

## Frequently Asked Questions (FAQ)

### HealthPathWashington Design Plan

Washington posted a draft design plan to integrate services for individuals who are eligible for both Medicare and Medicaid for a 30-day public comment period in March 2012. The following questions and answers are related to that design plan. As implementation conversations between Washington State and the Centers for Medicare and Medicaid progress an updated FAQ document will be created.

#### General Questions Related to the Overall Design Plan

**Q: Does ADSA / HCA have the capacity to implement all three strategies in the time line outlined?**

*A: Although state resources are very constrained, the three strategies build on current Washington state infrastructure, capacity and initiatives including: 1) DSHS Research and Data Analysis for expertise in data analysis, risk profiling, program evaluation, PRISM application development; 2) Health Care Authority for expertise in managed care implementation for the healthy options, SSI and Basic Health populations, medical home and payment reform, and the purchase of integrated service delivery networks; 3) DSHS/ADSA for expertise in delivery of services to individuals with physical, cognitive, developmental needs; self-directed service delivery models; development of home and community based service options; purchase of integrated service delivery networks; rebalancing systems of care from reliance on institutional settings; quality and provider network measures.*

*Successful implementation will rely on a partnership and collaboration of these areas of expertise and a prioritization of work to ensure tight timelines are achieved while maintaining quality of work. The state has requested additional resources from the Centers for Medicare and Medicaid Services to implement the integration strategies.*

**Q: How does this help stabilize the overall financial status of Medicaid program?**

*A: Analysis of expenditure and populations served shows that a small population of Medicaid and Medicaid/Medicare individuals account for a large amount of Medicaid expenditures. Targeting interventions to these individuals, sometimes referred to as the 5/50 population will ensure the programs are providing the right service at the right time and place and will reduce the overall expenditure trends. Reaching this goal will reduce duplication and use of avoidable emergency room visits, inpatient hospital and institutional stays. This will ensure beneficiaries and the state get the most value for each health dollar spent and that the future cost curve of health care spending will be reduced. For additional information, please refer to appendices F and Q of the final duals design plan.*

**Q: What is the family and caregiver's role and involvement in the plan of care?**

*A: Beneficiaries often give caregivers and family members a critical role in plans of care by supporting them to achieve their health goals, assisting them in accessing the right care at the right time and place and assisting beneficiaries when needed to communicate effectively with their health care and social service providers.*

**Q: How will the plan grow to include future eligible recipients?**

A: The duals integration proposal is a request to the Centers for Medicare and Medicaid services to implement a three year demonstration project. Implemented integration strategies will be available to future eligible recipients during that three year period. After that time, there will be an evaluation and analysis of the outcomes of the demonstration project and potential continuation of the program.

**Q: How many beneficiaries do you project will participate in each of the 3 strategies?**

A: *It is difficult to accurately estimate enrollment for several reasons including: the models are based on voluntary enrollment; the number of counties which will approve implementation of strategy 2 is currently unknown; the state is still in negotiation with CMS around implementation agreements. In the final design plan, the state estimated the following enrollment by the end of year 2:*

*Strategy 1: 21,000      Strategy 2: 27,000      Strategy 3: 58,000*

**Q: Are all areas of the State included?**

A: *Yes, the state intends to use at least one of the integration strategies in all areas of the state.*

**Q: Can Strategy 1 begin in a county in 2013, and then implement Strategy 2 for the remainder of the dual eligibles in 2014?**

A: *No, CMS will not allow the state to change the financial alignment strategy in a geographic region during the 3-year demonstration period.*

**Q: How does the plan improve care coordination?**

A: *The state intends to improve care coordination through clinical and financial integration of fragmented service delivery and funding silos and by creating shared outcomes and aligned financial incentives that will promote improved health outcomes, access to needed services and reductions of avoidable high cost services provided in institutional and hospital settings. Strategy one improves care coordination for high cost/high risk beneficiaries by offering a new set of services that will provide individualized education, coaching and interventions designed to improve health and functioning and reduce the impacts of chronic conditions. The health home is a care coordination model that supports integration by linking delivery systems.*

*Under strategy 2, health plans would be required to provide care coordination to all beneficiaries that enroll whether they are high cost/high risk or not. Intensive care coordination would be required for enrollees that meet the health home eligibility criteria.*

**Q: Please explain how ancillary Durable Medical Equipment (DME) providers will fit into the models.**

A: *Durable medical equipment is available under both Medicaid and Medicare, but each fund source uses different eligibility and coverage rules. Individuals receiving their Medicare and Medicaid services under strategy 2 will have a single health plan who is contracted to provide these services. That health plan will be responsible for providing DME and will coordinate and pay for these services.*

**Q: How will the state measure utilization/access for medical, mental health, chemical dependency, long term services and supports and services to beneficiaries?**

*A: The state can identify individuals receiving services through assessment and service payment data, and measure their utilization of services through claims and encounter data from both state and federal sources.*

**Q: Will the state require standardized screening tools for chemical dependency and mental health?**

*A: The state will require the use of evidence based screening tools and will pre-approve the tools used by health home providers and health plans.*

**Q: In a county who supports strategy 2, integrated managed care, what happens to clients who opt out? Do they go to strategy 3; the existing system of RSN, AAA, county alcohol/drug and fee for service medical; or, will they revert to fee for service for everything?**

*A: CMS has not yet approved Washington's implementation proposal. As proposed to CMS, an individual who opts out of strategy 2 would have the following options:*

- *For Medicare coverage the individual would be able to join any available Advantage, Special Needs Plan (SNP) or traditional fee for service option;*
- *For Medicaid coverage, the individuals would be served under fee for service for medical, long term services and supports, chemical dependency or developmental disability services and under the capitated prepaid inpatient health plans delivered through Regional Support Networks;*
- *High cost/high risk beneficiaries would be able to enroll in a qualified health home to receive intensive high touch care coordination under fee for service payment systems.*

### **Strategy 1: Health Homes**

**Additional questions & answers related to health homes can also be found at:**

[http://www.hca.wa.gov/documents/health\\_homes/Health\\_Homes\\_Comments\\_and\\_Responses.pdf](http://www.hca.wa.gov/documents/health_homes/Health_Homes_Comments_and_Responses.pdf)

**Q: Are health homes envisioned for ALL Duals, or just the high cost/risk duals?**

*A: Health homes are a very high touch intensive version of care coordination that is targeted at the high risk duals that score 1.5 or greater in PRISM or meet other criteria for health home eligibility. For additional information please refer to appendix F of the final HealthPathWashington design plan.*

**Q: Will qualified health home providers be limited to the Medicaid contracted health plans?**

*A: As required under the 2703 health home state plan amendment, health homes will be embedded in all service delivery systems, both managed care and fee for service. The current joint procurement language require the contracted health plans to deliver intensive care coordination/health home services to clients who score a 1.5 or higher in PRISM either by putting a network together to become a qualified health home or by contracting with a qualified health home. The funding for this health home service is already in the capitated payment paid to health plans. The funding to provide health homes to individuals who are dually eligible for both Medicare and Medicaid relies on leveraging the General-Fund State investment in the healthy options capitation to draw down the enhanced federal match available*

*under section 2703 of the Affordable Care Act. HCA and DSHS will be working closely with the 5 Medicaid contracted health plans to ensure a consistent implementation of health home services in WA state.*

*HCA will be releasing an application process for qualifying health homes in the late summer 2012.*

**Q: Can there be more than one lead entity in a health home – shared responsibilities?**

*A: No, there needs to be one lead entity. We are developing specific criteria for the lead entity in conjunction with the early implementation of Health Homes with the MCOs, so it may be a couple of months out before this is nailed down. The lead entity can delegate duties, however, as with any subcontracts, the lead entity has ultimate responsibility for their agreed upon services.*

**Q: Will health plans be required to contract for health home services with community providers?**

*A: For Medicaid only enrollees who are enrolled in a MCO, the MCO is required to be part of the health home network. For duals who are on the fee-for-service system, they may be enrolled in a FFS health home. A FFS health home and a MCO health home do not need to be distinct. One health home could serve both MCO enrollees and FFS enrollees.*

**Q: What is the long term impact for an agency participating in Health Home (post eight quarters of 2703)?**

*A: The funding for health home services under the Healthy Options contract is funded within the health plan capitation. The requirement to provide intensive care coordination through qualified health homes is a part of the Healthy Options contract and is not reliant on 2703 funding. Funding to provide health home services for eligible individuals not enrolled in Healthy Options contract will be done through section 2703 of the ACA. The state is working with the Duals Coordination office at CMS to determine how these services could be provided to duals after the enhanced federal match ends.*

**Q: Is the state expecting to create new entities or providers to provide health home services?**

*A: HCA and ADSA will not be creating new entities. We encourage new partnerships between existing community based and managed care delivery systems to provide care coordination for the high risk/high cost population. The health home network must be built using existing organizations with demonstrated expertise in providing those services.*

**Q: How will Health Homes avoid duplication of care managers?**

*A: Non-duplication of effort is a high priority for the State and CMS. Health homes will be coordinating care across service domains and will focus on the overall health goals of the enrollee. Specialized care management within particular services will continue. Health homes need to make a distinction between the care coordination services they provide and care coordination services that are provided by other entities.*

**Q: How are Health Homes different from Medical Homes?**

*A: Medical homes and patient-centered medical homes are delivered from a facility that delivers primary medical care and is focused on medical care coordination while health homes can be delivered from a variety of community based organizations and is focused on cross-system health and social service coordination.*

**Q: Where in the state are Health Homes already in the early stages of formation?**

*A: There are a number of local efforts underway to create health home networks including coordination between Community Mental Health Centers, Federally Qualified Health Clinics, Area Agencies on Aging, Regional Health Alliances and Accountable Care Organizations. Some geographic regions have begun discussions about health home networks in their local areas.*

**PRISM/Data**

**Q: Can you provide more detail on the type of data that will be available via PRISM?**

*A: The application is a web-based clinical decision support tool that provides client risk and service histories to care coordinators. PRISM pulls information from a number of data sources including claims paid by ProviderOne and the Social Service Payment System (SSPS). Claims history provides information such as pharmaceutical payments, physician visits, emergency room visits, hospital stays and services provided under chemical dependency, developmental disabilities and long term services and supports. PRISM also pulls from encounter data showing services provided through managed care such as medical and mental health interventions. PRISM also pulls targeted data from the DSHS CARE assessment application including classification level, cognitive performance scale score, behaviors that impact the provision of personal care and assessment dates and reasons for assessment.*

*DSHS and HCA are working together with CMS to create an integrated PRISM data base that will include Medicare claims history. The state will need to get authorization from CMS to use the Medicare data for care management/care coordination purposes.*

**Q: How will medical information be shared among providers and accessible to the recipients?**

*A: Releases of information and data use agreements will be used to share information across providers. Recipients can request access to their records at any time. The State of Washington is continuing to explore implementation of electronic health records that would be accessible to providers and recipients.*

**Q: How do duals look different than non-duals?**

*A: See section Bii of the duals design plan.*

**Strategy 2 and 3: Financial Capitation**

**Q: Will ONLY managed care plans selected through the existing joint solicitation (effective 7/1/12) be eligible to bid to provide Duals integrated services?**

*A: For counties that agree to implement strategy 2 for only the duals population, health plans with 2012 Medicaid or Medicare contracts in Washington State will be eligible to bid. For counties that agree to implement strategy 2 for both the duals and Medicaid only populations, health plans with 2012 Medicaid contracts in Washington state will be eligible to bid.*

**Q: Is there consideration of including Medicaid only clients in Strategy 2?**

*A: The budget proviso would allow a county legislative authority to agree to include duals only or duals and Medicaid only individuals in strategy 2.*

**Q: In strategy 3, what services would fall outside capitation?**

*A: Long term services and supports, services to individuals with developmental disabilities and chemical dependency would fall outside of health plan capitation. Medicaid mental health services would continue to be capitated and paid to Regional Support Networks who are responsible to provide those services.*

**Q: Will have plans be required to submit a Request for Proposal in order to participate in Strategy #2?**

*A: Health plans will need to compete in order to participate in strategies 2 or 3. Therefore plans will need to submit information in order for the both the state and CMS to evaluate whether or not the plan will meet criteria to participate in strategies 2 or 3. The state is anticipating release of county and state specific selection criteria for Medicaid services in November 2012. The federal government will issue selection criteria for Medicare services.*

**Q: Does this plan medicalize Long Term Services and Supports (LTSS)?**

*A: Long term services and supports are a mixture of skilled treatments, services and therapies and non-medical services such as personal care, home delivered meals, Personal Emergency Response System, adult day care, etc. The move to integrate long term services and supports with other services such as medical care and rehabilitation provided in skilled nursing facilities is not an attempt to medicalize the services. Beneficiaries and providers alike recognize that the need for medical and non-medical/supportive services are inter-related and of equal importance to those who rely on these services to meet their health and community care goals.*

**Q: Does the plan reflect core values of person centered, inclusive, community based services?**

*A: Yes, integrated systems of care 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*

**Q: Does strategy 2 include all government funding/clients for medical, mental health, substance abuse, long term care or does it only include the dual eligible population?**

*A: The county legislative authority approves whether or not strategy 2 will be implemented in a particular county. The budget proviso indicates that the county could approve implementation of strategy 2 limited to individuals who are eligible for both Medicare and Medicaid (duals) or also include individuals who are eligible only for Medicaid. Strategy 2 includes Medicaid funding for medical, mental health, substance abuse and long term services and supports for the population approved by the county legislative authority.*

**Q: Can Medicaid only clients opt out of strategy 3?**

*A: Strategy 3 has two parts. The part that duals can opt out of is enrollment in managed care that would include all Medicare services and Medicaid medical services in a blended capitation purchased through a health plan. That blended capitation does not apply to Medicaid only clients.*

**Q: For counties that give approval to implementation of strategy 2, will the RSN and AAA contract with health plans or the state?**

*A: The contract for strategy 2 will be between the federal government for Medicare funding, the state government for Medicaid funding and the health plan. Any contracts for services provided under strategy 2 will be between the health plan and provider organizations.*

**Q: Is there an expected timeframe between when a client is identified as needing a service and when they actually receive it?**

*A: Yes, this will be defined in the state specific selection criteria that will be issued in November 2012.*

**Q: Is there an expected timeframe between when the provider provides a service and when the Plan reimburses them?**

*A: Timely reimbursement of providers will be a state specific contract requirement. The timeframe will be identified in the selection/procurement document which is anticipated to be released in November 2012.*

**Q: Is there a threshold of complaints that would result in dropping a Plan?**

*A: The state is committed to ensuring high quality service delivery for beneficiaries receiving services under both Medicaid and Medicare. The state will use progressive corrective action steps when health plans are not meeting contract requirements including quality withholds, financial penalties, suspension of enrollments and if necessary contract termination.*

**Q: What is the process in joint procurement for plans establishing their formulary? Is it what currently occurs in FFS or are plans allowed to establish their own formularies?**

*A: The formulary must comply with both Medicare and Medicaid requirements. The selection/procurement document which will be issued in November 2012 will identify the formulary requirements plans must follow.*

**Q: What is the county legislative authority process, what does it look like, who does it come from in the county.**

*A: The budget proviso passed by the 2012 legislature includes a provision that strategy 2 will be implemented in areas where the county legislative authority has agreed to the terms and conditions. Agreement is viewed as a vote passed by the elected county legislative authority which is typically a county council or a board of commissioners.*

**Q: Will counties be able to select which plans they partner with or will counties need to work with all qualified plans in a county?**

*A: Strategy 2 will only be implemented in counties where county legislative approval has been granted. The state is working with counties to determine county specific selection criteria for incorporation into the plan selection process. Plans must meet county, state and federal selection criteria. To implement strategy 2, counties will need to partner with those health plans that are contracted as a result of that procurement/selection process.*