

April 12, 2012

Barbara Lantz
Quality Monitoring Section Manager
Washington State Health Care Authority

Bea Rector
Office Chief, Home and Community Services
Washington State Department of Social & Health Services

Re: Comments on the 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

Dear Ms. Lantz and Ms. Rector:

In March of this year, a number of individuals who have been working in the areas of health and social services around Washington State had the opportunity to come together and begin a conversation about the role of Medicaid Expansion in the Affordable Care Act (ACA). We formed the Medicaid Expansion Leadership Group.

The group is made up of individuals ranging from health care providers to policy professionals and senior leaders of local community based organizations. We meet monthly to share information and assess the needs and progress as we move towards implementation of the ACA.

On behalf of the Group, we first want to express our gratitude for the fine example of intergovernmental state leadership demonstrated by both the Washington State Department of Social and Health Services Aging and Disability Services Administration, and the Health Care Authority. The leadership and forward thinking demonstrated in this proposal will help ensure the delivery of quality health care to people living with Chronic Conditions as envisioned in the ACA.

Our Comments on the Proposal are attached. To help facilitate communication, if you have any specific questions regarding these comments, please feel free to direct them to BJ Cavnor who will then distribute them to the Group.

Sincerely,

The Members of the Medicaid Expansion Group

Organizations:

Randal H. Russell
Chief Executive Officer
Lifelong AIDS Alliance
Seattle, WA

BJ Cavnor
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Individuals:

Janet Johnson
Loon Lake, WA

Jack Johnson
Tacoma, WA

Joel V. Johnson
Vancouver, WA

Victoria Chipps
Burien, WA

Executive Summary (page 2)

1. We agree and support the state's integration of Section 2703 of the Affordable Care Act into a state-organized Health Home option and agree with the target of serving "...behavioral health long-term services and supports for persons across the lifespan with chronic illness." Given the definition references multidisciplinary health teams, we suggest the summary include this same wording for clarification this is a coordinating group, not an individual.
2. There is a description to propose an expanded health home model to serve chronically ill. Given the flexibility within the law, it is recommended that the language not limit the state's option to "a" health home, but rather this language could reference health home or health homes as long as a) health outcomes and reduced transmission of disease can occur and b) there is cost neutrality or savings of those in care.
3. We support and encourage the proposal to qualify community based entities to deliver health home services to Medicaid and Medicaid-Medicare dual eligible, chronically ill, high risk individuals. Community based organizations already provide clients with many of the comprehensive care management and coordination services outlined in the proposal.

Background (page 3)

4. The extent of analysis is greatly appreciated. However, a review of utilization data alone does not truly reflect the need or the story for many low-income persons with chronic disease. There are many sources of need – especially from public health. The growth from the uninsured to this chronic disease state as represented in Attachment A is missing those known diagnosed and not in care at present. The implementation of this model will cover several tens of thousands more people potentially. Utilization data is not an ample predictor of likely care needs. Is it possible to include diagnostics and known growth areas where possible?
5. The three groups analyzed (page 3) again does not include those not in a utilization state as they are currently not covered. For example, there are likely to be 120,000 (projection from the CDC) persons diagnosed with Hepatitis C – there is potential of oral mono-therapy to cure HCV available in 2014. This one area alone could change the need to focus on this group.

Facts (page 4)

6. The group supports the facts behind the concept. There are some areas of clarity that may be helpful. Those include:
7. Moving the majority of the Medicaid population into the managed care marketplace can make sense for many people and disease states, however clarity around who and how managed care marketplace participants (profit, nonprofit, and accountable care organizations) would be helpful to have defined here. Placing beneficiaries into managed care plans without understand and addressing this issue will not achieve desired cost savings or improved health outcomes. Only by working now with managed care plans, community organizations and integrating existing service networks, providers and payers can we ensure that we avoid the mistakes other states have made in designing and delivering services.

8. High Risk individuals is not defined – high risk in terms of utilization of expensive services, of unnecessary hospital costs at higher rate, and/or high risk of additional disease states leading to poorer health outcomes and higher costs. A definition could be helpful here as well.
9. We agree with concept of “treat to target” programs, and we and seek to integrate them into broader national public health goals. One example is the National HIV/AIDS Strategy; a chief measure of this strategy is measurable health outcomes including a 20% reduction in “community viral load” or detectable level of virus, in people living with HIV/AIDS, by 2015. By achieving this goal we will lower overall transmission and improve community health.
10. Regarding an integrated, health care service delivery model to serve high risk, high cost populations are supported by the agency and its stakeholders. We support this fact and we welcome the opportunity to share technical and practical assistance with new and existing partners.
11. The effective date of January 1, 2013 – while it is clear this may take full advantage of 8 quarters given the other parameters opted into by Washington state, could the request be made to CMS to still have the 8 quarters with the start date of January 1, 2014? What are the pros and cons of this potential wiser start date in order to integrate all of the moving parts in a smoother way to reach those high-need high utilizing persons and engage them in care in the best way?
12. We understand the Healthy Options and Basic Health contracts are implemented January 1, 2013; the non-disabled adult below 133% of FPL will be eligible January 1, 2014. Does this earlier trigger date allow for the coverage of non-disabled adults on 1/1/13 or will they only receive 4 quarters of 90% federal coverage? We are concerned that specialized medical care, treatment and supportive services are on par with, and fully integrated into, existing service models and programs. Only by working now, and continually with managed care plans, community organizations, stakeholder representatives and integrating existing service networks, providers can we ensure that we avoid the mistakes other states have made in designing and delivering services.

Assumptions (page 4)

13. Regarding the definition of eligible health homes; we support this plan as a sensible way to move forward in the design and creation of health homes. The role of community based organizations will be critical in disseminating information to beneficiaries, community partners and other stakeholders.
14. It is agreed and supported that community-based or primary care settings make sense.
15. Regarding health home standards; we support this assumption and encourage conversations and comments with the stakeholder community as it relates to Health Home Standards.
16. Health homes are an administrative and structural change invisible (theoretically) to the recipient.
17. Regarding payment reflecting risk, if the increased payment tied to risk is part of a comprehensive integrated mental, physical and case management plan we approve this provision. We understand the increased resources necessary to manage high-risk patients, and believe that providers of all services, including case management form community based organizations, should be compensated accordingly. One concern is how standards can be set and defined for nonprofit, for profit, ACO, and other provider groups when some are providers and some are third-party payers? It is not clear how

those payments will be tiered and/or be established on patient risk – it is assumed the risk is as defined by PRISM.

18. There is a reference of a health home provider network – would it be possible to include some models of what the authors think are successful options for consideration?

Timeline (page 5)

19. Given the Managed Care implementation of Healthy Options and the state-sponsored low cost coverage of Basic Health on January 1, 2013, would it not be wiser and smoother to consider a yearlong delay for health home implementation with a waiver from CMS for pulling the trigger sooner on the MCO and BH options?

Visions of an Integrated Health Home (page 5-6)

20. In the definition of the health home as the central point of contact, how will a single point of contact by person be established in the combination of efforts being undertaken in different counties and given the geographic disbursement (or lack of in rural settings) providers to form and create the health home? Is there an assumption or expectation that there will be a statewide system as well?
21. How can health home providers demonstrate abilities given the anticipated increase of persons in care and new networks that will undoubtedly be required to formalize given the growth in population coverage? Could that demonstration requirement on page 6 be done through demonstration of capacity without history given this is a newly requested establishment of systems to support an increased high-need population?
22. What about screening and diagnostic services to move those currently uninsured into care more quickly – will the health home be given that reimbursement and support to screen and diagnose including the full scale use of the PRISM model?

Health Home Goals (page 7)

23. We agree is with the goals as stated. Because of the ability to provide expanded coverage under the ACA, we suggest adding language which recognizes this fact and establishes as a stated goal, the ability to provide coverage to persons previously not covered through insurance of any kind.
24. We are concerned about the guidance that can be given for those who are undocumented. Acknowledging and planning for the care of this population remains a key concern of the Group.

Eligibility (page 7)

25. Eligible beneficiaries need to include those living with chronic communicable infections including HIV, viral hepatitis (especially C for coverage and A&B for vaccination), sexually transmitted infections (to intervene early with services to avoid contracting other more chronic conditions), and others as identified with co-morbidities. It is understood the PRISM score will have an impact here, but if listing disease states or conditions is to occur, it is strongly recommended to include the above language.

Health Home Guiding Principles (page 7)

26. The guiding principles do not address methodologies and perhaps purposefully so. However, as a matter of principle, managed care organizations and/or health home networks should/could be included in this section.
27. We are especially supportive of the goal of delivery of services at the local level, inclusion of self management and recovery principals, inclusion of family members and caregivers, and accountability to improved patient outcomes.
28. We support the inclusion of local community providers, including; mental health, chemical dependency, long term service and supports and medical services, and aging. We encourage you to promote the role of safe, affordable housing as a critical component of health care.

Health Home Networks (page 7-8)

29. We recommend the qualifications by the State of Washington Medicaid program for health home networks include anticipated examples for the urban, and less urban, centers of the state. By doing this providers, third party payers, primary care providers, and behavioral health providers will have a clearer picture of the expectations of the authors.
30. Will it be required that all members of the health home networks be Medicaid providers or could there be (or is it expected to be) that there will be one provider for a network that will be the provider with providers in their network?

Comprehensive Care Management (page 8-9)

31. It is recommended and strongly advised that a) access to, and b) retention in care and needed services be added to this section. For example, the new DHHS guidelines suggest any HIV+ person should be on treatment – using this standard there are about 48% of the state who are diagnosed (another 15%-20% not diagnosed) but not in treatment. Chronic disease and transmission of these chronic infection diseases can be zeroed out if people are on treatment with undetectable viral load. This disease management also means that it is very cost effective to not just link, but to be sure access to care is in place through tight personal connection and that the individuals/families stay in care.
32. Data sharing arrangements and compliance with HIPPA are obviously expected to be in place along with the use of Health information technology options.
33. We hope that as these programs are designed WSDSH/ADSA and HCA will look to existing community based organizations to assist you in this role. Please utilize us for our assistance and knowledge as partners in this endeavor.

Referral to Community and Social Support Services (page 11)

34. Please refer to comments in number 31 above. There is a strong need to include in the standards the confirmation and assurance that persons are not just linked, but truly have the ability to access care, on a regular basis before referrals can be considered complete.

