframes												
Design development & content creation												
Design implementation												
Programming & implementation of the site												
Training on CMS solution												
Website maintenance	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE
Additional web capabilities / interactive qualities	AS NEEDED											
Target Audiences												
Providers, Provider Orgs, Professional Assoc. & County	UPDATE											
Insurers, Health Plans	UPDATE											
Public Policy Decision-Makers	UPDATE											
State, County, Local & Federal Decision-Makers	UPDATE											
Opinion Leaders	UPDATE											
Advocacy Organizations	UPDATE											
Beneficiaries & Participants	UPDATE											
Tribes and Tribal Leaders	UPDATE											

2014 HealthPathWashington: Communications Timeline	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Stage 1: Grant Application Phase	COMPLETED											
Initial Planning Session												
Strategic Brief & Key Messages												
Naming, Fact Sheets, etc.												
Communications Plan												
Logo or Project Design												
Public Comment												
Stage 2: Pre-Grant Decision Phase	COMPLETED											
Logo or Project Design Style Guide												
Website: Strategic Direction and Concepts												
Website: Development & Launch* (OPTIONAL)												
PowerPoint & Letterhead Template												
Advisory Team (HAT): ID, Appoint, Hold Kick-Off												
Stage 3: Community Outreach and Education												
Identify opportunities / audiences												
Advisory Team (HAT): Periodic Meetings												
Outreach Toolkit	UPDATE											
Quarterly Newsletter												
Coordinated Campaign: Posters, direct mail, brochure, fact sheets, community meetings, statement staffers, etc.									OPEN ENROLLMENT	OPEN ENROLLMENT	OPEN ENROLLMENT	
Surveys: Feedback & Improvement Process												
Paid Media: Advertising - online, print, outdoor, broadcast (OPTIONAL)												
Earned Media: public relations												
Advocacy: Partnering with businesses, organizations, etc.												
Stage 4: Marketing Materials												
Outreach Toolkit	UPDATE											
Fact Sheet / Backgrounder	UPDATE											
Direct Mail	UPDATE											
Brochure	UPDATE											
Poster	UPDATE											
Website	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE	UPDATE
Internal Strategic Re-Connect & Review Meetings												
*Website Development & Launch												
Site architecture and wire frames												
Design development & content creation												
Design implementation												
Programming & implementation of the site												
Training on CMS solution												
Website maintenance	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED	AS NEEDED
Additional web capabilities / interactive qualities	AS NEEDED											
Target Audiences												
Providers, Provider Orgs, Professional Assoc. & County Governments	UPDATE											
Insurers, Health Plans	UPDATE											
Public Policy Decision-Makers	UPDATE											
State, County, Local & Federal Decision-Makers	UPDATE											
Opinion Leaders	UPDATE											
Advocacy Organizations	UPDATE											
Beneficiaries & Participants	UPDATE											
Tribes and Tribal Leaders	UPDATE											
Note: Open Enrollment (annually from approximately Oct. 1 -												

Appendix P. Performance Measures

Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
1. Increase Beneficiary Participation and Activation	1a. Increase percent of beneficiaries who do not opt out of the integrated care program by major service need areas including long-term services and supports; mental health and substance use (Retention rate)	Numerator: Number of beneficiaries who stay more than three months in an integrated care program Denominator: Total number of eligible beneficiaries initially enrolled in an integrated care program	Enrollment, eligibility, claims and encounter data	Managed Care Plan
	1b. Increase percent of high-risk health home beneficiaries willing to set a health action goal (Participation Rate)	Numerator: Number of high-risk health home beneficiaries willing to set a care plan goal Denominator: Total number of eligible high-risk health home beneficiaries	Enrollment data; validated in High-risk Client Assessment Database	Managed Care Plan and Health Home
	1c. Increase average PAM score of participating high-risk health home beneficiaries	Numerator: Sum of Patient-Activation Measure (PAM) scores Denominator: Total number of enrolled high-risk health home beneficiaries with baseline PAM score	Beneficiary reported. Insignia PAM database	Health Home
Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
2. Reduce Non-Emergent Emergency Department Visits	2a. Increase percent of high-risk health home beneficiaries who report a primary care provider	CAHPS: A personal doctor is one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?	High-risk Client Assessment Database	Health Home
	2b. Decrease non-emergent Emergency Department visits per 1000 enrolled beneficiary member months	Numerator: Number of non-emergent Emergency Department visits (New York University algorithm or Washington State – developed diagnosis list) Denominator: Total enrolled beneficiary member months/1000	Claims and Encounter data	Managed Care Plan and Health Home

Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
3. Reduce Avoidable Hospital Admissions and Nursing Home Placements	3a. Decrease hospitalization admissions per 1000 beneficiary member months for: - PQI 01- Diabetes, Short-term complications - PQI 15 – Adult Asthma -Overall hospitalization with Emergency Department activity	Numerator: - Admissions for diabetes - Admissions for adult asthma - Admission with emergency department revenue code Denominator: Total enrolled beneficiary member months /1000	Claims and Encounter data	Managed Care Plan and Health Home
	3b. Decrease skilled nursing facility placements per 1000 beneficiary member months	Numerator: Skilled nursing facility placements Denominator: Beneficiary member months /1000	Claims and Encounter data	Managed Care Plan
Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
4. Reduce Hospital Readmissions	4a. Decrease 30 day all-cause readmissions per 1000 enrolled beneficiaries	Numerator: Number of 30 day all cause readmissions Denominator: Health home member months/1000	Claims and Encounter data	Managed Care Plan and Health Home
	4b. Increase percent of hospitalized mentally ill individuals who had a visit with a mental health practitioner within 7 days of discharge	Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Denominator: Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year.	Claims and Encounter data	Managed care Plan and Health Home

Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
5. Improve mental health identification and treatment	5a. Increase percent of enrolled adult high-risk health home clients screened for clinical depression using PHQ-9 (Patient Health Questionnaire)	<p>Numerator: Number of enrolled high-risk health home clients 18 years and older screened for clinical depression using PHQ-9</p> <p>Denominator: Total number of enrolled high-risk health home clients 18 years and older</p>	High-risk Client Assessment Database	Health Home
	5b. Increase performance in Anti-Psychotic Medication Management	Specific measures under consideration	Claims and Encounter Prescription Drug Data	Managed Care Plan
6. Improve initiation and engagement of alcohol and substance use treatment	6a. Increase percent of beneficiaries with initiation and engagement of alcohol and other drug dependence treatment (HEDIS)	<p>Numerator: Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.</p> <p>Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p>Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>	Claims, encounters and High-risk Client Assessment Database	Managed Care Plan and Health Home

Appendix Q: The Medicare Savings Potential

This appendix discusses the potential for the strategies in the state’s design plan to achieve Medicare savings. Because the savings potential under strategy 2 is most straightforward, that model is examined first. The balance of the appendix focuses on the Medicare savings potential of the health home approach, and the importance of strategy 3 as a vehicle for sustaining health homes during this demonstration, after the availability of enhanced federal funding for health home services ends.

Medicare savings potential under strategy 2. Under the fully integrated strategy 2, Medicare and Medicaid savings are built into the capitation structure. The expectation is that a common savings rate would be applied to the actuarially determined expenditure trends for covered Medicare and Medicaid services. Savings actually achieved under strategy 2 will depend on the number of dual eligibles residing in the counties where the strategy is implemented, the degree of enrollment and retention, and the ability of risk adjustment processes to account for selective enrollment into the fully integrated products. The longer-term savings potential also depends on the continued financial viability of the fully integrated products from the health plan perspective.

Medicare savings potential under strategy 1. Strategy 1 leverages promising health home interventions to achieve Medicare savings. The approach is to target eligibility for health home services to clients who meet criteria that indicate they are at significant risk of experiencing poor health outcomes that are associated with hospitalization or use of other costly health care services. A key component of the targeting model is the use of PRISM risk scores with their demonstrated ability to identify clients who are at risk of adverse and costly future health outcomes. As the PRISM risk scoring algorithm is recalibrated to dual beneficiaries, additional criteria to identify high-opportunity populations for care management will be identified. These criteria are likely to include indicators related to medical and psychiatric re-hospitalization risk and care transitions from institutional settings (e.g., transitions from a nursing facility to a home or community setting).

The case for targeting health home services for high-risk clients is made more fully in Appendix F, but Table 1 below helps illustrate the potential of this approach. The potential for Medicare savings lies primarily in reductions in unplanned hospital admissions and use of Medicare-paid skilled nursing facility services. The table illustrates how the existing PRISM adult risk model is able to identify a high-risk subset of the broader dual eligible population that is at far greater risk of experiencing Medicare-paid inpatient admissions or nursing facility stays. Elderly duals who meet the PRISM risk score criterion of 1.5 or above have average PMPM Medicare expenditures of more than \$2,000 PMPM, including more than \$1,100 in Medicare-paid inpatient and skilled nursing facility costs. (Adding Medicaid-paid nursing facility costs would add substantially to this total.) In contrast, lower-risk dual elders have total PMPM Medicare expenditures of only \$334, and combined inpatient and skilled nursing expenditures of only \$86 PMPM. The non-elderly disabled dual population shows the same degree of extreme stratification in expenditures in the cost areas that are likely to be impacted through health home interventions.

Table 1 helps illustrate the magnitude of the impact on Medicare costs that health home services need to achieve to be cost effective. Health home services need to achieve approximately a 17 percent reduction in overall Medicare inpatient and skilled nursing facility expenditures among high-risk clients who engage in health home services to be cost neutral. Findings from the evaluation of WA State’s Chronic Care Management pilots show somewhat better impacts than the level necessary to “break

even”.⁸ These pilots have used a PRISM risk score of 1.5 or above to set the lower limit for eligibility. Unlike the evaluation of the Medicare Care Coordination Demonstrations⁹, these pilots have shown evidence of net cost savings, along with other key indicators of improved client health outcomes and satisfaction with participation in the program.

Table 1. Medicare expenditures on full-benefit duals eligibles in Washington State, SFY 2010

	Medicare Costs Per Member Per Month (PMPM), SFY 2010			
	Excludes Medicaid Expenditures			
	Elders		Disabled	
	Low Risk PRISM Score < 1.5	High Risk PRISM Score >=1.5	Low Risk PRISM Score < 1.5	High Risk PRISM Score >=1.5
Total PMPM	\$334	\$2,023	\$357	\$2,371
Inpatient PMPM	\$59	\$809	\$70	\$960
SNF PMPM	\$27	\$339	\$7	\$153
Covered Lives	46,241	28,703	39,560	20,117

Based on the state’s prior experience piloting similar chronic care management interventions, the preliminary financial modeling assumes a sustained ramp-up of engagement of high-risk clients into health home services, with a 40 percent rate of monthly engagement (among the 35-40 percent of duals meeting qualifying high-risk criteria) achieved through a 24-month ramp-up period. Thus, when fully ramped up, we anticipate that approximately 15 percent of the total dual eligible population will be engaged in health home services in a typical month.

Strategy 1 savings evaluation design issues. Given the targeted nature of the health home intervention, it is critical that the evaluation of Medicare savings resulting from this strategy does not rely solely on an intent-to-treat approach. We recommend an alternative evaluation approach that relies on careful matching – based on rich baseline risk data – of clients engaged in health home services with a “control” group of comparable clients who did not engage. The risk in using the intent-to-treat approach is that the impact of health home services on those who do engage will be less likely to be found statistically significant when the measurement of that impact is watered down across all dual eligibles in the analysis area, including those who did not engage in health home services. Given that the financial viability of the health home approach for duals from the state perspective depends on achieving “statistically significant” shared savings, the choice of an appropriate evaluation design is critical.

Medicare savings potential under strategy 3. Strategy 3 would integrate the Medicaid medical, behavioral health and skilled nursing facility benefit, along with the Medicaid medical under a health plan. Approval of strategy 3 is critical for several reasons. First, as noted in Table 2 below, the strategy 1 health home approach for duals is not financially viable from the state perspective after the end of the eight quarters of enhanced federal match for health home services, under the assumptions that 1) health home services for duals would then be funded at the standard Medicaid match rate and 2) the state would get a 50 percent share of Medicare savings. Strategy 3 solves this problem by providing a vehicle for funding ongoing health home services through the health plan capitation payment.

⁸ Mancuso, D and Court, B. *Chronic Care Management Pilots Show Early Promise*. Report to the Medicaid Purchasing Administration, November 2009. Available at: <http://publications.rda.dshs.wa.gov/1396/>

⁹ Jennifer Schore, J et al. Fourth Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration. The March 2011 report is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads//Schore_Fourth_Eval_MCCD_March_2011.pdf

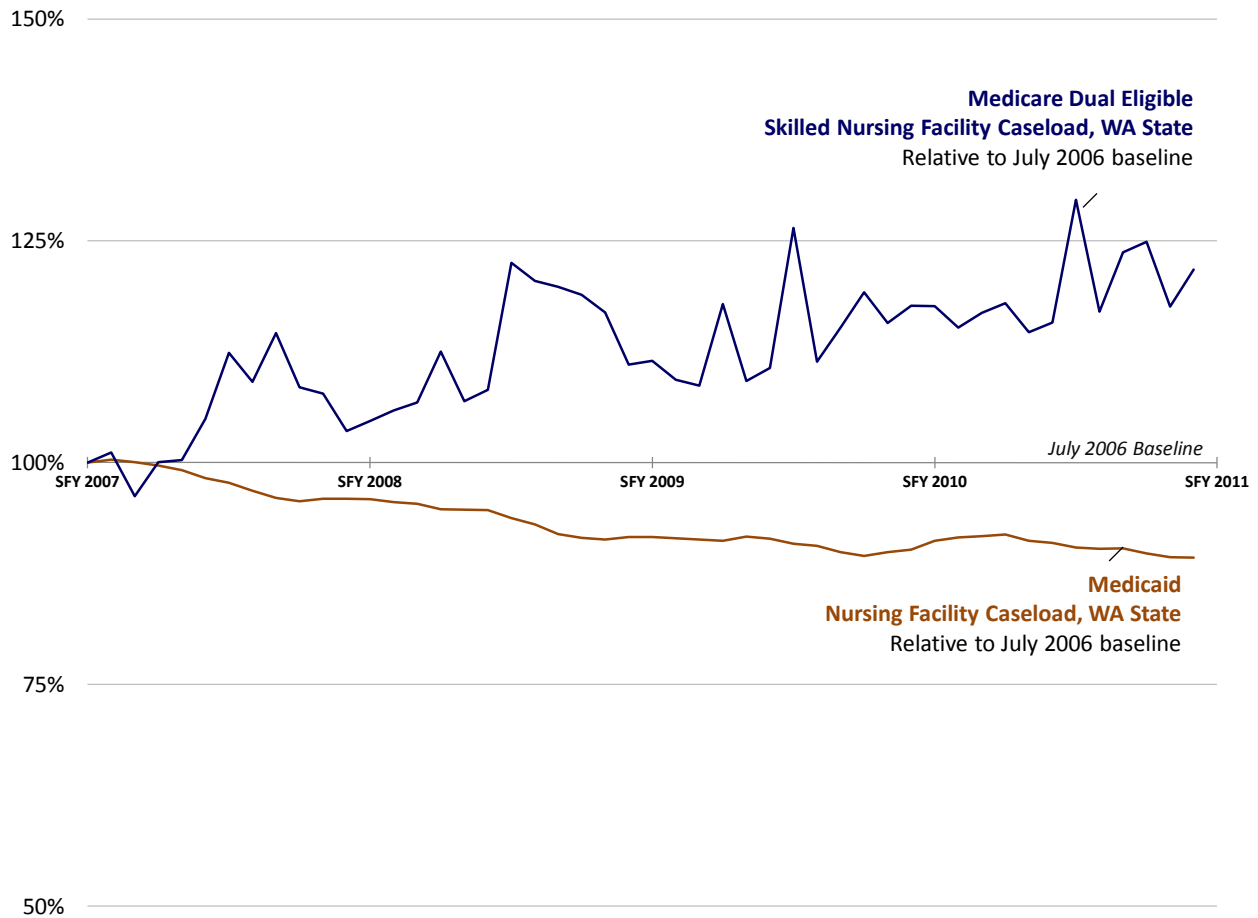
As shown in Table 2, the transition to strategy 3 results in a far more equitable sharing of savings between Medicare and Medicaid than operating strategy 1 alone. Without the ability to leverage strategy 3 to provide a more equitable method for funding health home services for dual eligibles, participation in this project leads to increased costs (negative savings) for the state following the end of the eight quarters of enhanced federal match for health home services. For example, we estimate that while Medicare would enjoy \$21.9 million in savings in SFY 2016, the state would lose \$1.7 million in that year if we were unable to implement strategy 3. By contrast, implementation of strategy 3 beginning in 2014 would result in more equitable sharing of savings, with \$12.1 million in savings to Medicare and \$8.1 million in Medicaid General Fund State savings. We note that from the broader CMS perspective, in addition to the Medicare savings reported here there would be additional federal Medicaid savings to complement the General Fund State Medicaid savings.

Table 2. General Fund-State and Medicare savings under alternative scenarios

State Fiscal Year (SFY)	Strategy 1 implemented 2013 Strategy 2 implemented in 2014 No Transition to Strategy 3		Strategy 1 implemented 2013 Strategy 2 implemented in 2014 Strat. 1 transitions to Strategy 3 in 2014	
	GF-State Share Medicaid Savings	Medicare Savings	GF-State Share Medicaid Savings	Medicare Savings
2013	-\$247,842	\$619,605	-\$247,842	\$619,605
2014	\$1,824,268	\$7,826,997	\$2,665,174	\$6,986,091
2015	-\$188,594	\$19,593,132	\$7,285,940	\$12,118,598
2016	-\$1,681,350	\$21,890,293	\$8,097,357	\$12,111,587

A second critical reason to support strategy 3 is that it makes major improvements in financial alignment, by aligning key incentives within health plans. In particular, the health plan has the incentive to improve patient health outcomes to reduce Medicare-paid inpatient hospitalizations – especially hospitalizations from a nursing facility setting that are likely to restart Medicare-paid SNF payments when the patient is readmitted to the nursing facility following hospital discharge. The chart below is suggestive of the potential scale of savings through financial alignment of the nursing facility and hospital inpatient benefit. The chart shows that Medicare-paid skilled nursing facility census of WA State dual beneficiaries has tended to grow in recent years, while the Medicaid-paid nursing facility census has continued its long-term decline. This finding is consistent with the inference that there may be significant potential savings associated with the alignment of incentives with a single accountable entity to focus on nursing facility entries and hospital readmissions that could be accounting for these divergent trends. We also note that in SFY 2010, more than 40 percent of duals who were hospitalized directly from a **Medicaid-paid** nursing facility stay were subsequently discharged from the hospital directly to a **Medicare-paid** skilled nursing facility stay, generally at high overall daily cost than the prior Medicaid-paid stay.

Figure 1. Washington State Medicare and Medicaid nursing facility monthly caseload trends relative to July 2006 baseline



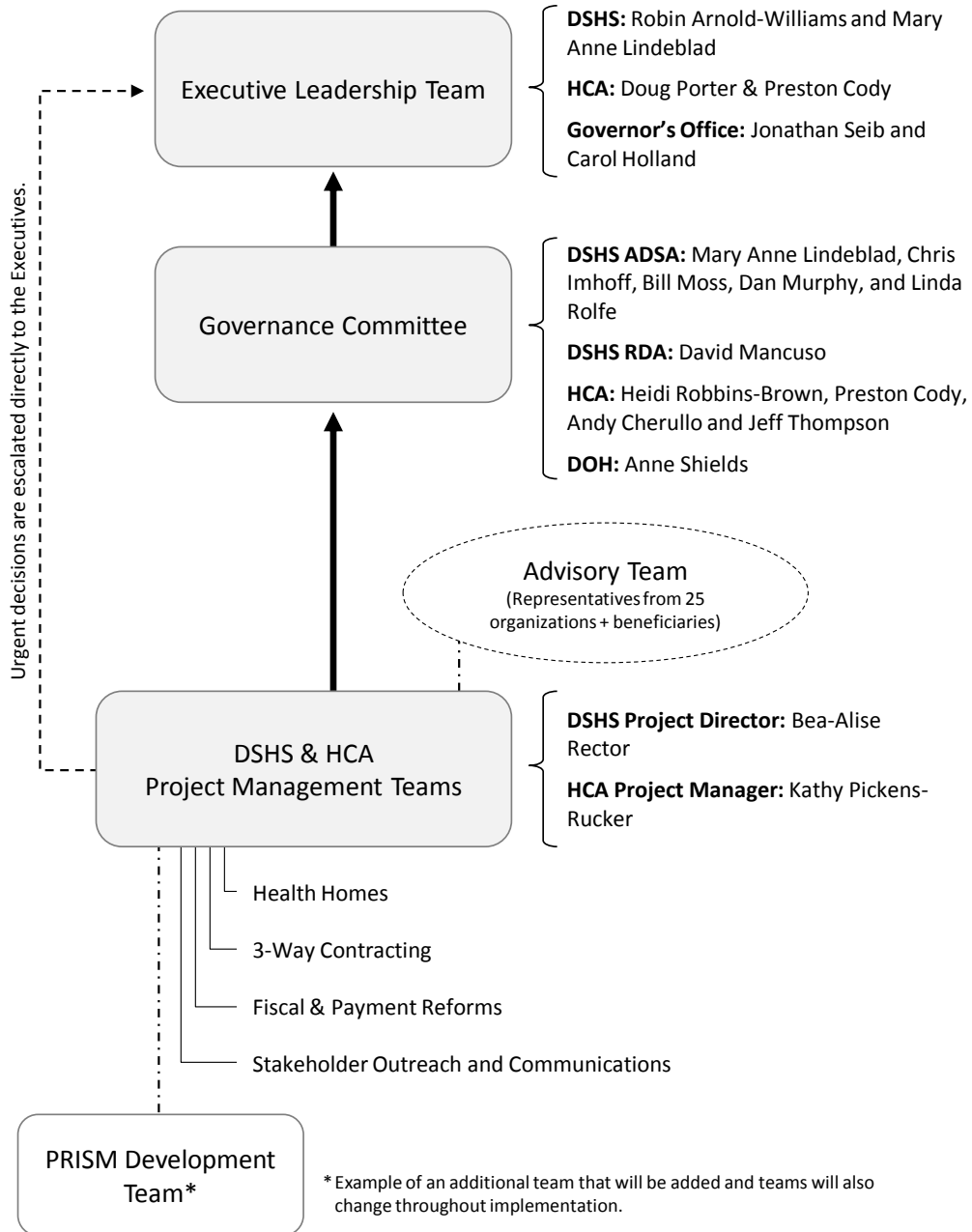
SOURCE: DSHS Research and Data Analysis Division, Integrated Client Outcomes Database, April 2012

The potential for Medicare savings related to reductions in hospital admissions and use of Medicare-paid skilled nursing facility services is further supported by more detailed analyses of hospital and nursing facility admission and discharge patterns. Analysis of integrated Medicare and Medicaid data for WA State duals in SFY 2010 shows that about 75% of duals admitted to a hospital directly from a Medicaid-paid skilled nursing facility stay are subsequently discharged from the hospital directly to a nursing facility. More than half of the time, these subsequent nursing facility stays are paid for by Medicare, often at a higher cost than the prior Medicaid nursing facility stay. Overall, inpatient hospital readmission rates are relatively high for duals who have been previously admitted to the hospital from a Medicare-paid skilled nursing facility stay. Among Elder duals admitted to the hospital from a Medicare-paid SNF stay, 90-day readmission rates are 38%. Among comparable disabled duals, 90-day readmission rates are 56%. Although more analysis is required to quantify the potential to reduce these readmission rates, these findings point to hospital readmissions associated with SNF utilization as potentially important sources of Medicare savings.

A third critical reason for implementing strategy 3 is that it creates an environment that increases the viability of further delivery system integration. Health plans participating in strategy 3 will contract with community mental health system providers who currently bill Medicare for outpatient services, and therefore will gain experience with the provider network that is the backbone of the current Medicaid RSN system. The health plans will contract with the nursing facilities that make up the vast majority of facilities that contract with the Medicaid program. In addition, the health plans will be contractually required to use providers in long-term care, DD or community mental health delivery systems, when appropriate, to provide health home services for high-risk beneficiaries who are served in those settings. These factors will push towards greater integration of service delivery and create a foundation for potential future expansion of the fully integrated capitated model.

Appendix R: Governance Structure

Governance Structure



Appendix S: Implementation Timeline

Timeframe	Key Activities/Milestones		
	Strategy 1	Strategy 2	Strategy 3
March 2012	Draft health home qualifications published for public comment	(Joint Procurement) Medicaid medical contracts signed for SSI, Blind, & disabled population	(Joint Procurement) Medicaid medical contracts signed for SSI, Blind, & disabled population
April	2 nd draft attached to Duals Design plan and submitted to CMS	Design Plan Submitted to CMS	Design Plan Submitted to CMS
May	Begin development of a common application process	(Joint Procurement) Medicaid medical readiness reviews complete County conversations	(Joint Procurement) Medicaid medical readiness reviews complete
June	Begin adoption of payment methodology and development of funding mechanisms	County conversations	
July	Earliest date of SPA submission to CMS; may be delayed due to CMS duals MOU negotiation Release of health home application	(Joint Procurement) Managed Medicaid medical coverage begins County conversations	(Joint Procurement) Managed Medicaid medical coverage begins
August	Training and partnership development	Counties define terms; Medicaid rates established; State specific selection criteria drafted	Medicaid medical rates established; Contract modifications developed for shared outcomes and financial alignment for pay for performance by Medicaid
September	Training and partnership development Begin receipt and qualification of health home applications	State specific selection criteria finalized; RFP development	RFP development
October	Receipt and qualification of health home applications	RFP development continues	RFP development continues;
November	Announcement of qualified health homes	RFP with state specific requirements published; Health plans submit "Notice of Intent to Apply"	RFP with state specific requirements published along with modified contract language
January 2013	New health home services begin under 2703; enrollment of beneficiaries begins		

Timeframe	Key Activities/Milestones		
	Strategy 1	Strategy 2	Strategy 3
February 2013	Receipt and certification of additional health home applications	RFP responses due, along with proof of County legislative approval	RFP responses due
April		CMS publishes Medicare guidance to health plans; Plans submit their Part D formularies	CMS publishes Medicare guidance to health plans; Plans submit their Part D formularies
May		Interested health plans submit Medication Therapy Management Program	Interested health plans submit Medication Therapy Management Program
June	Six month monitoring of delivery system	Health plans submit proposed benefit packages; Joint selection process between State & CMS begins	Health plans submit proposed benefit packages; Joint selection process between State & CMS begins
July		Final plan selections completed w/CMS	Final plan selections completed w/CMS
August		Joint State/CMS readiness assessments begin	Joint State/CMS readiness assessments begin
September		Contracts negotiated and signed with health plans	3-way contracts and other modified contracts negotiated and signed
October		Passive enrollment process begins; Jointly approved open enrollment information sent to beneficiaries	Passive enrollment process begins; Jointly approved open enrollment information sent to beneficiaries
November		Open enrollment	Open enrollment
December	12 month monitoring of delivery system	Open enrollment	Open enrollment
January 2014	Year 1 complete; retrospective savings calculation process begins	New coverage begins	New coverage begins

Appendix T: Terminology and Acronyms

Acronym	Definition
5/50	Refers to 5% of the population that utilizes 50% of the resources
AAA	Area Agency on Aging
AARP	American Association of Retired Persons
ACA	Affordable Care Act (Federal)
ACES	Automated Client Eligibility System used to capture Medicaid financial eligibility
ACO	Accountable Care Organization
Actuarially Sound Capitation Rates”	capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; and have been certified as meeting the requirements of 42 CFR 438.6(c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board (42 CFR 438.6(c)).
ADSA	Aging and Disability Services Administration
AI/AN	American Indian/Alaska Native
AIHC	American Indian Health Commission
AOD	Alcohol or other dependence
BH	Behavioral Health
CY	Calendar Year (January – December)
Capitation	A per member per month rate established for a specified set of services identified in a contract.
CCM	Community Mental Health Center
CD	Chemical Dependency
CDSMP	Chronic Disease Self Management Program
CMS/DHHS	Centers for Medicare & Medicaid Services is the federal agency within the U.S. Department of Health and Human Services (DHHS) with primary responsibility for the Medicaid and Medicare programs.
CMHC	Community Mental Health Center
DD/DDD	Developmental Disability/Division of Developmental Disabilities
DOH	Department of Health
DSHS	Department of Social and Health Services
DUALS	Individuals dually eligible for Medicare and Medicaid also referred to as beneficiary
EHR	Electronic Health Record
ER	Emergency Room
FFS	Fee For Service
FQHC	Federally Qualified Health Center
HAT	HealthPathWashington Advisory Team
HCA	Health Care Authority
HCB/HCBS	Home & Community Based/Home & Community Services
Health Action Plan	An enrollee-prioritized plan identifying what the enrollee plans to do to improve their health. The health action plan should contain at least one enrollee-prioritized goal; identify what actions the enrollee is taking to achieve the

Acronym	Definition
	goal(s); and includes the actions of the care manager, including use of health care or community resources and services that support the enrollee’s action plan.
HH	Health Home -A set of six services defined under the ACA. The purpose is to coordinate the full breadth of clinical and social service expertise for enrollees with complex chronic conditions, mental health and substance use disorder issues and/or long term service needs and supports. The qualified health home includes providers from the local community that authorize Medicaid, state or federal funded mental health, long term services and supports, chemical dependency and medical services.
Hi Cost/Hi Risk	Eligibility for health home services to clients who meet criteria that indicate they are at significant risk of experiencing poor health outcomes that are associated with hospitalization or use of other costly health care services.
HIT	Health Information Technology
HO	Healthy Options
HTA	Health Technology Assessment
ICF-MR	Intermediate Care Facility-Mental Retardation
LTC/LTSS	Long Term Care/Long Term Services & Supports
MCO	Managed Care Organization
MH	Mental Health
MMIP	Medicaid Medicare Integration Project
PACE	Program of All Inclusive Care for the Elderly
PMPM	Per Member Per Month Payment
PRISM	Predictive Risk Intelligence System: “Predictive Risk Intelligence System (PRISM)” means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next 12 months based on the patient’s disease profile and pharmacy utilization.
Procurement	
RSN	Regional Support Network
SHIBA	State Health Information Benefit Advisor
SMI/SPMI	Serious Mental Illness/ Serious & Persistent Mental Illness
SMHP	State Medicaid Health Information Technology Plan
SNP	Special Needs Plan
SPA	State Plan Amendment (Amendment made to the Medicaid State Plan)
SSI	Social Security Income
SFY	State Fiscal Year (July – June)
WA	Washington
WMIP	Washington Medicaid Integration Partnership

Appendix U: 2nd Revised Draft Health Home Proposal

**Second Revised Draft Health Home Proposal
Presented by the Washington State Department of Social and Health Services
Aging and Disability Services Administration and the
Health Care Authority**

April 26, 2012

http://www.hca.wa.gov/health_homes.html

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22. Executive Summary

In October 2010, The Centers for Medicare and Medicaid (CMS) released a State Medicaid Director letter that outlined preliminary guidance on the implementation of section 2703 of the Affordable Care Act, entitled “*State Option to Provide Health Homes for Enrollees with Chronic Conditions.*” This provision allows states to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use) and services and supports for persons across the lifespan with chronic illness. The letter outlines services definitions for health home providers or health teams and provides a potential payment methodology for health home services. Section 1945(c)(1) of the Act provides that the federal match for health home services shall be 90% for the first eight fiscal quarters that a State Plan Amendment, a program description and request for funding to CMS, is in effect.

Health homes expand the concept of the more commonly used term, medical homes by serving the whole person across the primary care, long-term services and supports, and mental health and substance use disorder treatment components of the health care delivery system. While health homes and medical homes were born of the same concept, the health care reform legislation established health homes as a new state Medicaid option for service delivery specifically for enrollees with chronic conditions. Health homes have a strong focus on behavioral health (including substance use disorder treatment), social support and other services, including nutrition, home health, and coordinating activities. Health homes coordinate a variety of services including primary care and specialty care, and ensuring referrals to community supports and services are effectively managed. The key feature of health home, comprehensive care management, supports the person in managing chronic conditions and achieving their self-management goals by facilitating the provision of clinical services that contribute to improved health outcomes.

Initially the Health Care Authority (HCA) and its partner agency, the Department of Social and Health Services, Aging and Disability Services Administration (DSHS-ADSA) developed a state plan amendment requesting program implementation and funding for the chronic care management program, a care management program currently delivered by six of thirteen Area Agencies on Aging (AAA) in WA. At the same time the agency received a 1) *Dual Eligible Innovation Planning Grant* from the CMS to design an innovative integrated care model to improve the quality, coordination and cost effectiveness of care for dual populations eligible for Medicare and Medicaid and 2) HCA added language to the draft Healthy Options/Basic Health procurement contract defining health home language on the assumption that some or all of the managed care plans should take steps to purchase health home services, especially for the newly managed care eligible blind and disabled population.

As the two agencies developed the best ways to improve care for chronically ill individuals through 2703 and the duals grant, as well as emerging knowledge of Medicaid high risk individuals, they made a decision to propose an expanded health home model that is sufficiently robust to serve the high risk, chronically ill population. Encompassed within this document is a proposal to qualify community-based entities to deliver health home services at an effective level to Medicaid and dual Medicare-Medicaid eligible chronically ill, high risk individuals (the top 5% of the Medicaid population) and a documented future risk score (of higher health care costs) of 1.5 or greater.

The proposal describes the data analysis undergirding the decision to expand health homes, the facts and assumptions that guide the recommendations, the standards required of health homes, a list of program goals, objectives and measures used to evaluate the program, a payment approach and a list of definitions defining the key components of the health home.

As the agency considers implementation, a county or regional approach to health homes may be considered. This decision is dependent upon the number of potential health home enrollees in each county or region, the availability of health home services in the county/region and the interest expressed by networks of organizations willing to serve and qualified as the health home.

As both agencies work towards an implementation date of January 1, 2013, milestones include:

1. July 2012 - Development of a common application process for health homes and release of the application
2. July 2012 - Development of a scoring method to examine health home proposals
3. July 2012 - Submission of the proposal to the Centers for Medicare and Medicaid (CMS)
4. July 2012 – Adoption of a payment mechanism for health home and development of funding specifications
5. September 2012 – CMS approval of the health home proposal.
6. September 30, 2012 - Receipt and certification of health home proposals
7. November 1, 2012 - Qualification and announcement of qualified health homes and
8. January 1, 2013 - Initial enrollment of high risk beneficiaries into health homes

Background

Health homes build upon and expand the concept of medical homes by serving the whole person across the primary care, long-term services and supports, mental health and substance use disorder treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, ensuring referrals to community supports and services are effectively managed. The key feature of health home, intensive care management, supports the person in managing chronic conditions and achieving their self-management goals by facilitating the provision of clinical services that contribute to improved health outcomes. Health homes emphasize a person-centered approach, offering an array of services and referrals to individuals and their families seeking care. “Health Home Services” as articulated by the Affordable Care Act, Section 2703 and in Washington State law (2011 SB5394) requires:

1. Comprehensive care management, using team-based strategies
2. Care coordination and health promotion
3. Comprehensive transitional care between health care and community settings
4. Individual and family support, including authorized representatives
5. Referral to community and social support services, such as housing if needed
6. The use of health information technology to link services, as feasible and appropriate

In developing the model for health home services in WA’s Medicaid programs, DSHS staff conducted extensive data analysis to identify the populations at greatest need for health home services. Analysis

resulted in examination of the health care resources typically accessed by groups of individuals served by various Medicaid programs, as well as conditions (or indicators of conditions) more commonly associated with a high risk designation. These programs and characteristics include:

1. Use of Medicaid developmental disability or long-term services and supports,
2. Evidence of use/need for substance use disorder treatment and evidence of a serious, persistent mental illness.

Three distinct groups were analyzed. These included the high risk, non-disabled, non-dual population (current Healthy Options), the blind and disabled population and the dually eligible, Medicare-Medicaid aged population. Although there were striking differences in utilization patterns among the groups in terms of use of behavioral health, long-term services and supports and developmental disability services, all population groups showed similarities between the high and impactable use of emergency room, inpatient hospitalizations and institutional stays when comparing individuals with high risk to those with low risk.

Among the high risk groupings, a higher percentage of current Healthy Options population used only Medicaid medical services and showed less evidence of single or multiple agency service use, while the high risk blind and disabled and dual beneficiary population showed greater use of multiple agency services with the dual beneficiary not unexpectedly receiving significantly higher levels of long-term services and supports.

These distinct utilization patterns among three high risk groupings suggest the need for varying approaches to the delivery of comprehensive care management services in a health home. For example, high risk Healthy Options individuals that use more primary care services (and less frequently require specialized Medicaid services) may best be served by a team-based health home in a primary care setting. Appropriate primary care settings might include “traditional” primary care clinics and primary care clinics located in nontraditional settings, such as community mental health centers. Those with more complex health conditions, including multiple diagnoses and social support needs may be best served in a team based, integrated service delivery system where care management is provided by a community based organization that has established relationships and frequent contact with the individual. See attachment A for diagrams that describe the utilization patterns among the groups analyzed.

An integrated, health care service delivery model to serve the high risk, high cost population is supported by the agency and its stakeholders. The model is intentionally broad-based, including both community-based and primary care-based options for delivering health home services, depending on how beneficiary needs can best be addressed. Analysis has shown overlapping, multiple service needs among high risk/high cost beneficiaries. As a result, it is the Department of Social and Health Services, Aging and Disability Services Administration and the Health Care Authority (DSHS-ADSA/HCA’S) intent to qualify health homes that have a strong integrated network that is capable of providing the degree of “high touch” support that is necessary to be effective with beneficiaries with complex chronic conditions.

In developing the model of health home services, the agency defined a number of facts and assumptions to guide their work. The facts and assumptions are listed below.

Facts

1. The Health Care Authority has made a policy decision to move the majority of the Medicaid population into the managed care marketplace for the delivery of medical services.
2. Targeting health home services for high risk, chronically ill individuals in demonstration projects across the country show the greatest promise for achieving improved quality while reducing the cost of care.
3. Programs that ‘treat to target’ and provide care management interventions focused on achieving a health goal (such as managed diabetes) show significant improvements in both the quality and cost of care.
4. An integrated, health care service delivery model to serve high risk, high cost populations are supported by the agency and its stakeholders. The model is intentionally broad-based, including both community-based and primary care-based options for delivering health home services, depending on how individual needs can best be managed.
5. The Centers for Medicare and Medicaid Services (CMS), through the Affordable Care Act has provided an avenue for obtaining 90% federal match for health home services for up to 8 quarters.
6. The state is working with CMS on approval of a 2703 health home State Plan Amendment (SPA) with an effective date of January 1, 2013.

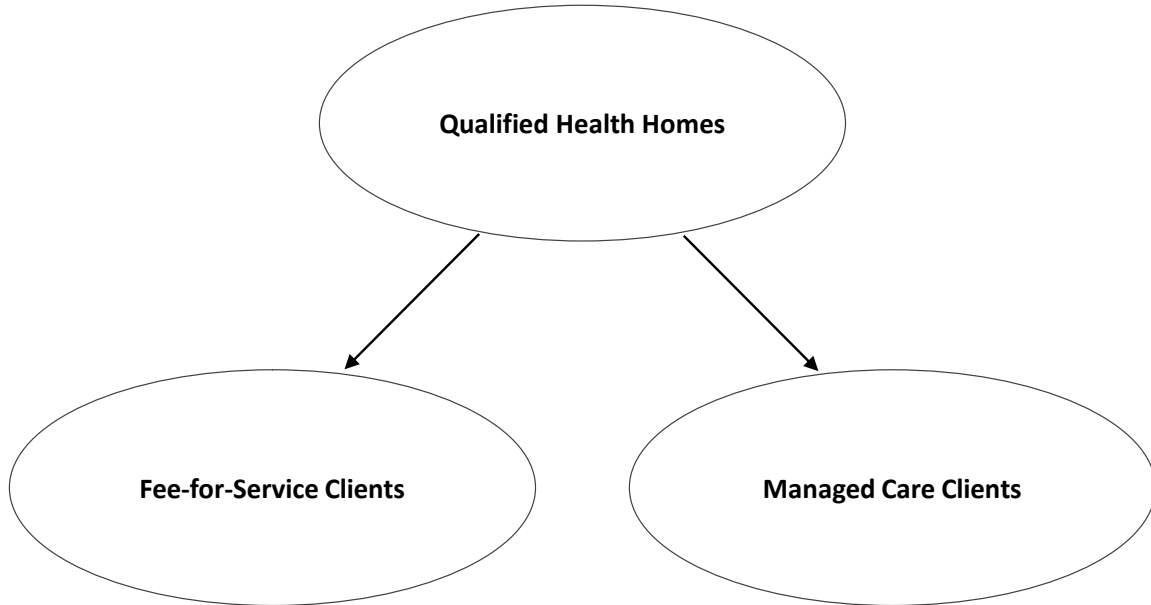
Assumptions

1. Entities within a health home could be Managed Care Organizations, community or regional consortiums (such as a partnership of local Community Mental Health Agency, Substance Use Disorder Treatment Providers, Specialty Care Providers, Primary Care providers and Long-Term Services and Supports providers or provider networks), Accountable Care Organizations or other qualified entities.
2. Depending on individual needs and preferences, health home services can be effectively delivered in community-based or primary care settings.
3. Health home standards will be defined and health homes qualified by the state.
4. Health home payment may be tiered and reflect payment according to individual risk and intensity of the intervention.
5. Performance measures will be defined and communicated to all health home providers with the goal of treating to target, i.e., focused effort on meeting the performance measures.
6. Current agency-contracted chronic care management programs (e.g., King County Care Partners, Cowlitz County and Area Agencies on Aging) could apply to be part of a qualified health home provider network.
7. Direct care workers (paid and unpaid) when available will be used to assist beneficiaries receiving home and community based long-term services and supports in working toward their health action plan goals.

The following model depicts the eligible populations for health home services and how such services will be delivered to individuals served through HCA and DSHS. The agencies will need to develop the capacity to qualify health homes to deliver services using a standardized approach and offer health home services to all high risk beneficiaries (i.e., non-disabled, non-dual, blind and disabled or dually eligible beneficiaries) or a subset, such as the blind and disabled and dually eligible beneficiary populations.

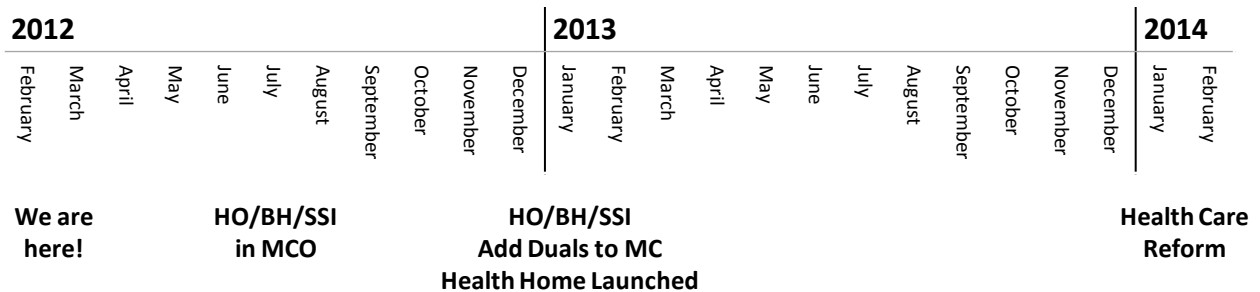
Integration of Healthy Options, Blind and Disabled, FFS, and Dual Eligible (Medicare-Medicaid) into Health Homes

Proposed Washington State Health Homes Model



The timeline for implementing health homes is described below. In developing this timeline, HCA and DSHS-ADSA intends to work with CMS to execute integrated care models to dual eligible individuals beginning in January 2013.

Timeline: Integration of Healthy Options, Blind and Disabled, FFS and Duals into Health Homes



Vision of an Integrated Health Home

Under WA's approach to health home implementation, the DSHS-ADSA/HCA is purposely limiting the naming of specific providers in the health home proposal. Health home networks should be developed to meet the needs of the population. Care coordination should occur across service domains and therefore include many different disciplines. Both DSHS-ADSA and HCA will review readiness to provide services prior to beneficiary enrollment in the health home.

A health home is qualified by the State and is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for *high cost/risk** persons with chronic illness across the lifespan. A health home is the central point of contact working with the managed care or fee-for-service beneficiary to:

1. Establish person-centered health action plan goals designed to improve health and health-related outcomes;
2. Coordinate across the full continuum of health services (medical, mental health, substance use treatment, long-term services and supports and other social supports such as housing, and food assistance);
3. Reduce avoidable health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and reduced use of institutional care, such as nursing homes, psychiatric hospitals and residential habilitation centers;
4. Organize and facilitate the delivery of evidence-based health care services targeted to the individual;
5. Interventions may change based upon the beneficiary age, cognitive limitations and required assistance.
6. Arrange for timely post-institutional or facility discharge follow-up, including medication reconciliation and substance use treatment after-care program; and
7. Increase the beneficiary's confidence and skills to self-manage their health goals.

Health home providers must demonstrate their ability to perform each of the following requirements and document the processes used to perform these functions. Documentation should include a description of the proposed multi-faceted health home service interventions, such as theory or research-based self-management support and transitional care provided to promote beneficiary engagement, participation in the development and management of the health action plan and assurance that beneficiaries have appropriate access to the continuum of physical, behavioral health, long-term services and supports and social services in the health home network. Health homes must assure that services are delivered in a manner described as follows:

1. Provide quality-driven, cost effective, culturally appropriate and person and family centered health home services.
2. Assign a dedicated care manager who is located in the community in which the beneficiary resides so that services can be provided in-person whenever possible.
3. Use high quality, evidence-based assessment and intervention protocols in working with the beneficiary to develop health action plans.
4. Coordinate and facilitate access to disease prevention and health promotion services. Coordinate with and include timely access points for mental health, substance use disorder and long-term services and supports.

5. Provide the full array of health home services within the provider's network in compliance with the definitions and standards listed below.
6. Develop a person-centered health action plan for each beneficiary that coordinates and integrates clinical and non-clinical services in support of achieving a beneficiary's health action goals.
7. Allow beneficiaries the opportunity to utilize formal and informal decision makers and caregivers as supports in assessing activation levels and achieving health action goals.
8. Demonstrate the capacity to use health information technology to link services, identify and manage care gaps; facilitate communication and case problem-solving among health home team members and between the health home network and the beneficiary, family members and caregivers.
9. Provide feedback to prescribing/authorizing health care, behavioral health and long-term service providers as feasible and appropriate to the health action plan.
10. Establish a continuous quality improvement program.

*High cost/risk is defined as having at least one chronic condition and a risk score of 1.5 or greater as measured by the algorithm within the Predictive Risk Intelligence System(S) PRISM, a State agency program that provides a unified view of health care service utilization. For more information about the risk score algorithm of the PRISM model and Targeting Health Home Services for High Risk Patients, see Appendix D and F in the Duals Grant proposal.

Health Home Goals

1. Improve the beneficiary's clinical outcomes and experience of care.
2. Improve the beneficiary's self-management abilities.
3. Improve health care quality and promote efficient and evidence-based health care service delivery.
4. Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

Eligibility

Health home services will be available to individuals of all ages served by Medicaid. Eligible beneficiaries must have a PRISM risk score of 1.5 or greater and at least one chronic condition OR have at least one chronic condition and one or more of the following:

1. Two medical hospitalizations in the past 12 months;
2. A psychiatric hospitalization in the past 6 months; and
3. A skilled nursing facility stay in the past 6 months.

The list of chronic conditions identified as meeting eligibility requirements are in Attachment B – Definitions.

Health Home Guiding Principles

1. Solutions to individuals with complex and chronic physical, mental health, cognitive, addiction issues and social service needs are inter-related and best delivered locally; therefore health home services shall be delivered at the local level.
2. Health home purchasing must recognize and support integrated service delivery development at the local level.
3. A health home network shall include the enrollee's managed care organization when the health home is serving a managed care enrollee.

4. A health home network that only serves fee-for-service enrollees does not have to partner with a managed care organization, but a lead entity within the health home network must be identified to provide administrative requirements.
5. Health home delivery system design and implementation must demonstrate self-management, recovery and resiliency principles using person-identified supports including family members, and paid and unpaid caregivers.
6. Health homes need to be implemented in a way that ensures adequacy of high quality contracting and oversight that achieve defined process and outcome measures.
7. Achievement of established performance measures must be objectively assessed and performance incentives applied along the continuum of care.
8. Health homes must deliver highly organized and efficient managed health care and social services.
9. Culturally competent care is fundamental to the delivery of health home services and reduction of health disparities.

General Requirements

1. All providers serving beneficiaries shall be part of a health home network. The health home network must:
 - Have procedures in place for referring any beneficiary with chronic conditions who seeks or needs treatment/services to a Medicaid designated provider.
 - Demonstrate use of an interdisciplinary team of providers that can address the full breadth of clinical and social service expertise for individuals who require assistance due to complex chronic conditions, mental health and substance use disorder issues and long-term service needs and supports.
 - Include providers from the local community that authorize Medicaid, state or federal funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services. For example, Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, and community supports that assist with housing.
2. Provide care coordination and integration of health care services to all health home beneficiaries through an assigned care manager who has access to an interdisciplinary team when necessary for care integration.
3. Directly provide or subcontract for the provision of, health home services.
4. Remain responsible for all health home program requirements, including services performed by any subcontractor and provide for measurement and monitoring of performance measures and outcomes to be achieved by the program.
5. Health homes must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements.
6. Interventions must be targeted to high risk/high cost beneficiaries and supported through assignment of a care manager who demonstrates the ability to:
 - Provide in-person beneficiary health assessments;
 - Accompany the beneficiary to critical appointments;
 - Actively engage the beneficiary in developing a health action plan, this shall be done in person whenever possible;
 - Reinforce and support the beneficiary health action plan;

- Coordinate with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals;
 - Advocate, educate and support the beneficiary to attain and improve self-management skills;
 - Assure the receipt of evidence-based care; and
 - Support beneficiaries and families during discharge from hospital and institutional settings, including providing evidence based transition planning.
7. The beneficiary's health action plan is under the direction of a dedicated care manager who is accountable for facilitating access to medical, behavioral health care, long-term services and support and community social supports and coordinating with entities that authorize these services as necessary to support the achievement of individualized health action goals.

Health home providers must meet the following core health home standards in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements will and are being met.

Comprehensive or Intensive Care Management

Service Definition

Comprehensive or Intensive Care Management shall provide for clinical health assessment and use engagement, coaching and advocacy strategies that assist beneficiaries to develop and implement health action plans. Most care management services are intended to be delivered in person with periodic follow-up by phone, and include a comprehensive health assessment (or use existing comprehensive assessments), demonstrate ability to provide continuity through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed. Care managers assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning. The health home provider will be accountable for engaging and retaining beneficiaries in health home services.

Standards

The beneficiary health action plan and/or care management case file shall provide evidence of:

1. A comprehensive and culturally appropriate health assessment conducted within 30 days of enrollment using evidence based/informed practices where available. The assessment identifies chronic conditions, severity factors and gaps in care, the beneficiary's activation level and opportunities for potentially avoidable emergency room, inpatient hospital and institutional use.
2. Screening for depression and alcohol or substance use disorder appropriate to the age of the individual and referral to services, as appropriate.
3. Measurement of the beneficiary's activation level using the Patient Activation Measure tool or when appropriate the Caregiver Activation Measure (Insignia products); the beneficiary shall be reassessed every 6 months while receiving health home services.
4. Beneficiary to care manager ratio not to exceed 50:1. The ratio may be adjusted when community health workers, peer counselors or other non-clinical staff is used to facilitate the work of the assigned care manager.
5. Active engagement of the beneficiary in goal setting, defining interventions and the timeframes for goal achievement identified in the beneficiary health action plan. Beneficiaries and their designees

play a central and active role in the development, implementation, and monitoring of their health action plan. An individualized health action plan shall reflect beneficiary and family preferences, education and support for self-management and other resources as appropriate.

6. Evidence-based/informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices.
7. Optimal clinical outcomes, including a description of how progress toward outcomes will be measured.
8. Outreach and engagement activities that support the beneficiary's participation in their care and that promotes continuity of care.
9. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.
10. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment.
11. Routine and periodic health reassessment, at minimum every 6 months to include reassessment of the patient's likelihood for continued benefit from care management and progress towards meeting clinical and patient-centered health action plan goals. Changes are made to the health action plan based upon changes in beneficiary need or preferences.
12. A shared health action plan with the beneficiary, health home team members and the beneficiary's providers.
13. Access to and retention of needed health care and community services and resources.
14. Identification of the role of formal and informal supports, including direct care providers of long-term services and supports, the beneficiary has identified to assist them in achieving health action goals.

Care Coordination and Health Promotion

Service Definition

The dedicated care manager shall play a central and active role in the development and execution of a cross-system health action plan of care including assisting the beneficiary to access needed services. The care manager shall assure communication is fostered between the providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports.

Standards

The beneficiary health action plan and/or care management case file shall provide evidence of:

1. Communication between the dedicated care manager and the treating/authorizing entities and assurance that the care manager can discuss with these entities on an as needed basis, changes in patient circumstances, condition or health action plan that may necessitate changes in treatment or service need.
2. Release of information to allow sharing of information that facilitates transitions in care, as agreed to by the beneficiary.
3. Care coordination and collaboration through case review meetings as needed.
4. 24 hours/seven days a week availability to provide information and emergency consultation services to the beneficiary.

5. Priority appointments for health home beneficiaries to medical, behavioral health, and long-term care services within the health home provider network to avoid unnecessary, inappropriate utilization of emergency room, inpatient hospital and institutional services.
6. Wellness and prevention education specific to the beneficiary's chronic conditions, health action plan, including routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on individual needs and preferences.
7. Policies, procedures and accountabilities (contractual or memos of understanding agreements) to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community based organizations.

Comprehensive Transitional Care

Service Definition

Comprehensive transitional care shall be provided to prevent beneficiary 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.

Standards

The beneficiary health action plan and/or care management case file shall provide evidence of:

1. A notification system in place with hospitals, nursing homes and residential/rehabilitation facilities in their network to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting.
2. The use of a health home care manager as an active participant in all phases of care transition; including discharge visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.
3. Beneficiary education that supports discharge care needs including medication management, follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers when requested by the beneficiary.
4. A systematic follow-up 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.

Individual and Family Support Services (including authorized representatives and beneficiary identified decision makers)

Service Definition

The health home provider shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the health home provider to increase beneficiary and caregiver's knowledge of the beneficiary's chronic conditions,

promote the beneficiary's engagement and self management capabilities and help the beneficiary improve adherence to their prescribed treatment.

Standards

The beneficiary health action plan and/or care management case file shall:

1. Identify and refer to resources that support the beneficiary in attaining the highest level of health and functioning in their families and in the community, including transportation to medically necessary services and housing.
2. Reflect and incorporate the preferences, education about and support for self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregiver to support the beneficiary's individualized health action goals.
3. Identify the role that families, informal supports and caregivers provide to achieve self-management and optimal levels of physical and cognitive function.
4. Demonstrate discussion of advance directives with beneficiaries and their families.
5. Demonstrate communication and information shared with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.
6. Demonstrate providing the beneficiary with access to health action plans and options for accessing clinical and service delivery information.

Referral to Community and Social Support Services

Service Definition:

The health home provider identifies available community based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports. Referral to community and social support services includes long-term services and supports, mental health, substance use disorder and other community and social services support providers accessed by the beneficiary.

Standards:

The beneficiary health action plan and/or care management case file shall:

1. Identify available community-based resources discussed with the beneficiary and actively manage appropriate referrals, advocates for access to care and services, provides coaching to beneficiaries to engage in self-care and follow-up with required services.
2. Provide assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations.
3. Have policies, procedures, and accountabilities (through contractual or memos of understanding agreements) to support effective collaboration with community based resources, which clearly define roles and responsibilities.
4. Provide documentation of referrals to and access by the beneficiary of community based and other social support services as well as health care services that contribute to achieving the beneficiary's health action goals.

Use of Health Information Technology to Link Service

Service Definition

Health home providers will make use of available HIT and access data through the Predictive Risk Intelligence System(s), Medicaid managed care organization or fee-for-service systems, and other processes as feasible as the state develops the Electronic Medical Records standards for Medicaid providers.

Standards

The health home infrastructure shall:

1. Use health information technology to identify and support management of high risk participants in care management.
2. Use conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).
3. Use a system to track and share beneficiary information and care needs across providers and to monitor processes of care and outcomes and initiate changes in care, as necessary, to address beneficiary need and preferences.
4. Use web-based health information technology registries and referral tracking systems.
5. Track service utilization and quality indicators and provide timely and actionable information to the care manager regarding under, over or mis-utilization patterns.
6. Develop a system with hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting.
7. Develop methods to communicate real time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to the care manager and use a clinical decision support tool (PRISM) to view cross-system health and social service utilization to identify care opportunities.

Health Home Payment

HCA and DSHS-ADSA are considering a per member per month (PMPM) tiered payment system for qualified health homes that meet state and federal standards. The model below describes a potential payment structure. This model is subject to change, based on further analysis and stakeholder input.

A care management fee will be based on at least two tiers in two distinct delivery systems - managed care and fee-for-service. Other tiers may be developed as rate modeling and program implementation is done. The following is a brief outline of a potential payment system.

1. Intensive Care Management
 - Description:
 - A treatment plan is developed, documented and maintained by the care manager. The treatment plan shall include:
 - A health action plan with enrollee self-management goals, identifications of barriers to meeting goals or complying with the treatment plan;
 - Time schedule for follow-up treatment and communication with the enrollee;
 - Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or care manager; and

- Integration and coordination of clinical and non-clinical services, including follow-up to ensure disciplines and services are accessed.

2. Reduced Care Management

- Description:
 - The care management fee shall be reduced when the care manager is providing care coordination and health promotion activities no more than one to two times per month; and
 - The enrollee's health status is relatively stable; and
 - Community resources and support services are fully implemented to promote the health action plan; and
 - Individual and family formal and informal supports are providing tangible assistance to the enrollee in meeting the health action plan goals and
 - The enrollee is demonstrating an improved activation rate (if the beneficiary is able participate in screening using the Patient Activation Measure.

Managed Care

Payment for health home services are built into the current managed care rates effective July 1, 2012 for high cost, high risk enrollees. No additional funding will be provided to the managed care organizations for health home services.

The managed care organization will distribute the payment for health home services to the lead entity. The lead entity will distribute the funds accordingly to the health home network. The lead entity will be charged with a specific role, including an agreed upon method for the distribution of funds. MCOs may be the lead entity in a network.

Fee-For-Service

Payment for health home services delivered through the fee-for-service will be available through an encounter payment made to the health home lead entity. Payment shall be made according to the tiering methods and associated encounter coding defined for health home services. The fee will only be paid when at least one of the six qualified health home services are provided in a given month.

Administrative Fees and Incentives

A small portion of the PMPM will be set aside for administrative activities and the creation of an incentive pool. The maximum administration rate will be paid when the qualifications document is finalized. The incentives will be payable following completion of the final health home evaluation and based on aggregated performance on the following health home program goals:

1. Reduction of non-emergent ED visits;
2. Reduction of avoidable hospital readmissions; and
3. Reduction of nursing home placements.

Health Home Goals and Associated Quality Measure Requirements

As a condition of receiving payment for 2703 health home activities, states must collect quality measures. The Centers for Medicare and Medicaid released a core set of health home quality measures. These measures are derived from and align with (1) mandatory quality measures within section 401 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA); (2) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and outcomes, and quality of care outcomes specific to the provision of health home services; and (3) mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act. The purpose of the core set is to assess individual-level clinical outcomes and experience of care

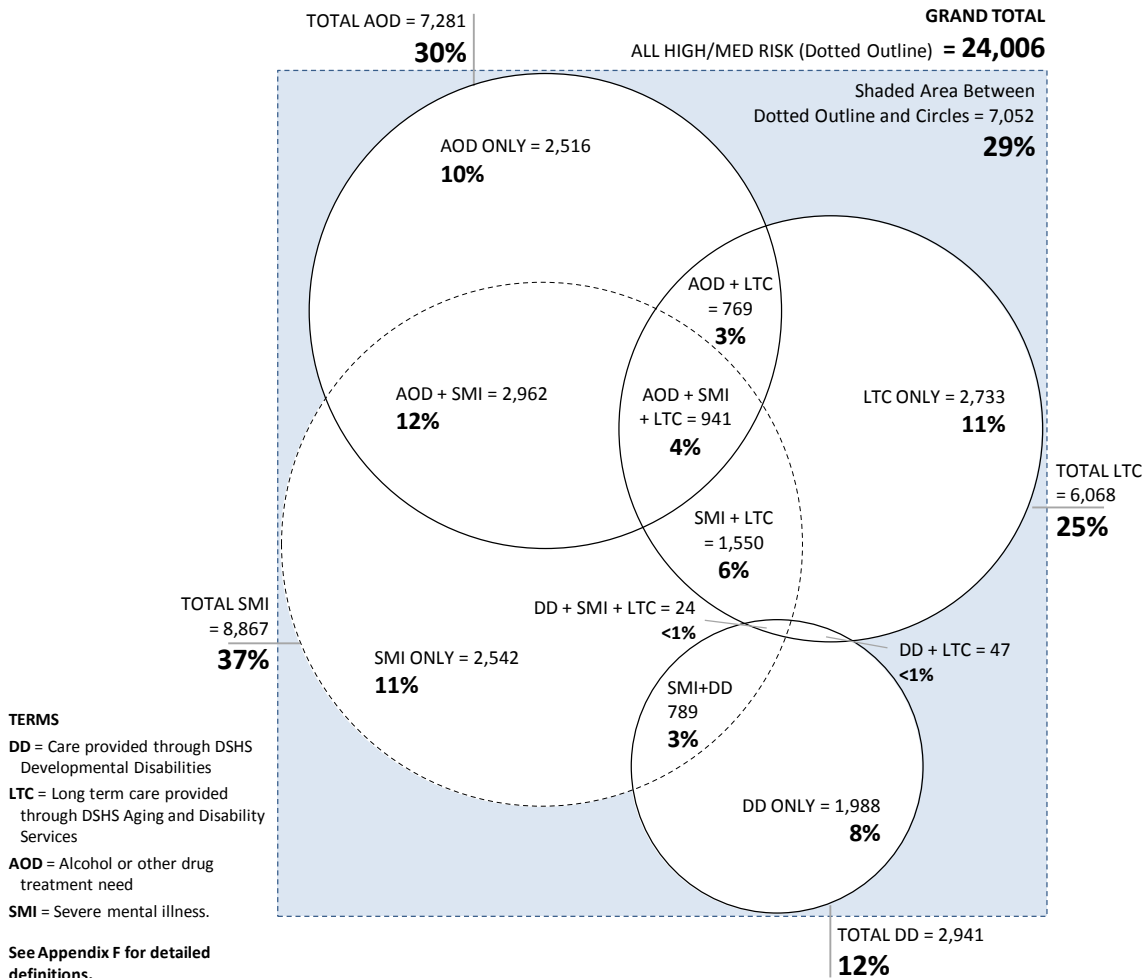
To the extent possible, measures that can be drawn from claims data are used in the core set in order to reduce burden on States, however, CMS recognizes that certain measures in the core set require data extractions from medical records and will require additional work for providers and States.

WA has selected the core, required measures and a small subset of recommended measures for health home assessment and reporting to CMS. See Appendix P of the duals grant. WA assumes that all evaluation data will be collected and analyzed by the State for evaluation purposes.

Attachment A - Characteristics of High Risk Medicaid Enrollees

Service Need and Risk Factor Overlaps among High Medical Risk, non-dual Medicaid Disabled Twenty percent (20%) of the Population is deemed high risk

BENEFICIARIES: STATE FISCAL YEAR 2009



NOTE: This diagram shows **almost** all the groups with overlapping risk factors. 93 people in the total population of 24,009 persons are not shown on the diagram (though they are included in the group subtotals), because they have combinations of risk factors represented in circles at opposite ends of the diagram. These are the 93 people with both developmental disabilities (DD) and alcohol/drug (AOD) need flags.

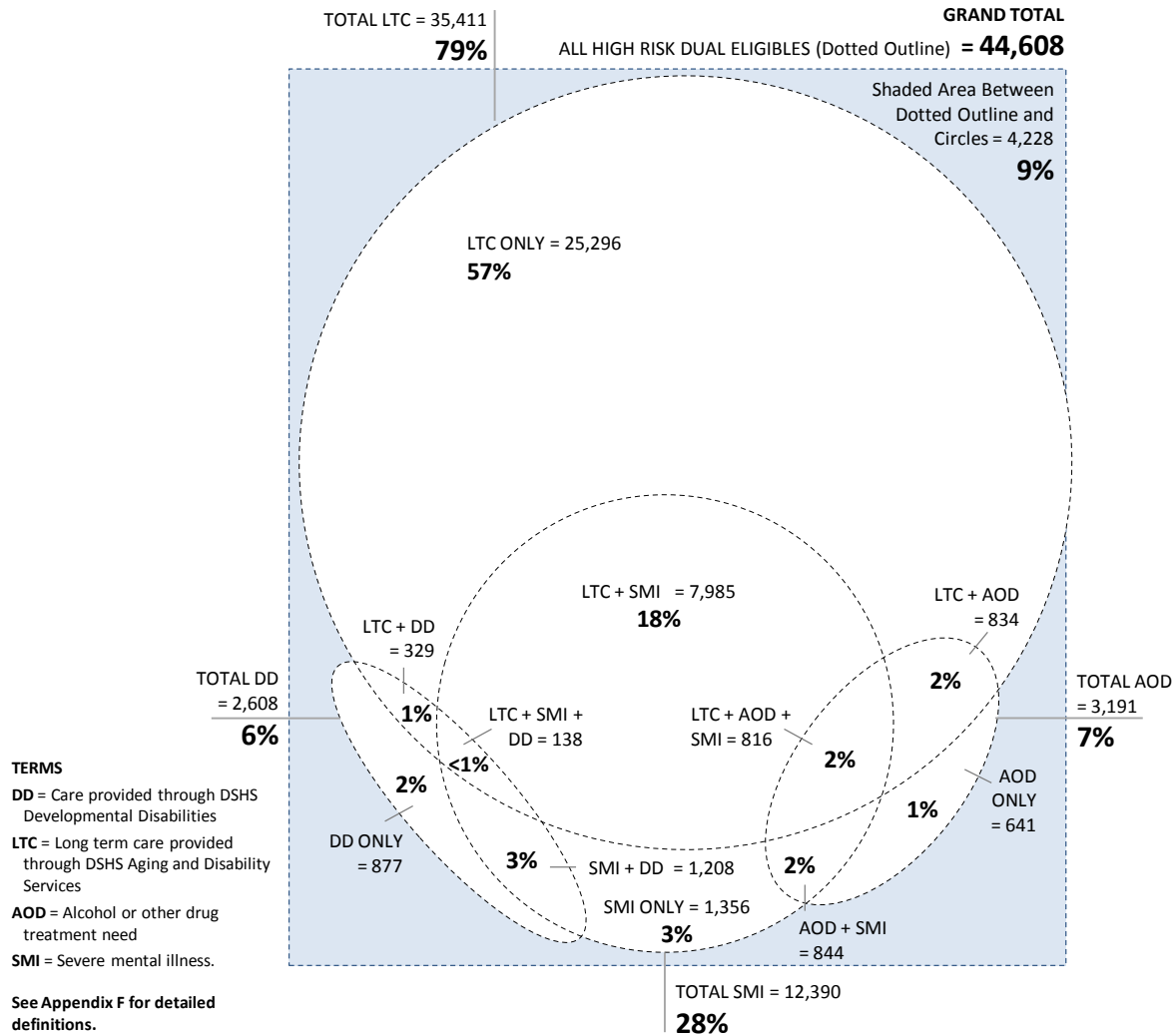
SOURCE: DSHS Planning, Performance and Accountability, Research and Data Analysis Division, Integrated Client Database, January 2012.

TERMS

DD = Care provided through DSHS Developmental Disabilities
 LTC = Long term care provided through DSHS Aging and Disability Services
 AOD = Alcohol or other drug treatment need
 SMI = Severe mental illness

**Service Need and Risk Factor Overlaps among High Risk Dual Eligible Aged or Disabled Beneficiaries –
Forty Percent (40%) of the Population is deemed high risk**

STATE FISCAL YEAR 2009



NOTE: This diagram shows **almost** all the groups with overlapping risk factors. 56 people in the total population of 44,608 persons are not shown on the diagram (though they are included in the group subtotals), because they have combinations of risk factors represented in circles at opposite ends of the diagram. These are the 56 people with both developmental disabilities (DD) and alcohol/drug (AOD) need flags.

SOURCE: DSHS Planning, Performance and Accountability, Research and Data Analysis Division, Integrated Client Database, January 2012.

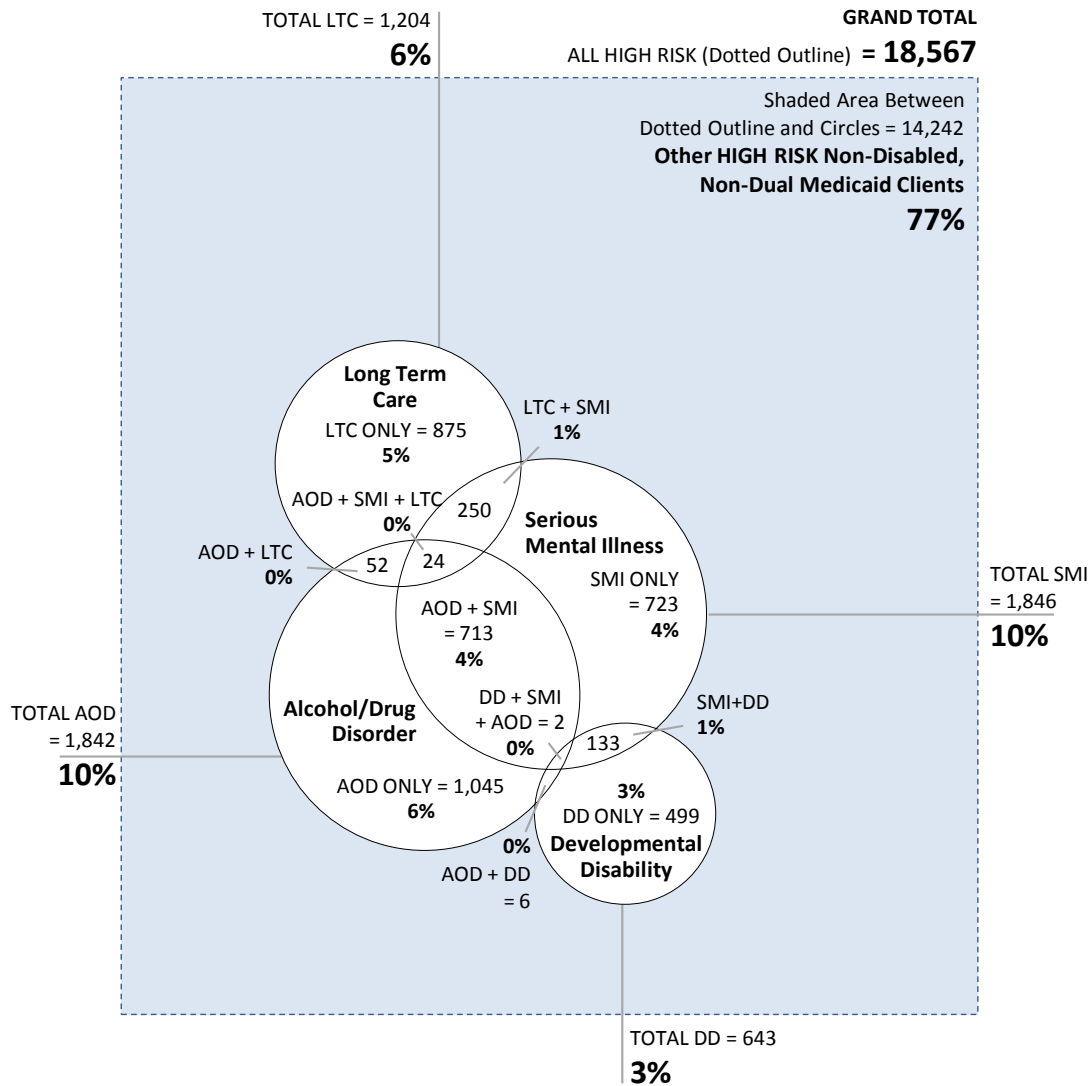
TERMS

- DD** = Care provided through DSHS Developmental Disabilities
- LTC** = Long term care provided through DSHS Aging and Disability Services
- AOD** = Alcohol or other drug treatment need
- SMI** = Severe mental illness

Service Need and Risk Factor Overlaps among High Risk, non-Disabled, non-Dual Medicaid Beneficiaries (Current Healthy Options beneficiaries)

Five percent (5%) of the Population is deemed high risk

STATE FISCAL YEAR 2009



NOTE: This diagram shows **almost** all the groups with overlapping risk factors. 3 people in the total population of 18,567 persons are not shown on the diagram (though they are included in the group subtotals), because they have combinations of risk factors represented in circles at opposite ends of the diagram. These are the 3 people with both developmental disabilities (DD) and long-term care (LTC) flags.

SOURCE: DSHS Planning, Performance and Accountability, Research and Data Analysis Division, Integrated Client Database, January 2012.

TERMS

- DD** = Care provided through DSHS Developmental Disabilities
- LTC** = Long term care provided through DSHS Aging and Disability Services
- AOD** = Alcohol or other drug treatment need
- SMI** = Severe mental illness

Attachment B - Definitions

1. **Care Manager** means a health care professional, licensed in the state of Washington, linked to a designated provider; or subcontractor responsible for providing care management services to enrollees. Care managers may be:
 - a. A primary care provider delivering care management services in the course of conduct of care;
 - b. A registered nurse, licensed practical nurse, or BSW or MSW prepared social worker employed by the health home;
 - c. A registered nurse, licensed practical nurse, or BSW or MSW prepared social worker contracted by the health home;
 - d. Staff employed by the primary care provider; and/or
 - e. Individuals or groups subcontracted by the primary care provider/clinic or the health home.Nothing in this definition precludes the health home or care manager from using allied health care staff, such as community health workers, peer counselors or other non-clinical staff to facilitate the work of the care manager.
2. **Care management** means health care management delivered by Care Managers. Care management includes a comprehensive health assessment, care planning and monitoring of patient status, implementation and coordination of services, ongoing reassessment and consultation and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including case closure, as warranted with beneficiary improvements and stabilization. Effective care management includes the following:
 - a. Actively assists patients to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
 - b. Employs evidence-based clinical practices in screening and intervention;
 - c. Coordinates care across the continuum of medical, behavioral health and long-term services and supports including tracking referrals and outcomes of referrals;
 - d. Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and
 - e. Uses appropriate community resources to support individual beneficiaries, families and caregivers in managing care.
3. **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions between: facility to home; facility to facility; providers or service areas; managed care contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; and from substance use care to primary and/or mental health care.
4. **Coordination of Care** means the mechanisms to assure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services (42 CFR 438.208).

5. **Chronic condition** means a prolonged condition and includes, but is not limited to:
- Cancer
 - Cardiovascular
 - Cerebrovascular
 - Central Nervous System conditions
 - Dementia/Alzheimer's
 - Developmental Disabilities
 - Diabetes
 - Hematological
 - Infectious disease including HIV/AIDS
 - Metabolic
 - Psychiatric
 - Pulmonary
 - Renal
 - Chronic pain
 - Substance Use Disorder
 - Serious Mental Illness
 - HIV/AIDS
 - Significant child development delays or conditions, e.g., severe autism/behavioral disorders
 - Chronic pain due to musculoskeletal conditions
 - Being overweight, as evidenced by a body mass index over 25.
6. **Designated provider** means a primary care provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, authorizer of long-term services and supports or multidisciplinary health care team that is qualified to be a health home provider and has the systems and infrastructure in place to provide health home services for enrollees with special health care needs and chronic conditions.
7. **Enrollees with Special Health Care Needs** mean an enrollee who has: at least two chronic conditions; one chronic condition and be at risk for another chronic condition; or one serious and persistent mental health condition. Enrollees scoring in the highest five percent (5%) of Medicaid enrollees or having a risk score of 1.5 or greater, using the Predictive Risk Intelligence System (PRISM) risk scoring methods, are considered enrollees with special health care needs.
8. **Health Action Plan** means a beneficiary-defined plan about what the beneficiary intends to do to improve their health. The health action plan should contain at least one beneficiary-defined goal; identify what actions the beneficiary is doing to achieve the goal; and includes the actions of the care manager and/or use of formal/informal caregivers (including direct care providers of services and supports), health care or community resources and services that support the enrollee's action plan.
9. **Health Home** means coordinated health care provided to beneficiaries with special health care needs by a Primary Care Provider, Designated Provider, a team of health professionals or a health team. At minimum, health home services include:

- a. Comprehensive care management including, but not limited to, chronic disease management;
 - b. Self-management support for the beneficiary, including parents of caregivers or parents of children and youth;
 - c. Care coordination and health promotion;
 - d. Multiple ways for the beneficiary to communicate with the team, including electronically and by phone;
 - e. Education of the beneficiary and his or her parent or caregiver on self-care, prevention, and health promotion, including the use of patient decision aids;
 - f. Beneficiary and family support including authorized representatives;
 - g. The use of information technology to link services, track tests, generate patient registries and provide clinical data;
 - h. Linkages to community and social support services;
 - i. Comprehensive transitional health care including follow-up from inpatient to other settings;
 - j. A single plan that includes all beneficiary's treatment and self-management goals and interventions; and
 - k. Ongoing performance reporting and quality improvement.
10. **Multidisciplinary Health Care Team** means a team of health professionals which may include, but is not limited to: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, including substance use disorder prevention and treatment providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, home and community based care providers (including direct care providers of services and supports) and physician's assistants.
11. **Direct Care Provider of Services and Supports** provides personal care and is a member of the interdisciplinary team that can assist beneficiaries in attaining the highest level of health and functioning in their families and in the community. Beneficiaries receiving personal care services will identify in their Health Action Plans the supportive role that their direct care worker, families and other informal supports can provide to achieve self-management and optimal levels health and functional status.
12. **Predictive Risk Intelligence System (PRISM)** means a DSHS-secure, web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next 12 months based on the patient's disease profile and pharmacy utilization.
13. **Transitional Healthcare Services** means the mechanisms to ensure coordination and continuity of care as enrollees transfer between different locations or different levels of care within the same location. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization or re-hospitalization, and recidivism following substance use disorder treatment.

Appendix V: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Standards and Conditions

October 2011

Washington assures compliance with the following standards and conditions

Integration of Benefits

Proposed model ensures the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services.

Care Model

Proposed model offers mechanisms for person-centered coordination of care and includes robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.

Stakeholder Engagement

State can provide evidence of ongoing and meaningful stakeholder engagement during the planning phase and has incorporated such input into its proposal. This will include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed model with relevant stakeholders. Stakeholders include, but are not limited to, beneficiaries and their families, consumer organizations, beneficiary advocates, providers, and plans that are relevant to the proposed population and care model.

State has also established a plan for continuing to gather and incorporate stakeholder feedback on an ongoing basis for the duration of the demonstration (i.e., implementation, monitoring and evaluation), including a process for informing beneficiaries (and their representatives) of the changes related to this initiative.

Beneficiary Protections

State has identified protections (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care, etc.) that would be established, modified, or maintained to ensure beneficiary health and safety and beneficiary access to high quality health and supportive services necessary to meet the beneficiary's needs. At a minimum, States will be required to:

- Establish meaningful beneficiary input processes which may include beneficiary participation in development and oversight of the model (e.g., participation on Participating Plan governing boards and/or establishment of beneficiary advisory boards).
- Develop, in conjunction with CMS, uniform/integrated enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech and vision limitations, and limited English proficiency.
- Ensure privacy of enrollee health records and provide for access by enrollees to such records.
- Ensure that all care meets the beneficiary's needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community.

- Ensure access to all services in a manner that is sensitive to the beneficiary’s language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately.
- Ensure an adequate and appropriate provider network, as detailed below.
- Ensure that beneficiaries are meaningfully informed about their care options.
- Ensure access to grievance and appeals rights under Medicare and/or Medicaid.
 - *For Capitated Model*, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes.
 - *For Managed FFS Model*, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.

State Capacity

State demonstrates that it has the necessary infrastructure/capacity to implement and oversee the proposed model or has demonstrated an ability to build the necessary infrastructure prior to implementation. This includes having necessary staffing resources, an appropriate use of contractors, and the capacity to receive and/or analyze Medicare data.

Network Adequacy

The demonstration will ensure adequate access to medical and supportive service providers that are appropriate for and proficient in addressing the needs of the target population as further described in the MOU template.

Measurement/Reporting

State demonstrates that it has the necessary systems in place for oversight and monitoring to ensure continuous quality improvement, including an ability to collect and track data on key metrics related to the model’s quality and cost outcomes for the target population. These metrics include, but are not limited to beneficiary experience, access to and quality of all covered services (including behavioral health and long term services and supports), utilization, etc., in order to promote beneficiaries receiving high quality care and for purposes of the evaluation.

Data

State has agreed to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to:

- Beneficiary level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models;
- Description of any changes to the State plan that would affect Medicare-Medicaid enrollees during this three year period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and
- State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

Enrollment

State has identified enrollment targets for proposed demonstration based on analysis of current target population and has strategies for conducting beneficiary education and outreach. Enrollment is sufficient to support financial alignment model to ensure a stable, viable, and evaluable program.

Expected Savings

Financial modeling demonstrates that the payment model being tested will achieve meaningful savings while maintaining or improving quality.

Public Notice

State has provided sufficient public notice, including:

- At least a 30 day public notice process and comment period;
- At least two public meetings prior to submission of a proposal; and
- Appropriate tribal consultation for any new or changes to existing Medicaid waivers, State Plan Amendments, or demonstration proposals.

Implementation

State has demonstrated that it has the reasonable ability to meet the following planning and implementation milestones by end of 2012:

- Meaningful stakeholder engagement;
- Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments;
- Receipt of any necessary State legislative or budget authority;
- Joint procurement process (for capitated models only); and
- Beneficiary outreach/notification of enrollment processes, etc.

Appendix X: Letters of Support

Letters of support have been attached from the following entities:

- Christine O. Gregoire, Governor
- Representative Eileen Cody and Senator Karen Keiser, Washington State Legislature
- Washington State Department of Health
- AARP Washington
- Developmental Disabilities Council
- Medicaid Expansion Health Home and Chronic Disease Stakeholder Collaborative
- State Council on Aging
- Washington Association of Area Agencies on Aging
- The ARC – Washington State
- Senator Maria Cantwell and Senator Patty Murray, United States Senate
- Washington Association of Community and Migrant Health Centers
- Washington Community Mental Health Association