Washington State Department of Social & Health Services

ADSA Aging & Disability Services Administration

Washington State Health Care Authority

Report to the Legislature

Purchasing Mental Health, Chemical Dependency and Long Term Services and Supports, Including Services for People With Developmental Disabilities

As Required by Engrossed Second Substitute House Bill 1738, Chapter 15, Law of 2011

November 2013

Washington State Health Care Authority

PO Box 45502

Olympia, WA 98504

(360) 725-1880

Department of Social and Health Services

Behavioral Health and Service Integration Administration

PO Box 45600

Olympia, WA 98504-5600

(360) 725-2261

Table of Contents

Executive Summary

House Bill 1738 transferred oversight of the Medicaid program from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) on July 1, 2011, including the responsibility to purchase medical assistance for all Medicaid recipients. DSHS retains responsibility for purchasing long term services and supports for people with physical, cognitive and/or developmental disabilities and behavioral health services for people facing mental health and/or substance abuse challenges, primarily using Medicaid funds available via cooperative agreement with HCA.

House Bill 1738 directed DSHS and HCA to develop options for more effectively coordinating the purchase and delivery of care for Medicaid populations. At the same time, passage of the Patient Protection and Affordable Care Act in 2010 presented an unprecedented opportunity for change and infusion of resources in Washington state. The state is participating in the Medicaid expansion and launched a fully operational Health Benefit Exchange in October 2013. These efforts enrolled 250,000 individuals aged 19-65 not previously eligible for Medicaid and 75,000 individuals who were eligible but didn't realize it, providing an opportunity for many of the state's most vulnerable residents to receive necessary care that until now was not affordable.

It is in this context that HCA and DSHS have been collaborating on major health care initiatives aimed at transforming the current system into one that achieves better health outcomes, creates needed system efficiencies, and effectively manages costs as the number of people receiving services grows. Collaboration has taken the form of planning and implementing new models of care that integrate acute medical services with mental health and chemical dependency care, and reach into community long term supports and services to achieve common goals of independence and recovery. Since the passage of HB 1738, the agencies have worked closely implementing ambitious integration demonstrations around the state, and this work remains the focus today. Significantly, the agencies are in the first phase of work implementing state legislation SB 5732 and HB 1519 that set major new outcome-based contracting standards into the future across the entire Medicaid system. They are also collaborating on implementing SB 6312 which directs the state to establish behavioral health organizations for the purchase and delivery of mental health services and substance disorder treatment into managed care statewide. This legislation also directed the state to purchase both behavioral health services and medical care services to Medicaid clients regionally, and directed counties to recommend regional boundaries.

Finally, HCA and DSHS have collaborated on an ambitious federally funded 5-year state health care innovation plan. The plan proposes a future of health care delivery that builds dramatically on current regional integration efforts, and envisions new procurement strategies for purchasing Medicaid services. The plan proposes moving the state largely away from fee-for-service system that pays for encounters, to a system much more focused on delivering the best outcomes possible. After months of working across agencies and with public and private thought leaders to develop the details of the innovation plan, the mandatory second round of Model test grant application was submitted to the federal government by Governor Inslee.

Since the passage of HB 1738, on-going federal and state initiatives have directed the transformation of Medicaid services. The close collaboration between HCA and DSHS continues to infuse the process of change with expertise from the broadest reach of state government.

Current Demonstrations: Health Homes and HealthPath WA Integration

The passage of the federal Affordable Care Act in 2010 provided both direction and funding opportunities for states to try integrated models of care. Currently Washington has two such federal demonstrations underway; one fully implemented Health Homes demonstration, and the second fully capitated integrated service delivery demonstration that is in final planning in two counties (HealthPath WA Integration.) Both of these demonstrations draw on the expertise and commitment of HCA and DSHS to implement ambitious and complex new health care delivery models. Their core features are to provide care that is:

- The right care for the client, provided at the right time and place
- Team-based care that coordinates medical, behavioral and long-term services and supports
- Provider networks capable of meeting the full range of health care needs
- Emphasis on primary care and home and community based services
- Provision of strong consumer protections that ensure access to qualified providers
- Respect for consumer choices in the supports they receive
- Uniting consumers and providers in eliminating use of unnecessary care
- Aligned financial incentives to drive integration of care

Health Homes

The Health Homes demonstration is currently one of the most ambitious federally-funded integrated care innovations in our state. Following two years of extensive stakeholder meetings and close collaboration between DSHS and HCA, Health Homes are now offered to the high risk, high cost Medicaid clients, and full dual beneficiaries of both Medicaid and Medicare in our state. Health Homes is not a place. It is a set of new care coordination services, provided to consumers as part of their Medicaid benefit. Enrollment is voluntary. These individuals are very likely to need medical, behavioral and long-term services and supports, and statistically have a much higher rate of emergency department use, hospitalization and re-

hospitalization. Client needs vary dramatically among enrollees who are as different as a 30-year-old male with severe mental illness and an 85-year-old woman with dementia and chronic illness. Coordinating care for people with very complex and individual needs requires skill and training for care coordinators, and a network of services available in the network area. The Health Home model seeks to: simplify and streamline medical, behavioral and social support systems; and create financial incentives for providers to cooperate in a manner that shares responsibility and outcomes for a very medically complex population.

The Health Homes design qualifies "Lead Entities" to act as the administrative hubs for organizing networks of providers in different coverage areas of the state. Lead entities link community based networks of providers that include medical providers, hospitals, nursing homes, mental health centers, chemical dependency treatment facilities, to name some examples. A key highlight of the health home networks are the Care Coordination Organizations whose trained care coordinators provide case management, individual and family support, referral to community and social support services, and assistance with health information technology. Care coordination is the cornerstone of Health Homes. Coordinators are trained to engage clients in improving their care and in seeking goals that are personal and motivating. Care coordinators are required to:

- Coordinate clinical treatment plans, functional support plans, and other care plans
- Conduct screenings to identify health risks and referral needs
- Work with beneficiaries to develop their client-centered Health Action Plan
- Coordinate transition from hospitals to other care settings and get necessary follow-up care
- Reduce avoidable health care costs

Lead Entities are accountable for core performance measures, including, as examples; enrollees' use of emergency departments for care, the adequacy of follow up after hospitalizations, use of depression screening, or engagement in drug and alcohol treatment.

Thus far most areas of the state are in the initial phase of health homes demonstrations. The first phase began in July 2013 offering the health home system in Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima. The second phase started in October 2013 offering these networks in Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Thurston, Island, San Juan, Skagit, Whatcom, Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman counties. The key milestones that have been accomplished, or that remain, are:

- Executed a federal memorandum of understanding for health home services (October. 24, 2012)
- Conducted regional forums to engage and get input from stakeholders on demonstration design (October-May 2013)
- Issued Health Home request for applications (November, February, May 2013)
- Executed federal Final Agreement for a managed care FFS Demonstration June 28,2013)

- Secured 2703 State Plan Amendment (June 2013, November 2013)
- Qualified eight Health Homes Lead Entities (February, April, August)
- Provided training and technical assistance (June 2013 and ongoing)
- Implementation of health homes (July 1; October 2013)

Steps for the future

Today there are challenges with the Health Homes demonstration. Despite months of stakeholder work, it remains important that trusting relationships are established and maintained between key providers in a community. Without these, resistance to change makes progress difficult. Another challenge is the inadequacy of a solid electronic platform for Lead Entities to provide encounter data to the state, and to submit information related to health action plans. Successful evaluation and implementation of payment models is contingent on expanded health information exchange. Further, community-based providers who might participate in Health Homes may be hampered by electronic medical record systems that are essential but too expensive for them to install. These are issues that are actively under discussion now and the lessons learned from this demonstration will inform future integration efforts.

HealthPath WA Integration

The second federal demonstration that moves our state toward integrated care is the HealthPath WA full integration strategy. This is limited to clients who are dually eligible for Medicaid and Medicare and is only being offered in King and Snohomish counties. Enrollment is voluntary.

Under this model, beneficiaries will go through health plans to access all services, including medical, mental health, chemical dependency, and long-term services and supports. Health plans will coordinate and authorize care, be at full financial risk, and receive a capitated per member per month payment for the full range of contracted services.

This model assumes close working relationships between plans, the state, the counties, and local entities. As examples, health plans will work directly with licensed residential facilities such as nursing homes, adult family homes, and assisted living facilities to ensure that enrollees' needs are adequately addressed. They will be required to follow up on any negative regulatory enforcement actions that may have been placed on licensed residential care facilities. They will be responsible for discharge planning for individuals who leave a state hospital or nursing facility .These are examples reflect opportunities for new and expanded relationships between health plans and the broader community of services.

As of June, 2013, Regence AmeriHealth Caritas and UnitedHealth Care were the two successful bidders for this fully capitated contract in King and Snohomish counties. July 2015 is the target date for starting enrollment.

Payment in the HealthPath WA Integration demonstration is based on outcome expectations articulated in contracts and includes provisions for withholding a portion of the payments if outcomes are not met. Outcome measures included in this demonstration range from medication management practices to transitioning clients between institutions and homes.

The key milestones that have been reached or that remain are:

- First County legislative approval (December 2012)
- Labor discussions on role of state workers (September-November 2012)
- County agreement to move forward with HealthPath Wa Integration (January 2013)
- Health Plans submit letter of intent (November 2012)
- State specific Medicaid request for applications to Health Plans completed (May 2013)
- Apparently successful bidder announced (June 2013)
- Federal memorandum of understanding signed for HealthPath WA Integration (November 2013)
- Review conducted by CMS and state to assure readiness for implementation (November 2013-April 2014)
- Contracts signed (April 2015)
- (Voluntary) Opt-in enrollment begins (July 2015)
- (Voluntary) Passive Enrollment begins (September 2015) Enrollment phased in over five months

New state legislation: Paying for outcome based care

The 2013 Legislature passed SB 5732 and HB 1519, two bills that are closely related and are being implemented through a single DSHS/HCA work plan currently underway. SB 5732 defines system outcomes for the publically funded behavioral health system- mental health and chemical dependency services. House Bill 1519 reinforces those same outcomes by applying them to the publically funded medical and long term systems as well, with performance measures related to the outcome adopted and applied across all of these systems.

The identified client outcomes are:

- Improved health status and wellness;
- Increased participation in meaningful activities, such as education and employment;
- Reduced involvement in the criminal justice system;
- Reduction in avoidable utilization of and costs associated with hospital, emergency rooms, crisis services, jails and prisons;
- Increased housing stability in the community;
- Improved client satisfaction with quality of life;
- Decreased population level health disparities.

As required under SB 5732, DSHS convened a steering committee comprised of behavioral health service recipients, their families, local government, representatives of regional support networks, representatives of county coordinators, law enforcement, city and county jails, tribal representatives, behavioral health service providers- including at least one chemical dependency provider and a psychiatric advanced registered nurse practitioner, housing providers, Medicaid managed care plan representatives, long-term care service providers, organizations representing health care professionals providing services in mental health settings, the Washington State Hospital Association, the Washington State Medical Association, individuals with expertise in evidence-based and research based practices, organized labor, and the Health Care Authority.

The steering committee is guiding DSHS/HCA in the development and implementation of improvement strategies, including

- Development of performance measures for the behavioral health system.
- Assessing the state's current capacity to provide evidence-based, research-based, and promising practices.
- Creating a transparent quality management system, including outcome measures and reporting.

Identifying methods to promote workforce capacity, efficiency, stability, diversity, and safety

Washington's Vision for Health System Transformation: State Health Care Innovation Plan

In March 2013 Washington received a "pre-testing" federal grant award from the Center for Medicare and Medicaid Innovation (CMMI) to develop a 5-year State Health Care Innovation Plan (SHCIP). Planning has been intense during 2013. The SHCIP builds on the efforts already occurring across the state by providers, health plans, private purchasers, state agencies, consumer groups, industry, communities and others. Innovations around the state abound in new payment and service delivery models, care coordination and disease management initiatives, primary care and community transformation models. The SHCIP establishes the mechanism to scale and spread these promising practices statewide, and establishes the leadership, direction and support essential to improving health and health care, and lowering costs. Fundamental goals include:

- Drive value-based purchasing across the community, starting with the State as "first mover."
- Improve health overall by building healthy communities and people, prioritizing prevention and early mitigation of disease throughout the life course.
- Improve chronic illness care with particular focus on better integrated care and supports for individuals with physical and behavioral-co-morbidities.

The Innovation Plan's core strategies are for the State to fundamentally reorient payment toward value rather than volume; incentivize care delivery redesign; encourage create regionally based organizations

for improving health and health care through cross-sector resource sharing and build a robust health information technology and interoperability infrastructure throughout the state. The SHCIP challenges Washington to:

Lead by example as a purchaser and market organizer. The plan envisions the state setting the example for change by transforming how it purchases care and services in state-purchased insurance programs. It proposes that multiple payers and purchasers would adopt common performance measures, and increasingly move away from fee-for-service payments and toward value-based purchasing.

Coordinate and integrate the delivery system with community services, social services, education, and public health. Recognizing health is largely influenced by factors outside the health care system, the Innovation Plan encourages locally governed public-private partnership organizations that support communities, sectors and systems in seven to nine newly designated regional service areas. These "Accountable Communities of Health" will align state and community priorities and encourage cross-sector resource sharing and funding strategies.

- **Align and focus state priorities and provide community practice transformation support to achieve state goals**. The SHCIP describes the Primary Health Regional Extension System as a way to provide information and assistance to networks and providers at the state and community levels. The plan calls for this extension system to serve as information source, convener, and coordinator of the state's many transformation efforts, with tools and resources to provide communities with as much technical assistance as needed to participate in transformative, integrated health care.
- **Enhance data and information infrastructure**. The plan anticipates building on current efforts for performance measurement and price transparency through an all-payer claims database, common performance measures, and expanded health information exchange capacity.
- **Expand successful Washington payment and delivery models**. The plan envisions an expansion of transformational models of care, such as the Collaborative Care approach for physical and behavioral health integration. It calls for value-based plan design strategies that promote consumer incentives and price transparency, such as reference pricing, an accountable care organization option for public employees, and tiered/narrowed networks selected on their ability to deliver better outcomes and value.
- **Activate and engage individuals and families in their health and health care**. The plan assumes at its core, that regardless of the system of care, Washington state residents will be treated as individuals who benefit more from being informed and engaged consumers than they

do by simply showing up for care. This assumption will play a role in directing everything from establishing coordinated care networks, to developing care plans, to establishing wellness programs, to training a workforce that understands the essential importance of consumers being engaged in their own health and recovery.

The Future of Behavioral Health Services:

Last year, the state received a $1 million grant to develop the State Health Care Innovation Plan. The plan was the basis for the state's Healthier Washington project and submission of a $92.4 million grant application in July 2014. The grant seeks to support innovative models for transforming the state's health care system. More than 1,100 providers, insurers, consumers, hospitals, clinics, businesses, tribes and social service organizations, working with 12 state agencies, contributed ideas that shaped the direction of the innovation plan and resulting grant application. Further, in 2014 the Legislature passed HB 2572 authorizing the state to work with "communities of health" as designated areas where partnerships between local public health and key stakeholders develop capacity to lead health improvement activities. Over the coming months, DSHS and HCA will be working closely to meet legislative mandates to implement behavioral health organizations by April 2016 and to ultimately provide fully integrated behavioral and medical managed care health to Medicaid clients by January 1, 2020. The agencies under the leadership of Governor Inslee will continue to implement significant changes to Medicaid services through ongoing and close collaboration.