



ADSA Aging & Disability
Services Administration



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, Laws of 2011

March 2012

Department of Social & Health Services
P.O. Box 45600
Olympia, Washington 98504-5600
360-725-2300
Fax: 360-407-0304

Health Care Authority
PO Box 42682
Olympia, Washington 98504-5502
360-923-2600
Fax: 360-586-9551

This page left intentionally blank.

CONTENTS

Contents	3
Executive Summary	4
Background	4
Integrated Care Vision	4
Recommendations	4
Report.....	7
Introduction	7
Current Services and Purchasing	7
Cost Growth	10
High Medical Risk is Associated with Need for DSHS Services	11
Service Needs and Risk Factors Overlap	12
Stakeholder Involvement Process.....	14
Summary of Stakeholder Input	15
Discussions with Tribes	16
Recommendations	16
Acknowledgements.....	22
Appendixes	20
Appendix A: Engrossed Second Substitute House Bill 1738, Chapter 15, Laws of 2011, Section 116....	22
Appendix B: HB 1738 Request for Comment Letter	23
Appendix C: Tribal Invitation to discuss HB 1738 and Duals Integration.....	28
Appendix D: Groups, Organizations and Individuals who provided written input	30
Appendix E: Summary of Major Benefits and Risks Identified by Stakeholders.....	33
Appendix F: Service Definitions Used for VENN Diagrams	37

This page left intentionally blank.

Executive Summary

Background

House Bill 1738¹ 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 services for people facing mental health and/or substance abuse challenges, primarily using Medicaid funds available via cooperative agreement with HCA.

Section 116 of HB1738 directs DSHS and HCA, after seeking input from a broad range of stakeholders, to consider options for more effectively coordinating the purchase and delivery of care for the populations served by DSHS and to make preliminary recommendations regarding the role of HCA in purchasing the related services. The statute requires DSHS and HCA to consider, at minimum, transitioning the purchasing of long-term services and supports and behavioral health services from the DSHS to HCA, or strategies for the agencies to collaborate seamlessly while purchasing services separately.

Integrated Care Vision

Opportunities for better outcomes, system efficiencies and cost containment lie in the purchase of increasingly coordinated and managed medical, behavioral health and long-term services and supports. The recommendations in this report are based on a 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 medical, behavioral, and long-term services
- Be provided by networks capable of meeting the full range of needs
- Emphasize primary care and home and community based service approaches
- Provide strong consumer protections that ensure access to qualified providers
- Respect consumer choices in the supports they receive
- Unite consumers and providers in eliminating use of unnecessary care
- Align financial incentives to impel integration of care

Recommendations

1. DSHS should retain responsibility for purchase of long-term services and supports and behavioral health services.

Stakeholders reviewed multiple options for complete or partial transition of purchasing responsibility. They were also asked to suggest ideas of their own. Rather than focusing on *which agency should do the purchasing* they directed their comments more to *what should be purchased*. Discussions will continue between the Executive Branch, Legislature and stakeholders on the proper alignment of roles and

¹ Full text available at <http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202011/1738-S2.SL.pdf>.

responsibilities between DSHS and HCA, including consideration of a recommendation by the Association of Counties that HCA increasingly purchase services in support of delivery system design priorities developed by DSHS.

2. To ensure coordinated purchasing, DSHS and HCA should collaborate on three integrated purchasing initiatives:

Substantive and timely progress in developing innovative integrated care models that improve care for all Medicaid enrollees requires a balance of strategies. The best chance for people with physical or cognitive disabilities, developmental disabilities, mental health, or substance abuse challenges to experience better care sooner rather than later will come with:

- Increased purchase of health care through risk-bearing entities (e.g., health plans) that compete based on service, access, quality and price and
- Modernization of the current systems of care for people to simplify, improve financial alignment, and increase accountability; and embedding robust health home functions in all sectors.

Mindful of extensive stakeholder input, movement toward the shared vision of integrated care will best be achieved by strategic DSHS and HCA collaboration on three key, parallel initiatives:

INITIATIVE A | Expand service delivery through capitated contracts with health plans

We recommend that DSHS and HCA take steps in 2012 to finalize design and implementation planning for a fully integrated approach to purchasing health and support services for people with medical needs that overlap the long-term services and supports, mental health and substance abuse delivery systems. Movement toward fully integrated, managed care has the potential to yield long-term benefits through improved financial flexibility, overall accountability and incentives to develop comprehensive care management approaches. The recent HCA procurement of managed care plans to serve the Medicaid Healthy Options program and its expansion to the SSI population of blind and disabled individuals provides a foundation upon which to expand this capacity and expertise. To enable assessment of potential impacts and avoid unintended consequences, implementation of this initiative will be limited to counties where the opportunity for care coordination and capacity of health plans to deliver integrated care can be demonstrated and monitored.

INITIATIVE B | Modernize and simplify the current DSHS systems of support

In geographic areas where managed care plans are not in place, or for individuals who opt out of them, we recommend steps to modernize and simplify the current DSHS systems of support. Change is necessary to improve care coordination, align financial incentives and increase accountability for overall costs and health outcomes. In 2012, DSHS and HCA will collaborate with stakeholders to review the DSHS services, administrative functions, financing and delivery mechanisms for the purpose of reconfiguring them (including recommendations for budgetary and statutory changes) in ways that more readily and efficiently achieve our vision of integrated care. This initiative requires development of methods for cost risk/gain-sharing (including both Medicaid and Medicare financing through the Duals Innovation Project) across primary care, long-term services and supports, mental health and substance abuse services to incent investments and coordinate efforts to reach shared health outcomes and cost targets.

INITIATIVE C | Embed robust delivery of health home services in all systems

Section 2703 of the Affordable Care Act defines health home functions that are key to reaching our vision of integrated care. The ACA also provides financial incentives to implement those functions, which are essential to improve coordination between long term services and supports, mental health, substance abuse and medical care systems for targeted, high-risk/high-cost Medicaid enrollees. We recommend establishment of clear standards, outcome measures and financial incentives for health homes that will embed that capacity in all systems, whether delivered through capitated health plans or in a modernized version of the current delivery system.

DSHS and HCA will continue collaborative decision-making to balance strategies.

This report was developed through extensive collaboration within a leadership team that included membership from HCA, DSHS, the Governor's policy office and Office of Financial Management. Implementation of the strategies recommended in this report will require continued use of that team, under direction of the Governor, DSHS Secretary and HCA Director, to weigh risks against rewards and ensure that the gains for some enrollees do not come at the expense of others. Throughout the planning process, discussion will continue with tribal governments and interested stakeholders, including recipients, healthcare and other service providers, health insurance carriers, local governments and the legislative branch.

Report

Introduction

House Bill 1738² transferred oversight of the Medicaid program from the Department of Social and Health Services to the Health Care Authority on July 1, 2011. This includes the responsibility to purchase medical assistance for all Medicaid recipients. Consolidation of health care purchasing in HCA positions the state to:

“... use its full purchasing power to get the greatest value for its money, and allowing other agencies to focus even more intently on their core missions.”

Primarily using Medicaid funds available via cooperative agreement with HCA, DSHS remains responsible for purchasing long-term services and supports for people with physical, cognitive, and/or developmental disabilities; and services for people facing mental health and/or substance abuse challenges. Section 116 of HB1738 requires that:

- By December 10, 2011, DSHS and HCA provide a preliminary report, and by December 1, 2012, provide a final implementation plan, to the Governor and the Legislature with recommendations regarding the role of the HCA in the state's purchasing of mental health treatment, substance abuse treatment and long-term care services, including services for those with developmental disabilities.
- The reports consider options for effectively coordinating the purchase and delivery of services that include (but are not limited to) transitioning purchase of services from the DSHS to HCA, and strategies for the agencies to collaborate seamlessly while purchasing services separately.

This report provides the preliminary recommendations to the Governor and the Legislature required by HB1738 on how to achieve integrated care, in which medical, behavioral health and long-term services and supports are increasingly coordinated to improve health outcomes while controlling costs. The year 2012 will be used to plan the details, with a final implementation plan submitted to the Governor and Legislature by December, 2012.

Current Services and Purchasing

Approximately 1.2 million individuals enrolled in Medicaid receive primary care, other physical health and limited mental health services purchased by HCA through managed care and fee-for-service financing arrangements. Those services cost the state and federal government approximately \$10 billion each biennium. By July 1, 2012, about 70 percent of all Medicaid enrollees will be covered by one of five managed care plans.

DSHS provides \$7 billion in services each biennium to people with needs related to physical, cognitive, or developmental disabilities, and for people facing challenges related to mental health or chemical dependency.

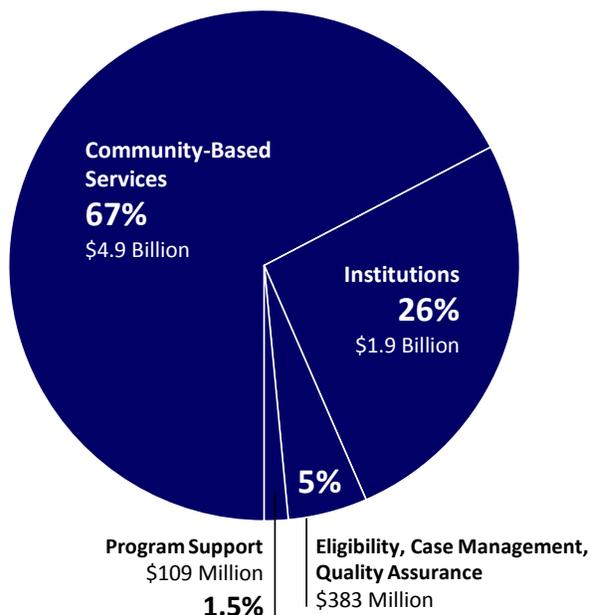
Those services reach approximately one in five of the people enrolled in Medicaid. DSHS spends its funds on four main types of activities: 1) community-based services; 2) institutional services; 3) eligibility, case management and quality assurance; 4) program support/administration.

² Full text available at <http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202011/1738-S2.SL.pdf>.

DSHS community-based and institutional spending on the populations that are the focus of this report is organized in four main ways (all numbers are for the 2011-13 Biennium, are rounded and approximate):

**Community Based and Institutional Spending:
DSHS/ADSA Expenditures, All Fund Sources**

2011-2013 Biennium



SOURCE: Aging and Disability Services Administration, March 2012

1. Long-term services and supports for people with physical and/or cognitive disabilities.

\$3 billion is appropriated and distributed to providers on a fee-for-service basis for the following major services:

- a. \$1 billion for nursing home care for approximately 11,000 people each month.
- b. \$2 billion to purchase assistance with activities of daily living, such as bathing, dressing, personal hygiene, and help with mobility, for 44,000 people each month. \$1.4 billion of that provides help in the client’s own home, with the balance provided in adult family homes or boarding homes.

2. Long-term services and supports for people with developmental disabilities.

\$2 billion is appropriated and distributed to providers on a fee-for-service basis for the following major services:

- a. \$350 million for state-operated Residential Habilitation Centers, which care for 800 people.
- b. \$577 million for instruction and support to persons who live in their own homes in the community.
- c. \$527 million for activities of daily living assistance similar to what is described above for long-term care.
- d. \$330 million in supports that help people live in the community, including employment, family support and programs to preserve public safety.

3. Supports for people with serious mental health diagnoses.

\$1.6 billion is appropriated for the following services:

- a. \$445 million for state-operated mental health hospitals that serve 2,400 people in a year.
- b. \$1.1 billion for community mental health services, purchased through 13 Regional Support Networks operating as Prepaid Inpatient Health Plans. Community mental health services reach 129,000 people each year and include outpatient and residential treatment, crisis and commitment services, crisis stabilization, family treatment, medication management, peer supports and employment and housing supports.

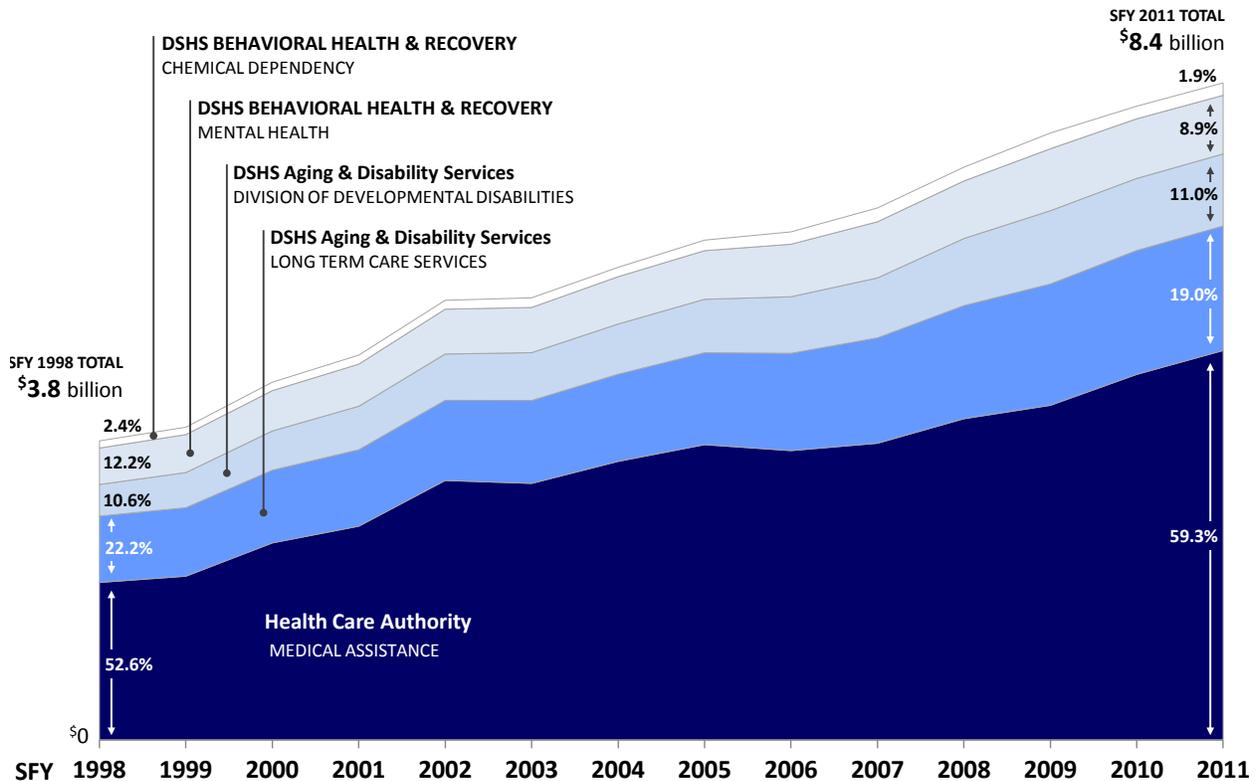
4. Supports for people with chemical dependency challenges.

Approximately \$345 million is appropriated for services that reach approximately 40,000 people each year, primarily purchased through DSHS-administered contracts with counties. The services include: assessment, crisis management, acute and subacute detoxification, outpatient and residential treatment and criminal justice programs.

Cost Growth

Since 1998 there has been average annual growth of 6 percent in the combined costs of medical services and the supports for people with needs related to physical, cognitive, or developmental disabilities, and those facing challenges related to mental health or chemical dependency. Expenditure trends reflect the combined impact of changes in eligibility rules, caseload levels, utilization rates, payment rates and other policy changes.

Total Health Expenditures, All Fund Sources

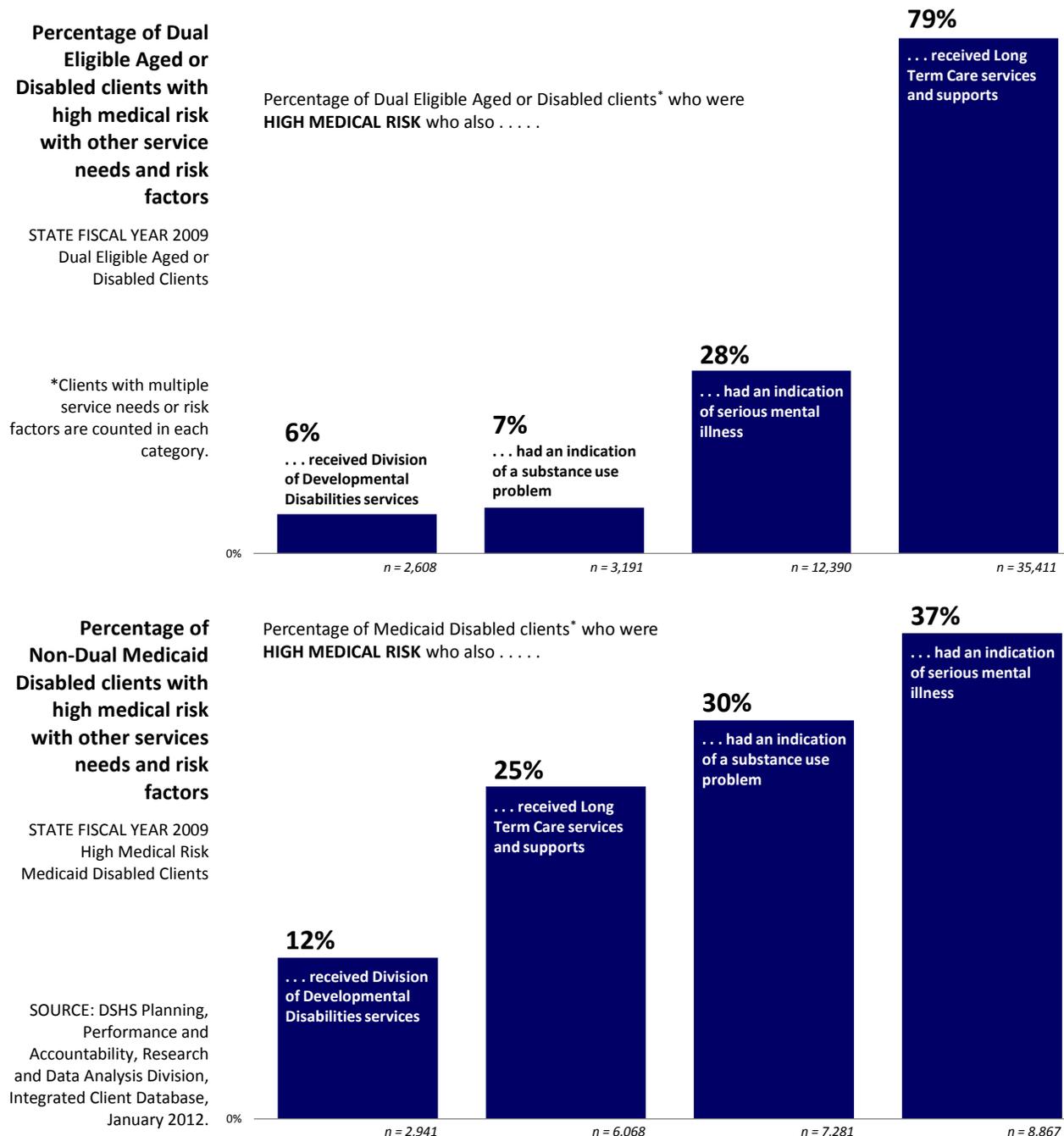


SOURCE: DSHS Planning, Performance and Accountability, Research and Data Analysis Division, Integrated Client Database, January 2012.

High Medical Risk is Associated with Need for DSHS Services

Among the people who are eligible for Medicaid because of age or disability, there is a strong association between risk of high medical cost and presence of a need for long-term services and supports, and/or the presence of indicators that point to substance abuse problems or serious mental illness. The association of high cost with substance abuse and mental illness is strongest for people on Medicaid who are not also eligible for Medicare.

For those who are also qualified for Medicare, the association of high cost with a need for long-term services and supports is by far the strongest. These strong associations are the reason for taking steps that will foster coordination across the full range of medical, behavioral, and long-term services and supports.



Service Needs and Risk Factors Overlap

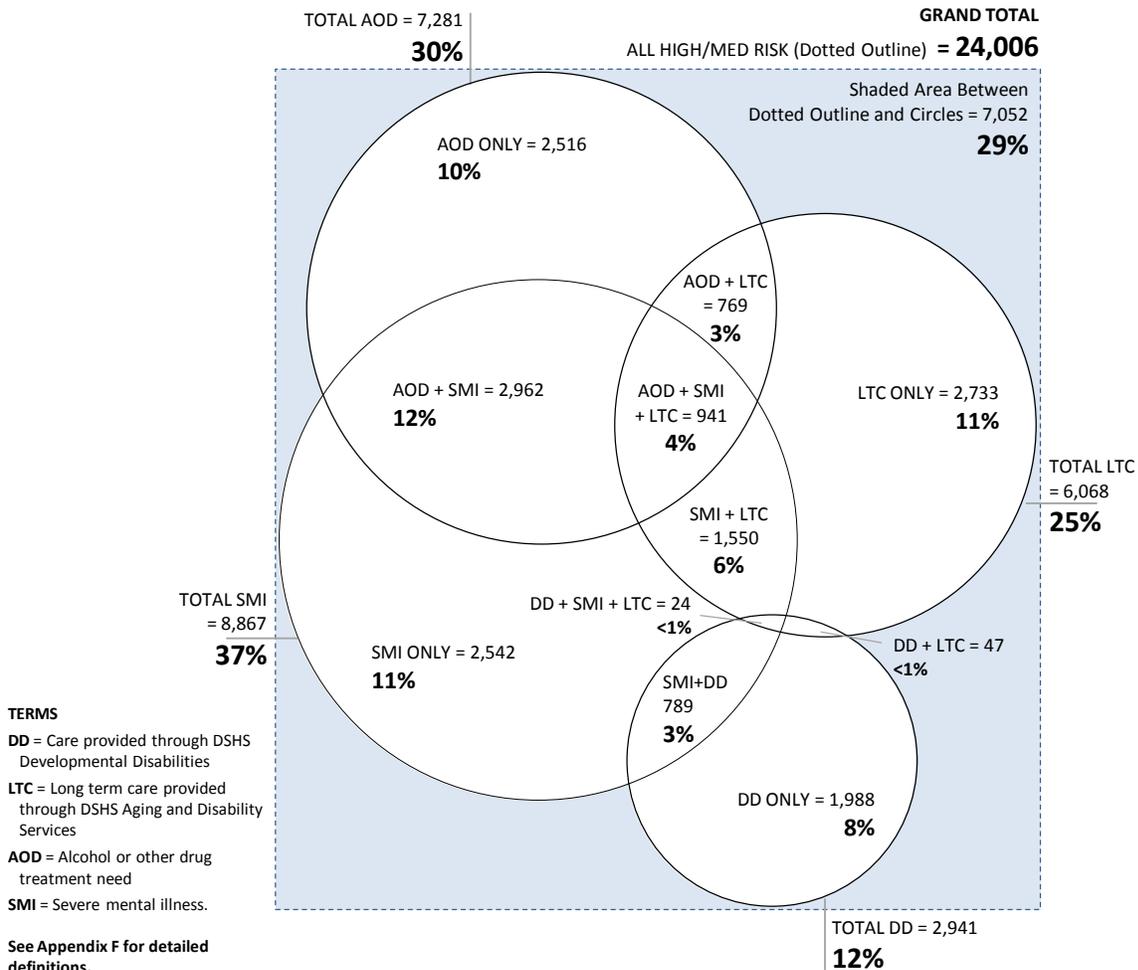
Policy discussions frequently refer to individuals with particular service needs as if they are part of distinct groups—the “long-term care population,” the “mental health population,” etc.

As displayed by the charts on the next page, the conditions and support needs that are the subject of this report—disabilities, mental illness, and substance abuse—frequently co-occur. For people who are high medical risk and not dually eligible for Medicare, almost two thirds have at least one of those additional risk factors and 28 percent have more than one additional risk. For those who are high risk and dually eligible for Medicare and Medicaid, 91 percent have at least one additional risk factor and 31 percent have more than one additional risk.

The current medical system and the systems of support managed by DSHS are not designed to address that level of complexity. Service planning does not create coordinated responses to address co-occurring needs. Financing is not aligned to support comprehensive responses. 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 recommendations in this report.

Service need and risk factor overlaps among HIGH MEDICAL RISK non dual Medicaid Disabled clients

STATE FISCAL YEAR 2009

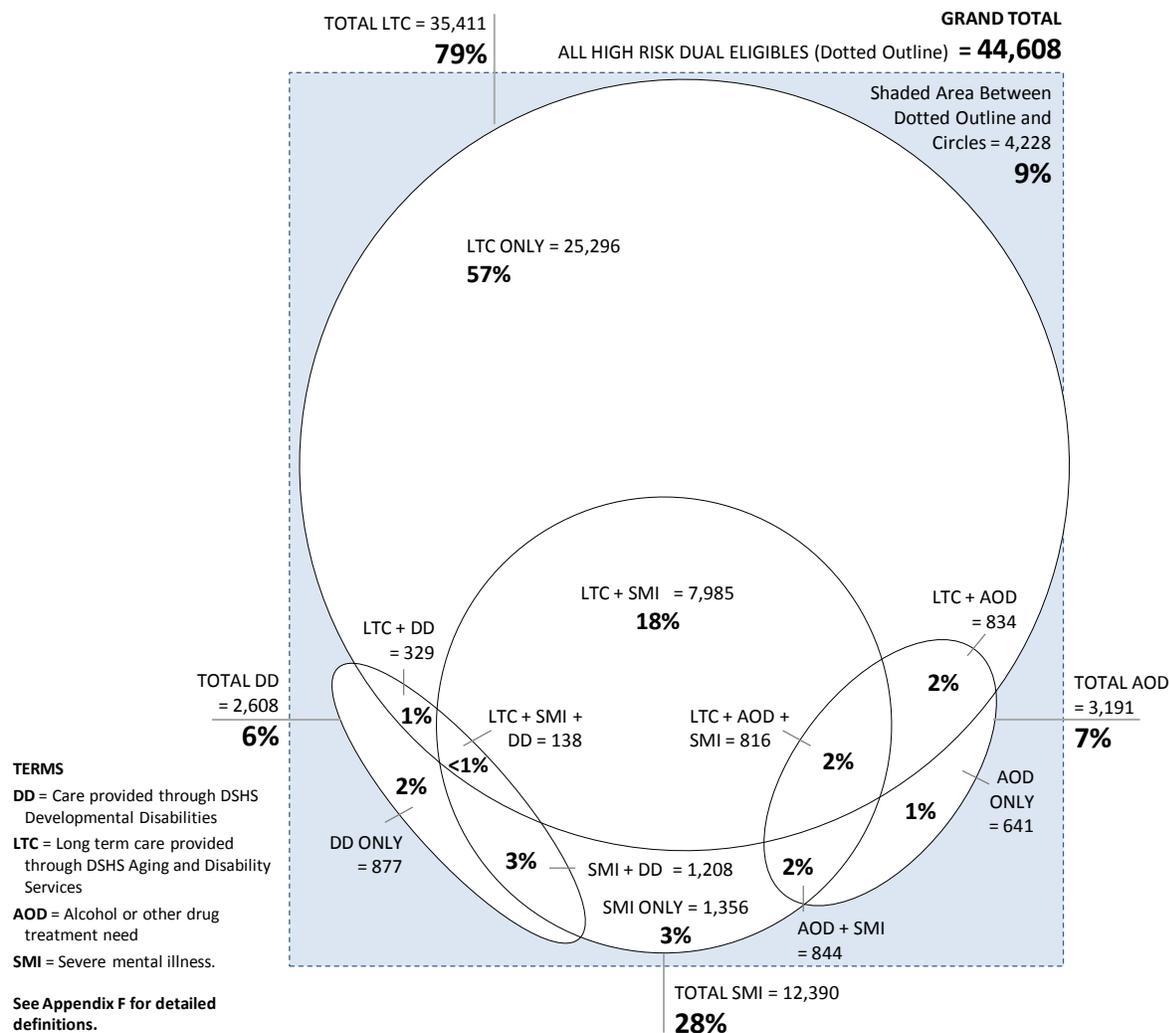


NOTE: This diagram shows **almost** all the groups with overlapping risk factors. 93 people in the total population of 24,009 persons are not shown on the diagram (though they are included in the group subtotals), because they have combinations of risk factors represented in circles at opposite ends 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.

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

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.

Stakeholder Involvement Process

DSHS and HCA worked in partnership to provide information to the broadest representation of interested parties. Between August and December 2011:

- E-mail communications were provided to organizations and individuals that included beneficiaries and families, community and local government providers, health plans, professional associations and collateral providers such as drug courts and criminal justice providers.
- Survey opportunities were extended to associations and organizations invited to participate in Duals Innovation meetings. They, in turn, were encouraged to share the invitation with their members and peers.
- Face-to-face and online meetings occurred with more than 20 groups representing professional organizations, advocates, providers, collateral groups and beneficiaries and families.

- A combined meeting of DSHS and HCA Advisory Committees was held on September 20. The membership participated in an interactive forum on all five options and provided additional input on their general views of health care reform.
- Updates were provided to the Joint Select Committee on Health Care Reform Implementation on November 8.

Feedback gathered through Duals Innovation stakeholder engagement activities were also used to inform the content of this report.

Stakeholders were asked to comment on five “straw man” options for how purchasing responsibilities could change. The survey and questions used to solicit stakeholder feedback are in Appendix B. The options were presented as a catalyst for discussion, rather than as specific proposals. A request was also made for alternative options and general feedback as well. The five “straw man” options were:

1. **Keep the status quo:** *Purchasing for long-term services and supports and behavioral health remains with DSHS. HCA continues to purchase medical benefits through contracts with managed care plans and fee-for-service providers, and provides technical assistance to the Department regarding evidence-based purchasing strategies and joint applications for federal waivers, as needed. The agencies align their approaches through contracting requirements including performance measures.*
2. **Enhance primary care coordination with more integrated community supports:**
For people who are not at risk of institutionalization, transition purchase of a core set of behavioral health services to HCA, along with accountability for related budget oversight. Services could be included in amended managed care contracts. DSHS continues to purchase supplemental behavioral health supports for people at risk of institutionalization, as well as long-term services and supports, under federal authority that allows for a multi-population home and community-based waiver. This option includes requirements and incentives to coordinate with primary care and community supports systems, with risk-sharing and gain-sharing between the systems.
3. **Transfer all behavioral health treatment and services purchasing to HCA:**
Move all purchasing responsibility for behavioral health treatment and services (mental health outpatient and community treatment and services, substance abuse services) to the HCA. Accelerate the inclusion of medical and behavioral health services in fully capitated managed care contracts. DSHS continues to purchase long-term services and supports and services for individuals with developmental disabilities.
4. **Pilot integrated financing and delivery through managed care and health home models:**
In regional pilots, transfer all purchasing of behavioral health plus long-term services and supports to the HCA, for inclusion in fully capitated contracts where managed care plans are at full risk for all care delivered and the contribution of health homes is maximized. Purchasing responsibility outside the pilots remains with DSHS along with the overall policy and program development decision-making for eligibility, benefits and performance monitoring.
5. **Transfer all health care-related purchasing to HCA:**
Transfer all purchasing of mental health (including outpatient and community treatment and services, crisis response, involuntary treatment oversight, state hospital oversight), substance abuse services, and long-term services and supports to the HCA, for inclusion in capitated managed care contracts. The HCA would be responsible for all health care-related purchasing. Systems support for eligibility determination may need to remain with the Department until Affordable Care Act -related administrative details are clarified.

Summary of Stakeholder Input

A summary of the major risks and benefits of each option is in Appendix E. Overall, stakeholders expressed little interest in which agency should take what role in purchasing. Concerns focused on the fragmented delivery of health care and related services and how and when it should change. While it was generally agreed that the status quo is not acceptable, there was equal sentiment that any change should be accomplished in thoughtful stages. Common themes emerged about the direction of changes that would create systems of care that would:

- Be based in organizations that are accountable for costs and outcomes
- Be delivered by teams that coordinate medical, behavioral, and long-term services
- Be provided by networks capable of meeting the full range of needs
- Emphasize primary care and home and community based service approaches
- Provide strong consumer protections that ensure access to qualified providers
- Respect consumer choices in the supports they receive
- Unite consumers and providers in eliminating use of unnecessary care.
- Align financial incentives to impel integration of care.

Understandable tensions were evident in the feedback. For example, change is both feared (*don't rush / avoid disruption*) while also seen as essential (*innovation won't occur without change*); the desire to enhance individual choice (*access to more services and providers is necessary*) is at odds with the desire to decrease system complexity and reduce system costs.

Discussions with Tribes

Information on the options was provided to the tribes in two separate meetings (Indian Policy Advisory Committee (IPAC) and the Indian Health Services Board meeting). Discussion on the impact of purchasing ADSA services was more fully explored in a preliminary video conference. Unlike other groups, Federally Recognized Tribes operate and deliver services in their capacity as sovereign governments that may differ from standard Medicaid and/or Medicare regulations.

A videoconference was held on November 16 to provide tribal representatives with an overview of both HB 1738 and the Duals Innovation project. Feedback from participants encouraged DSHS and HCA to participate in face-to-face meetings for meaningful discussion. As a result, DSHS and HCA were invited to attend the Regional Tribal Coordinating Council Meeting on December 13 in Arlington. The meeting provided an additional opportunity to listen to concerns and ideas on Tribal Health Care for Medicaid recipients. Tribal government discussion will continue during calendar year 2012. Although preliminary discussions have begun, more extensive dialogue is necessary prior to consultation and specific recommendations related to tribal concerns.

Recommendations

The recommendations in this report strive to balance input, framing a purchasing roadmap that will continue to evolve. The recommended purchasing initiatives are intended to maximize the benefits commonly identified by stakeholders, mitigate the risks, and allow room to make changes thoughtfully, while at the same time making it clear that even the first steps will be a significant departure from the status quo.

1. DSHS should retain purchase of long-term services and supports and behavioral health services.

As the summary of stakeholder perceptions in Appendix E makes clear, there are risks and benefits associated with each option. Among the multiple options for complete or partial transition of responsibilities there was no consensus on a change in purchasing approach that would, by itself, improve the integration of services for people who have complex and overlapping needs. Instead, HCA and DSHS will be most effective by ramping-up collaboration strategies to (a) define purchasing requirements, (b) identify opportunities to phase-in aggregation of financing streams to achieve desired system changes and savings, and (c) minimize unintended consequences that might disrupt the delivery of care to those most in need. Rather than shifting duties, it is recommended DSHS and HCA focus instead on implementing a shared vision of integrated care using the three collaborative purchasing strategies outlined below.

Structures that support consolidated and efficient purchasing, with clear accountability for improved health outcomes and reduced costs, will evolve over time. A suggestion on an approach to purchasing by the Washington Association of Counties may provide a basis for that future evolution. Their recommendation was:

"... define HCA as the agency providing an administrative role of purchasing in support of the delivery system design priorities as laid out by the state agencies (DSHS, Department of Corrections, Department of Personnel, etc). HCA would be the support entity within state government that "brokers" the most cost effective "products." This idea is based on a number of county governments where the "purchasing departments" respond to procurement requests from all of the county departments. We believe this would build checks and balances into the system and provide the best opportunity for the state to leverage purchasing.

"The agencies are more familiar with, and should have expertise with specific programs, so would be responsible to define the benefits package, delivery system and priorities for each program. These priorities would be communicated to the HCA, whose role would be to find the most cost effective way to fill the purchasing request of the agency.

"In her executive order and remarks regarding the move of purchasing authority to HCA, Governor Gregoire spoke to the cost savings that come from leveraged purchasing across state agencies. We believe the DSHS and HCA relationship should not be different from relationships with other agencies. As an example, if the DOC needs to purchase pharmaceuticals, the agency drives the policy with HCA providing the expertise specifically in the purchasing. In this way, all agencies would provide HCA with health purchasing request and the HCA would leverage the purchase based on consolidated needs."

2. To ensure coordinated purchasing, DSHS and HCA should collaborate on three integrated purchasing initiatives:

Substantive and timely progress in developing innovative integrated care models that improve care for all Medicaid enrollees requires a balance of strategies. Increased purchase of health care through risk-bearing entities (e.g., health plans) that compete based on service, access, quality and price; modernization of the current systems of care for people to simplify, improve financial alignment, and increase accountability; and embedding robust health home functions in all sectors gives the best chance for physical or cognitive disabilities, developmental disabilities, mental health, or substance abuse challenges to experience better care sooner rather than later.

Mindful of extensive stakeholder input, movement toward the shared vision of integrated care will best be achieved by DSHS and HCA collaboration on three key, parallel initiatives:

INITIATIVE A | Expand service delivery through capitated contracts with health plans

We recommend that DSHS and HCA take steps in 2012 to finalize design and implementation planning for a fully integrated approach to purchasing health and support services for people with medical needs that overlap the long term care, mental health and substance abuse delivery systems. Movement toward fully integrated, managed care has the potential to yield long-term benefits through improved financial flexibility, overall accountability and incentives to develop comprehensive care management approaches. The recent HCA procurement of managed care plans to serve the Medicaid Healthy Options program and its expansion to the SSI population of blind and disabled individuals, provides a foundation upon which to expand this capacity and expertise. To enable assessment of potential impacts and avoid unintended consequences, implementation of this initiative will be limited to counties where the opportunity for care coordination and capacity of health plans to deliver integrated care can be demonstrated and monitored.

A number of states are currently purchasing the full array of services that are the subject of this report as a health plan benefit using fully risk bearing, capitated approaches. A number of additional states are exploring this model of purchasing. The chief advantage of this approach is the ease with which funding from a variety of sources can be blended and the advantage of having a single entity that can be held accountable for care and costs. In a recent AARP report³ on long-term care systems, the highest-rated system in the nation is in Minnesota, which uses largely a managed care approach. On the other hand, AARP has voiced opposition to Florida's plans to include long-term care in such an approach, based on concerns about accountability, network capacity, financial design and quality.

Additionally, recently published federal guidelines press states toward a January 1, 2013 roll-out of approved Duals Innovation state plans to align with the standard Medicare procurement timeline. Preliminary review suggests that to keep in step with these requirements, an initial integrated care demonstration would be possible in areas where successful partnerships can be rapidly established. To capitalize on potential inclusion of Medicare resources through the Duals Integration Project⁴, a proviso in the FY2013 Supplemental Budget is necessary to allow movement of funds (subject to agreement by the affected jurisdictions) and enrollment of a statistically significant number of dual eligible individuals in time for Medicare open enrollment for January of 2013.

This initiative most closely resembles Option 4 in the "straw man" proposals reviewed by stakeholders. Care will be taken to mitigate the downside risks while realizing the benefit capitated financing provides. Unlike many other states, Washington has a well-developed system for home- and community-based care. Stakeholders have been clear that they want to maintain and build on that capacity and are interested in using a managed care health benefit approach, provided it is structured in a way that mitigates the downside risks and avoids the types of concerns that have emerged in Florida. To effectively deliver integrated care as a health plan benefit, specific accountability measures must be developed, financial incentives aligned, and health plans with capacity and expertise in providing such services must be identified and ready.

Stakeholders were clear in seeking assurance that any expansion of a managed care approach would be accomplished through health plans that are ready to support and deliver integrated care that spans the full range of services and supports for the populations that are the subject of this report. HCA and DSHS efforts must now assess and address the fiscal, contractual, health plan readiness, and administrative

³ S. C. Reinhard, E. Kassner, A. Houser, and R. Mollica, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, AARP, The Commonwealth Fund, and The SCAN Foundation, September 2011 . <http://www.longtermscorecard.org/Report.aspx>.

⁴ Design an innovative model to improve the quality, coordination, and cost effectiveness of care for populations eligible for Medicaid and Medicare.

details associated with expansion of service delivery through health plans. Key elements would need to include, at minimum:

1. Clear and measurable requirements related to the key elements of integration
2. Clear benchmarks for the network capacity, experience and skill necessary to provide the services to the complex populations that are the subject of this report
3. Requirements based on learning from the Washington Medicaid Integration Project
4. Federal requirements related to the Medicaid and Medicare Integration Project
5. A clear approach to finance and deliver state mental health hospital and nursing home services
6. A method to include community and social services that are not part of the basic benefit into individual care plans
7. Methods to avoid, or mitigate adverse impacts on surrounding community services such as criminal justice, courts, local government and other community services

INITIATIVE B | Modernize and simplify the current DSHS systems of support

In geographic areas where managed care plans are not in place, or for individuals who opt out of them, transition the current population-based, categorically funded service and delivery systems for people with physical or cognitive disabilities, developmental disabilities, mental health, or substance abuse challenges into a more integrated system that provides supports on a person-centered basis.

The current community delivery systems have evolved separately around physical and cognitive disabilities, developmental disabilities, mental health, and substance abuse when, as described earlier in this report, individuals often face a combination of these challenges. If service systems were structured and funded differently, services could more efficiently and effectively address client needs in an integrated manner, link with the health system to improve care coordination, better align financial incentives, and increase accountability for overall costs and health outcomes. DSHS and the HCA should collaborate to make programmatic changes and recommend necessary budget and statutory changes to:

1. Simplify the current DSHS funding authorities and delivery systems to support person-centered care that is accountable (a) to a mission that emphasizes home- and community-based supports and (b) for achieving overall cost and health outcome targets.
2. Develop an integrated benefit that responds comprehensively to individually assessed need, including:
 - a. Assistance with daily living tasks and support to live in the setting of choice
 - b. Skilled tasks and supportive community services
 - c. Specialized services
 - d. Individualized health action planning
 - e. Measured use of consumer self-direction.
3. Develop flexible financing structures that support the integrated benefit using managed fee-for-service or capitation methods
4. Develop a method for cost-risk/gain-sharing (including both Medicaid and Medicare financing through the Duals Innovation Project) across primary care, long-term services and supports, mental health and substance abuse services to incent investments and coordinate efforts to reach shared health outcomes and cost targets.

Key elements of the planning for those improvements would need to include, at a minimum:

1. Clear and measurable requirements related to the key elements of integration
2. Review of the related services administrative functions, and delivery structures of contracts currently distributed in fragments to local governments (through Area Agencies on Aging, Regional Support Networks, and individual county contracts) against those requirements for the purpose of reconfiguring them in ways that more readily and efficiently achieve those goals
3. Clear benchmarks for the capacity, experience and skill necessary to provide the integrated benefit to the complex populations that are the subject of this report
4. Develop access and utilization standards that recognize medical risk as a criteria, but also recognize differences in populations
5. Develop necessary statutory and budgetary changes for the 2013 legislative session

INITIATIVE C | Embed robust delivery of health home services in all systems

To provide the kinds of care coordination necessary to achieve our shared vision of integration across an individual's full range of service need it is essential to embed robust health home supports in all systems, whether services are delivered through capitated health plans or in a modernized version of the current delivery system. To achieve the greatest return, coordinating support for those with chronic illness and at high future risk for higher healthcare costs should be emphasized.

Health homes build upon and expand the concept of medical homes by serving the whole person across the primary care, long-term care, and mental health and substance abuse treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, to ensure 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 self-management goals by helping to provide clinical services that contribute to improved health. 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) includes:

- Comprehensive care management, using team-based strategies
- Care coordination and health promotion
- Comprehensive transitional care between health care and community settings
- Individual and family support, which includes authorized representatives
- Referral to community and social support services, such as housing if relevant
- The use of health information technology to link services, as feasible and appropriate.

Analysis to identify the populations at greatest need for health home services 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) that were more commonly associated with a high-risk designation. These programs and characteristics include: use of Medicaid developmental disability or long-term care services, evidence of use/need for substance use services and evidence of a serious, persistent mental illness. Although there were striking differences in utilization patterns among the groups in terms of use of behavioral health, long-term care and developmental disability services, all populations groups showed similarities between the high and impactable use of emergency room and inpatient hospitalizations between high-risk and low-risk individuals.

Among the high-risk groupings, the non-disabled tended to use more primary care and showed less evidence of single or multiple agency service use, while the SSI and dual beneficiary population showed greater use of multiple agency services, with the dual beneficiary not unexpectedly receiving significantly higher levels of long-term care 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 non-disabled 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.

This initiative requires continued HCA and DSHS collaboration to develop:

1. A method for targeting priority populations
2. Health outcome objectives, cost targets and measures, shared across primary care, long term services and supports, and mental health and substance abuse services
3. Contractual requirements to improve coordination via health home functions, as defined in the Affordable Care Act, and replicable across the state based on rigorous certification standards
4. Methods to expand use of integrated Web-based clinical decision support tools such as PRISM, which aggregates claims, eligibility, assessment and risk identification information organized by individual service recipients

Acknowledgements

Health Care Authority Purchasing Role for Mental Health, Chemical Dependency and Long Term Services
Report Participants:

Health Care Authority (HCA)

Doug Porter	Heidi Robbins Brown	Preston Cody
Jenny Hamilton	Thuy Hua-Ly	

Department of Social & Health Services

Robin Arnold-Williams	Mary Anne Lindeblad	Marietta Bobba
Bea Rector	Pat Lashway	Travis Sugarman
James Kettel	Dan Murphy	

Office of Financial Management

Carole Holland	Ryan Black	Adam Aaseby
Jonathan Seib	Andi Smith	Jason McGill

Tribal Government

Members of the IPAC Health Care Committee
Members of the Indian Health Services Board
Members of the Regional Tribal Coordinating Council

Stakeholders

See appendix D for a listing of groups, organizations and individuals who provided written input.

APPENDIX A

Engrossed Second Substitute House Bill 1738, Chapter 15, Laws of 2011, Section 116

NEW SECTION. **Sec.116.** (1) By December 10, 2011, the department of social and health services and the health care authority shall provide a preliminary report, and by December 1, 2012, provide a final implementation plan, to the governor and the legislature with recommendations regarding the role of the health care authority in the state's purchasing of mental health treatment, substance abuse treatment, and long-term care services, including services for those with developmental disabilities.

(2) The reports shall:

(a) Consider options for effectively coordinating the purchase and delivery of care for people who need long-term care, developmental disabilities, mental health, or chemical dependency services. Options considered may include, but are not limited to, transitioning purchase of these services from the department of social and health services to the health care authority, and strategies for the agencies to collaborate seamlessly while purchasing services separately; and

(b) Address the following components:

(i) Incentives to improve prevention efforts;

(ii) Service delivery approaches, including models for care management and care coordination and benefit design;

(iii) Rules to assure that those requiring long-term care services and supports receive that care in the least restrictive setting appropriate to their needs;

(iv) Systems to measure cost savings;

(v) Mechanisms to measure health outcomes and consumer satisfaction;

(vi) The designation of a single point of entry for financial and functional eligibility determinations for long-term care services; and

(vii) Process for collaboration with local governments.

(3) In developing these recommendations, the agencies shall:

(a) Consult with tribal governments and with interested stakeholders, including consumers, health care and other service providers, health insurance carriers, and local governments; and

(b) Cooperate with the joint select committee on health reform implementation established in House Concurrent Resolution No. 4404 and any of its advisory committees. The agencies shall strongly consider the guidance and input received from these forums in the development of its recommendations.

(4) The agencies shall submit a progress report to the governor and the legislature by November 15, 2013, that provides details on the agencies' progress on purchasing coordination to date.

APPENDIX B

HB 1738 Request for Comment Letter⁵



STATE OF WASHINGTON

August 23, 2011

Greetings:

Through enactment of House Bill 1738, the 2011 Legislature directed the Health Care Authority (HCA) and the Department of Social and Health Services (the Department) to submit a preliminary report in December that makes recommendations on the future role of the HCA in the state's purchasing of behavioral health and long-term services and supports, including long-term care and developmental disability services. The report must include consideration of options for the Department and HCA to effectively coordinate the purchase and delivery of care, and must address a variety of health system components. We are seeking your input to this effort.

As you know, HCA currently purchases medical benefits for Washington's low-income populations through managed care plans and fee-for-service arrangements. With this letter we have included an overview of five possible approaches to purchasing behavioral health and long-term services and supports for these individuals. These options are by no means intended as an exhaustive or final list. We believe that candid feedback from stakeholders and Tribal governments will improve the options, possibly add new ones, and certainly inform the development of our preliminary recommendations. To that end, the list of options includes several questions on which we would specifically like your input. We encourage you to submit comments by Friday, September 30, 2011 to Marietta Bobba at bobbam@dshs.wa.gov or <https://www.surveymonkey.com/s/5JH81FF> to provide your comments electronically.

We will share a compilation of your comments with the Joint Select Committee on Health Reform later this fall and use your feedback to inform development of the December preliminary report.

Additionally, we want to share with you parallel initiatives that will also inform recommendations on HCA's purchasing role while shaping Washington's path toward a health system that accomplishes Governor Gregoire's goals for controlling expenditures, improving patient safety and quality of care, and increasing access to care that is coordinated and tailored to the needs of individuals and communities. There are several key efforts underway on which you will have opportunities to contribute. These include:

Demonstration to Integrate Care for Dual Eligible Individuals – Washington is one of 15 states that received an 18-month planning grant from the Centers for Medicare and Medicaid Services (CMS) to design a model that will improve the quality, coordination, and cost effectiveness of care for individuals who receive services through Medicare and Medicaid. Beginning next month, discussions will consider core elements and consumer protections

⁵ The letter was utilized through November 2011 with edits to date and exclusion of the survey.

August 23, 2011

Page 2

needed in an effective delivery system; ways that care can be better integrated to achieve improved quality and cost effectiveness; and risk and shared savings opportunities for more effective use of Medicare and Medicaid financing. For further details and information on opportunities to contribute please contact Bea Rector at bea.rector@dshs.wa.gov or Kathy Pickens-Rucker at kathy.pickens-rucker@hca.wa.gov.

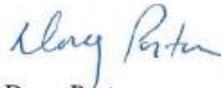
- Planning for the Implementation of Health Homes as authorized in Section 2703 of the Affordable Care Act – In July 2011, Washington received approval from CMS for federal matching dollars to help plan and develop the framework for advancing health homes in Washington. Generally, health homes take a holistic view of a person's health care across a variety of services including primary care, specialty care, and behavioral health to improve chronic disease management and ensure that referrals to community supports and services (that address the bio-psycho- social needs of vulnerable populations) are effective. Initial planning will focus on a process for identifying specific delivery system strategies to be defined in Medicaid State Plan amendments that reflect the diversity of health home activity in Washington State. For further details and information on opportunities to contribute as planning proceeds later this fall, please contact Juno Whittaker at juno.whittaker@hca.wa.gov.
- Health Innovations for Washington – On April 29, 2011, Governor Gregoire submitted a request to the Secretary of Health and Human Services for flexibility plus technical and financial assistance to support improvement in Washington State's health care delivery system. The overarching goals are to control costs and achieve better health outcomes. Through the duals integration and health homes planning projects, federal support has been initiated. Further avenues through which the state may be able to innovate have not yet been confirmed; however, we expect to have clearer guidance from CMS in September. Details on opportunities for input will then be made available.

We thank you for your time and interest in helping the state to more effectively serve its low-income income populations. We look forward to your comments on the preliminary list of options for the future role of HCA in the state's purchasing of behavioral health, long-term care and developmental disability services.

Sincerely,



Susan N. Dreyfus
Secretary
Department of Social and Health Services



Doug Porter
Director
Health Care Authority

Possible Options for a Health Care Authority Role in Purchasing Behavioral Health, Long-Term Care and Developmental Disability Services

Overview of Current Purchasing Functions

The Health Care Authority (HCA) purchases medical benefits for Washington's low-income populations, delivered primarily through contracts with managed care plans. As a purchasing strategy to build a platform that will support the expansion of Medicaid in 2014 under the Patient Protection and Affordable Care Act (ACA)¹, we anticipate that these contracts will gradually be expected to serve additional populations.

The Department of Social and Health Services (the Department) currently purchases Medicaid-funded long-term services and supports (for people with physical, cognitive, or developmental disabilities), and behavioral health (mental health and substance abuse) services. Medicaid services are delivered primarily through fee-for-service contracts with service providers.

In both agencies there are policy and program development, administrative, and fiscal functions that support Medicaid purchasing. For example, the Department and HCA must currently:

1. Define who is eligible to receive care.
2. Determine the type, scope, and duration of service/support that will be publically funded.
3. Determine acceptable models for service delivery.
4. Develop payment methodologies.
5. Procure care through contracts with vendors and/or managed care organizations.
6. Determine contract accountability standards.
7. Calculate rates and pay contractors.
8. Measure contract performance against accountability standards.
9. Secure appropriations and funding.
10. Monitor budget projections and expenditures.
11. Negotiate Medicaid authority agreements with the federal government (e.g., State Plan amendments and Waivers).

Possible Options

The following five options offer a wide range of possibilities for how the state purchases long-term services and supports, and behavioral health services. They vary from keeping everything as is, to transferring all purchasing of services to the HCA for inclusion in fully capitated contract arrangements in which the contractor is at risk for all care delivered. Options in between offer strategies for capacity building and incremental change.

1. **Keep the status quo:** Maintain the existing approach in which purchasing for long-term services and supports, and behavioral health services, remains with the Department. HCA continues to purchase medical benefits through contracts with managed care plans and fee-for-service providers, and provides technical assistance to the Department regarding evidence-based purchasing strategies and joint applications for federal waivers,

¹ In 2014, an estimated 400,000-500,000 individuals could be eligible for Medicaid-funded health care.

as needed. The agencies align their approaches through contracting requirements including performance measures.

2. **Enhance primary care coordination with integrated community supports:** For people who are not at risk of institutionalization, transition the purchasing of a core set of behavioral health services to the HCA, along with accountability for related budget oversight. Services could be included in amended managed care contracts. The Department continues to purchase supplemental behavioral health supports for people at risk of institutionalization, as well as long-term services and supports, under federal authority that allows for a multi-population home and community-based waiver. This option includes requirements and incentives to coordinate with primary care and community supports systems, with risk-sharing and gain-sharing between the systems.
3. **Transfer all behavioral health treatment and services purchasing to HCA:** Move all purchasing responsibilities for behavioral health treatment and services (mental health outpatient and community treatment and services, substance abuse services) to the HCA. Accelerate the inclusion of medical and behavioral health services in fully capitated managed care contracts. The Department continues to purchase long-term services and supports and services for individuals with developmental disabilities.
4. **Pilot integrated financing and delivery through managed care and health home models:** In regional pilots, transfer all purchasing of behavioral health plus long-term services and supports to the HCA, for inclusion in fully capitated contracts where managed care plans are at full risk for all care delivered and the contribution of health homes is maximized. Purchasing responsibility outside the pilots remains with the Department along with the overall policy and program development decision-making for eligibility, benefits and performance monitoring.
5. **Transfer all health care-related purchasing to the HCA:** Transfer all purchasing of mental health (including outpatient and community treatment and services, crisis response, involuntary treatment oversight, state hospital oversight), substance abuse services, and long-term services and supports to the HCA, for inclusion in capitated managed care contracts. The HCA would be responsible for all health care-related purchasing. Systems support for eligibility determination may need to remain with the Department until ACA-related administrative details are clarified.

Feedback Requested

There are two *general* areas on which we ask for your frank comments. Please let us know:

- What you like and don't like about each option.
- Where you see opportunities for alternative options.

Through House Bill 1738, the Legislature established *specific elements* that must be considered in the preliminary report. Where your comments on the general ideas don't already provide details, we ask for your feedback on these elements as they relate to each option.

- What strategies do you think are needed to support seamless collaboration between the Department and the HCA when services are purchased separately?
- How might this option provide:
 1. Incentives to improve prevention efforts.
 2. Service delivery approaches, including models for care management and care coordination and benefit design.
 3. Rules to assure that those requiring long-term care services and supports receive that care in the least restrictive setting appropriate to their needs.
 4. Systems to measure cost savings:
 - Slow the rate of cost increase.
 - Coordinate shared savings.
 5. Mechanisms to measure health outcomes and consumer satisfaction:
 - Simplify access to essential, needed supports and benefits.
 - Improve care continuity and ensure safe and effective care transitions.
 6. Designation of a single point of entry for financial and functional eligibility determinations for long-term care services, and
 7. Process for collaboration with local governments.
 8. Improve the quality and effectiveness of Medicare and Medicaid-purchased services.

Please send your comments by September 30, 2011 to Marietta Bobba at bobbam@dshs.wa.gov or <https://www.surveymonkey.com/s/5JH8HFF> to provide your comments electronically. Thank you for your time and contribution.

APPENDIX C

Tribal Invitation to discuss HB 1738 and Duals Integration



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Disability Services Administration
PO Box 45050, Olympia, WA 98504-5050

November 7, 2011

Greetings,

Dorothy Flaherty (Quinault)
Ed Fox (Port Gamble)
Jim Roberts (NWPAlHB)
Ann Dahl (Spokane)
Steve Kutz (Cowlitz)
Barbara Wasserman (Swinomish)
Robert Ramirez (Yakima)
Stephanie Tompkins (Suquamish)
Leslie Wosnig (Suquamish)
All Tribes
Recognized American Indian Organizations

On behalf of Susan Dreyfus, Secretary, Department of Social and Health Services (DSHS) and Doug Porter, Director, Health Care Authority (HCA), we are contacting you to continue the preliminary discussion started at the October Indian Policy Advisory Committee and Indian Health Board meetings on House Bill 1738 and the Medicare/Medicaid Duals Integration Project. These initiatives will assist Washington State to bend the cost curve for health care and coordinate an improved system of care for those who utilize Medicaid or Medicare/Medicaid to obtain health and community support services.

Videoconferencing time has been reserved for Wednesday, November 16th from 9:00 a.m. through 11:00 a.m. to brainstorm about care coordination for individuals who utilize long-term services and supports, behavioral health services, developmental disabilities services and/or are dually eligible for services.

Videoconferencing sites and conference phone information is included, below.

We are particularly interested in hearing your ideas and experiences that may improve care coordination in the future. Additionally, we would like to explore future opportunities to consult with you around these important initiatives. According to ADSA records, over 3,000 tribal members receive Aging and Adult Services; over 2,500 tribal members receive Developmental Disability services and over 10,000 tribal members receive Behavioral Health services through Medicaid resources while over 5,000 members are dually eligible for services.

Duals Innovation Grant
HB 1738
Brainstorming Invitation

House Bill 1738 requires a preliminary report to the State Legislature in December 2011 with a follow-up Implementation Report in December 2012. Our goal is to begin an exploration of ideas that will continue into 2012 and through consultation help frame the implementation plan recommendations.

Please contact any one of us if you have any questions, additional agenda items or other recommendations.

Sincerely,



Marietta Bobba
Planning and Program Development Manager
Legislative Policy & Analysis Unit
DSHS/ADSA
(360) 725-2618
bobbam@dshs.wa.gov



Bea Rector
Project Director
Duals Innovation Grant
DSHS/ADSA
(360) 725-2254
Bea.rector@dshs.wa.gov



Jenny Hamilton
Program Manager
MPA/HCA
(360) 725-1101
Jenny.Hamilton@dshs.wa.gov

Directions:

Available Video Conferencing Sites:



Directions to DSHS
Group Video Conferen

If you are unable to attend by video, but would like to participate by phone, please call:
(360) 407-3780 **Participant PIN Code: 144483#**

APPENDIX D

Groups, Organizations and Individuals who provided written input

	Name	Title	Organization	
1	Misha Werschkul	Legislative & Policy Director	SEIU Healthcare 775NW	Labor
2	Janis Luvaas	Program Director	Yakima Valley Farm Workers Clinic	Community Provider
3	Joe Roszak	Executive Director	Kitsap Mental Health Services	Community Provider
4	Janet St Clair	Deputy Director	Asian Counseling and Referral Services	Community Provider
5	Sheila Gilliam	Finance Director	Kitsap Mental Health Services	Community Provider
6	Ann Christian	CEO	Washington Community Mental Health Council	Association
7	Marcie Taylor	Executive Director	Community Employment Alliance	Association
8	Barbara LaBrash	Human Services Manager	San Juan County Health and Community Services	Public Health
9	Faith Richie	VP; National Marketing & Development	Telecare Corporation	Community Provider
10	David Bruxer	Quality Improvement Director	Lutheran Community Services Northwest	Community Provider
11	Bob Hicks	Operations Manager	Skagit County Community Services	Local Government
12	Bruce Tabb	Executive Director	Elmview	Community Provider
13	Roger Bauer	CEO	Okanogan Behavioral HealthCare (OBHC)	Community Provider
14	Sharon Krupski	Executive Director	Community Services Northwest	Community Provider
15	Brian Davis	Director	Good To Be Home Care, LLC	Community Provider
17	Erin Treiber	Owner	Erin Treiber, LLC	Community Provider
18	Annabelle Payne	Director	Pend Oreille County Counseling Services	RSN
19	Mary E Hanna	Executive Director/Owner	Independent Services, Corp	Community Provider
20	Barbie Rasmussen	Director; Planning & Program Management	Olympic Area Agency on Aging	Area Agency on Aging
21	Sue Elliott	Executive Director	ARC of Washington	Advocate
22	Samantha Waldbauer	CM Services Manager - TXIX	SW WA Agency on Aging and Disabilities	Area Agency on Aging
23	Mary Strehlow	Manager	Clark County Developmental Disabilities	Local Government
24	Dennis Regan	Data Analyst	North Sound Mental Health Administration	RSN
25	Marc Avery	Chief Medical Officer	Valley Cities Counseling	Community Provider
26	Greg Falk	Executive Director	The Arc of Spokane	Advocate
27	Jackie Fullerton	Vice President, Patient Care Services	Walla Walla General Hospital	Hospital
28	Dian Cooper	CEO	Cowlitz Family Health Center	Community Provider
29	John Lund	CEO	Tangible Systems	Consultant
30	Scott Malone	Program Director	The Arc of Spokane	Advocate
31	Roy Walker	Executive Director	Olympic Area Agency on Aging	Area Agency on Aging
33	Becky Frankeberger	Owner	Butterfly Knits	Self-Advocate
34	Annabelle Payne	Director	Pend Oreille County Counseling Services	Regional Support Network
35	Betty Shanks	Advocate	The Arc	Advocate
36	Tami LaDoux	Executive Director	Tri-Cities Residential Services	Community Provider
37	Amanda Beller	Area Director/	Bethesda Lutheran Communities	Community Provider

Appendix D: Groups, Organizations & Individuals who provided written input continued.

	Name	Title	Organization	
		Administrator		
38	Andrew Dym	MD	Pacific Medical Centers	Hospital
39	Cindy Doyle	Program Director	Adams County Developmental Disabilities	Local Government
40	Jackie Mitchell	Program Specialist AOD Coordinator	Whatcom County	Local Government
41	Donna Overman	Director, Contracting & Network Development	Columbia United Providers	Health Plan
42	Lori Brown	Director	SouthEast WA Aging & Long Term Care	Area Agency on Aging
43	Jackie MacLean	Director	King County Department of Community & Human Services	Local Government
44	David Fleming, MD	Director & Health Officer	Public Health-Seattle-King County	Public Health
45	Saskia Davis, RN	Family Guardian	Family Guardian	Advocate
46	Viktoria Sazhina	Program Coordinator	Circle of Friends	Community Provider
47	Diane Narasaki	Executive Director	Asian Counseling & Referral Services	Community Provider
48	David W. Kelly	Director	South West WA Agency on Aging and Disabilities	Area Agency on Aging
49	Doris Visaya, RN, BSN	Director of Professional Affairs	Home Care Association of Washington	Community Provider
50	Jesse Hunter	Executive VP & Operating Committee Chair	Centene Corporation	Health Plan
51	David F. Maltman	Policy Analyst	WA State Developmental Disabilities Council	Advocate
52	Faye Lincoln	Senior VP: Policy & Government Relations	Avalon Health Care Group	Health Plan
53	Trish Blanchard	Chief Clinical Officer	Sound Mental Health	Community Provider
54	Claudia Sanders	Senior VP, Policy Development	WA State Hospital Association	Association
55	Barbara Berg	President	Rural Health Clinic Association of WA	Association
56	Charles R. Benjamin	Executive Director	North Sound Mental Health Administration	Regional Support Network
57	Rashi Gupta	Policy Director	Washington State Assoc of Counties	Association
58	Lynne Barker RN, MBA, CPHQ	Director, Medicaid/Charitable Programs	Kaiser Permanente	Health Plan
59	Claudia St. Clair	Director, Government Contracts	Molina Healthcare of WA, Inc	Health Plan
60	Nick Beamer	Director	Aging and Long Term Care of Eastern Washington	Area Agency on Aging
61	Multiple Signers:	n/a	Cross Cultural Alliance of King County	Advocate
	Diane Narasaki; Janet St. Clair; Yoon Joo Han		Asian Counseling and Referral Services	Community Provider
	Terri Vispo		Consejo Counseling & Referral Services	Community Provider
	Ann McGettigan		Seattle Counseling Services for Sexual Minorities	Community Provider
	Norm Johnson		Therapeutic Health Services	Community Provider
	Beth Farmer		International Counseling & Community Services, Lutheran Community Services	Community Provider
62	Anders Edgerton	Regional Administrator	Peninsula Regional Support Network	Regional Support Network
63	Maria Nardella	Access & Care Coordination Section	WA State Department of Health; Office of Health Communities	Public Health

Appendix D: Groups, Organizations & Individuals who provided written input continued.

	Name	Title	Organization	
64	Molly Belozzer Firth	Director of Public Policy	Community Health Network of Washington	Health Plan
65	Mary C. Looker	Chief Executive Officer	WA Association of Community & Migrant Health Centers	Association
66	Betsy Jones	Director; Product Development	Community Health Network of Washington	Health Plan
67	Jan Daughenbaugh, RN, CCM, BSN, MA	Manager: Utilization Review	The Regence Group	Health Plan
68	Valerie Martinolich	Government Programs Coordinator	Regence Blue Shield	Health Plan

APPENDIX E

Summary of Major Benefits and Risks Identified by Stakeholders

Benefits and Risks Identified By Stakeholders In Response to “Straw-man” Proposals

3. **Keep the status quo:** *Purchasing for long-term services and supports and behavioral health remains with DSHS. HCA continues to purchase medical benefits through contracts with managed care plans and fee-for-service providers, and provides technical assistance to the Department regarding evidence-based purchasing strategies and joint applications for federal waivers, as needed. The agencies align their approaches through contracting requirements including performance measures.*

BENEFITS

- ✓ Greater access to a more comprehensive, specialized health and social supports for those with serious mental illness, substance abuse or disability-related problems than is typically available under traditional medical managed care plans.
- ✓ Builds on the strengths of the current system by maintaining a well integrated local system of care [within existing silos] that includes housing, employment, wraparound and other social supports for those with highest needs.
- ✓ Allows for broad range of services that prevent use of more restrictive and expensive hospital, detoxification, and residential care. Such services include community crisis stabilization, community case management, rehabilitation and skill building, family and consumer education, assertive community treatment, peer support and other recovery oriented services.

RISKS

- ✓ Keeps certain silos in place. Accountability and care coordination challenges remain a significant issue.
- ✓ The carve-out model provides specialty services with access limited only to those who meet specific qualifications criteria.
- ✓ Except in limited initiatives does not allow for early identification and intervention services that prevent more serious illness and greater cost later.
- ✓ Does not easily allow for or provide incentive for a cross-disciplinary/improved chronic care.

4. **Enhance primary care coordination with more integrated community supports:**

For people who are not at risk of institutionalization, transition purchase of a core set of behavioral health services to HCA, along with accountability for related budget oversight. Services could be included in amended managed care contracts. DSHS continues to purchase supplemental behavioral health supports for people at risk of institutionalization, as well as long-term services and supports, under federal authority that allows for a multi-population home and community-based waiver. This option includes requirements and incentives to coordinate with primary care and community supports systems, with risk-sharing and gain-sharing between the systems.

BENEFITS

- ✓ Recognizes and provides specialized services for those with more severe mental illness or substance abuse problems, ensuring access to a broader range of services and supports that help maintain these individuals in the community.
- ✓ Provides increased access to care for individuals with less severe mental health or substance abuse symptoms, ensuring early identification and treatment to prevent more serious problems down the line (building on the successful Mental Health Integration Program).

RISKS

- ✓ Individuals do not fall neatly into categories of “at risk for institutionalization” or not and move back and forth in symptom severity, requiring a change in providers and/or plans as changes happen.
- ✓ Maintains bifurcated system of behavioral health financing and treatment and health care financing, posing challenges with care coordination and multiple points of accountability

5. **Transfer all behavioral health treatment and services purchasing to HCA:** *Move all purchasing responsibility for behavioral health treatment and services (mental health outpatient and community treatment and services, substance abuse services) to the HCA. Accelerate the inclusion of medical and behavioral health services in fully capitated managed care contracts. DSHS continues to purchase long-term services and supports and services for individuals with developmental disabilities.*

BENEFITS

- ✓ Recognizes the complexity of the long-term care and developmental disabilities clients and systems; HCA lacks experience with these populations and managed care plans may not have the needed level of expertise or models that will be adequate or safe for them.

RISKS

- ✓ This option further fragments the payment and delivery systems by transferring purchasing for Medicaid behavioral health services but not non-Medicaid funding and services. It also leaves long-term care and developmental disabilities purchasing with DSHS.
- ✓ Many individuals at the state psychiatric hospital are also recipients of the long term services. With purchasing under the same authority at DSHS coordination is strong, produces better outcomes and reduces hospital costs. Splitting purchasing could disrupt needed integration for this vulnerable group and also make primary care coordination more difficult.
- ✓ Individuals tend to move back and forth in eligibility, which could result in disruption of services and changing of providers and/or plans.
- ✓ This option is likely to hinder ability to provide person centered care and will not allow for a single point of entry.

6. Pilot integrated financing and delivery through managed care and health home models:

In regional pilots, transfer all purchasing of behavioral health plus long-term services and supports to the HCA, for inclusion in fully capitated contracts where managed care plans are at full risk for all care delivered and the contribution of health homes is maximized. Purchasing responsibility outside the pilots remains with DSHS along with the overall policy and program development decision-making for eligibility, benefits and performance monitoring.

BENEFITS

- ✓ Allows for the ability to “test” different models and learn from other regions, providing opportunities to fine tune integration before taking it “to scale”.

RISKS

- ✓ There is significant variability in the populations and service systems across the state, making it difficult to apply a single model to all regions.
- ✓ A thorough analysis of the challenges and outcomes of the Snohomish County integration pilot would be necessary to ensure success of any pilot program.

7. Transfer all health care-related purchasing to HCA:

Transfer all purchasing of mental health (including outpatient and community treatment and services, crisis response, involuntary treatment oversight, state hospital oversight), substance abuse services, and long-term services and supports to the HCA, for inclusion in capitated managed care contracts. The HCA would be responsible for all health care-related purchasing. Systems support for eligibility determination may need to remain with the Department until ACA-related administrative details are clarified.

BENEFITS

- ✓ Allows for a single point of authorization and accountability.
- ✓ Opens up greater access to care for clients who do not qualify for behavioral services under the current criteria. Creates a more population-based approach, helping assure that individuals are screened and treated early on and preventing more serious problems.
- ✓ More readily supports access to care within the context of a primary care medical home, where the majority of the population is likely to first seek care for behavioral health issues or who present with physical conditions that have behavioral factors.
- ✓ Would help assure that people with behavioral health conditions and those in long-term care have a regular health care home and access needed preventive and primary care services.

RISKS

- ✓ Traditional medical managed care organizations may not have the capacity or skill to serve individuals with the most complex issues leading to worsening of symptoms and increases in overall health costs.
- ✓ May not adequately address access to the supportive services such as housing, employment and wraparound services, which are necessary to stabilize individuals with serious and complex conditions.
- ✓ Would likely increase the risk of cost shifting to other systems (such as hospitals and jails). Managed care organizations would not have the same incentives to serve the most complex individuals.
- ✓ If populations with more complex issues are spread across multiple managed care plans, any given plan may not have incentive to develop or procure specialized programs for those enrollees.

- ✓ Having all services under one plan enhances ability to coordinate and integrate services; more readily removes financial silos and technology barriers that can stand in the way of effective care coordination.
- ✓ Less confusion for clients who would experience less shuffling between different systems of care.
- ✓ A fully integrated system could more easily allow for a single care plan that can be shared across providers.

APPENDIX F

Service Definitions Used for VENN Diagrams

- **AOD (Alcohol-Other-Drug Need):** During the past two years, these people experienced one or more of the following: an alcohol or drug diagnosis from medical providers or chemical dependency treatment providers; at least one episode of state-funded treatment for chemical dependency; or an arrest for alcohol or drug-related issues.
- **SMI (Severe Mental Illness):** During the past two years, these people experienced one or more of the following: A diagnosis of psychotic disorder, mania, or bi-polar disorder; a prescription for anti-psychotic or anti-mania medication; or a psychiatric hospitalization. All these administrative records could have come from the Regional Support Networks, medical providers, or state or community psychiatric hospitals.
- **DD (Developmental Disability):** During the past year, these people received at least one service from the DSHS Developmental Disabilities Division.
- **LTC (Long Term Care):** During the past year, these people received at least one of the following services -- personal care, community residential care or nursing facility -- from the DSHS Aging and Disability Services Administration.