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

December 2012

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TABLE OF CONTENTS

Summary of the Initial Report 3

Making the Initial Recommendations a Reality 4

Current Status and Plans 5

Where Washington Goes Next 9

Future Considerations 14

House Bill 1738 Implementation Plan

Summary of the Initial Report

In the March, 2012 Report to the Legislature on *Purchasing Mental Health, Chemical Dependency and Long Term Services and Supports, Including Services for People with Developmental Disabilities*[1]*,* the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) outlined preliminary recommendations as required by House Bill 1738. This report is in follow-up to provide the plan for implementation of those preliminary recommendations. HB 1738[2] 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. That included the responsibility to purchase medical assistance for all Medicaid recipients.

Primarily using Medicaid funds available via cooperative agreement with HCA, DSHS retained 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. Section 116 of HB1738 directed 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. The March, 2012 report outlined an overarching vision for integrated care in which medical, behavioral health and long-term services and supports are increasingly coordinated to improve health outcomes while reducing costs:

> "*Opportunities for better outcomes, system efficiencies and cost containment through 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."*

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[1] http://www.hca.wa.gov/documents/legreports/2E2SHB1738HCAPurchasingRoleLegReport.pdf

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

Toward that vision, DSHS and HCA presented two primary 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 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 or strategies.

   Substantive and timely progress in developing innovative integrated care models that improve care for all Medicaid enrollees requires a balance of strategies. The best opportunity 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:

   - Embedding robust health home functions in all systems.
   - 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 supports and services to simplify, improve financial alignment, and increase accountability

Making the Initial Recommendations a Reality

This implementation plan outlines the steps that have been taken, and that remain, to move these purchasing strategies to reality:

- Washington submitted its HealthPathWashington[3] proposal in April, 2012 to improve services for people who are eligible for both Medicare and Medicaid through a partnership with the federal government that coordinates and integrates investment of federal and state resources in supporting health home services and expanded delivery of integrated services through health plans.

[3] http://www.aasa.dshs.wa.gov/duals/

- Discussions with CMS have prepared the way for statewide rollout of health home services in 2013, targeted to high-cost, high-risk populations based on a state Medicaid Plan Amendment (SPA) under Section 2703 of the Affordable Care Act (ACA). All health home services will adhere to the requirements of the SPA and be available, regardless of a beneficiary's eligibility status, as follows:

  (a) People who are only eligible for Medicaid will receive health home services through the newly expanded Healthy Options program.
  (b) People who are dually eligible for Medicaid and Medicare will have access to health homes in one of two ways:
      i. Under HealthPathWashington, in geographic areas where their Medicare and Medicaid services have been combined into a single benefit administered by a health plan, beneficiaries will have access to health home services as part of their benefit.
      ii. Under HealthPathWashigngton, in other areas of the state, people who are dually eligible will have access to health home assistance paid for as an individual service.

- Under HealthPathWashington, a memorandum of understanding (MOU) has been signed with CMS that will allow the State and the Federal government to benefit from savings resulting from improvements in quality and reductions in costs generated from health home services for people who are dually eligible.

- Over 100,000 people who are solely eligible for Medicaid (from the eligibility category "blind and disabled") were transitioned into the Health Options program, which provides medical and limited mental health services delivered by health plans (long-term services and supports and more intense mental health and chemical dependency services are not included within Healthy Options). The November completion of that transition brings more high-cost, high-needs persons into managed care where their care will be effectively overseen and coordinated, in part through health home services that will start in 2013.

- Although much developmental work remains, recent legislative changes in the Affordable Care Act, and the related regulatory clarifications, make the Section 1915(i) and 1915(k) Medicaid State Plan options a potentially promising legislative and financial base for modernizing the home and community-based services system in a manner that would support the joint DSHS/HCA vision of integrated care.

<u>Current Status and Plans:</u> 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 and that have shown a positive effect on costs, health outcomes,

and mortality in preliminary Washington tests. The ACA provides financial incentives in the form of enhanced federal matching funds to implement those functions, which center on a health home coordinator working with the consumer's care team to:

- Conduct screenings to identify health risks and referral needs
- Set goals that will improve beneficiaries' health and service access
- Improve management of health conditions through education and coaching
- Improve beneficiaries' ability to function and their self-care abilities
- Slow the progression of disease and disability
- Access the right care, at the right time and place
- Coordinate clinical treatment plans, functional support plans and other care plans to achieve an integrated, whole-person perspective across delivery systems
- Successfully transition from hospital to other care settings and get necessary follow-up
- Reduce avoidable health care costs.

Availability of health home services will depend on the beneficiary's eligibility category:

Eligibility Category	Healthy Options	HealthPathWashington Health Plan Benefit	HealthPathWashington Fee for Service
Solely Medicaid Eligible	**X**		
Dually Eligible		**X** - in counties that agree to health plan delivery method	**X**- in other counties

To ensure consistency and engage the maximum number of people who are at the highest risk for significant medical cost , DSHS and HCA will use the health homes SPA to establish clear and consistent standards, outcome measures and financial incentives for health homes, whether delivered through expanded use of capitated health plans as described below for Healthy Options or HealthPathWashington Strategy 2, or in the current or modernized version of the fee for service delivery system, also described below. Rollout of health home services, targeted to high cost, high-risk beneficiaries, will start in 2013. The key milestones that have been accomplished, or that remain, are:

- Include requirements to adhere to health home standards in Healthy Options s (July, 2012)
- Execute a federal MOU for a managed FFS demonstration (October, 2012)
- Conduct regional forums (October-November, 2012)
- Issue first health home request for applications (November 2012)
- Submit 2703 State Plan Amendment (December 2012)
- Include requirement to adhere to health home standards in HealthPathWashington Strategy2 RFP (February, 2013)
- Qualify/contract for health homes (beginning March, 2013)
- Provide training and technical assistance (winter 2012 and on-going)
- Secure federal approval of 2703 State Plan Amendment (March 2013)
- Contingent on State Plan Amendment approval, implement health homes starting April 2013 (rolled out geographically with a new SPA for each area).

The geographic rollout of health home services is scheduled to occur as follows:

Health Home Implementation Schedule

Release A	
Coverage Area Four – Pierce Coverage Area Seven – Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, & Yakima	
Request for Applications	Release - November 9, 2012
Request for Applications	Due -December 14, 2012
Health Home Start Date	April 1, 2013
Release B	
Coverage Area Six – Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens & Whitman	
Request for Applications	Release - January 11, 2013
Request for Applications	Due - February 8, 2013
Health Home Start Date	July 1, 2013
Release C	
Coverage Area One – Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason & Pacific Coverage Area Five – Clark, Cowlitz, Klickitat, Skamania, & Wahkiakum	
Request for Applications	Release - March 11, 2013
Request for Applications	Due - April 8, 2013
Health Home Start Date	September 1, 2013
Release D	
Coverage Area Two – Island, San Juan, Skagit, Snohomish, & Whatcom Coverage Area Three – King	
Request for Applications	Release - May 13, 2013
Request for Applications	Due - June 11, 2013
Health Home Start Date	November 1, 2013

<u>Current Status and Plans:</u> Expand delivery of integrated services through capitated contracts with health plans

Because the underlying federal authorities for Medicaid and Medicare are different, the approaches to expansion of capitated approaches to delivery of care also differ based on whether an individual is solely eligible for Medicaid and receiving services under Healthy Options, or dually eligible for both Medicaid and Medicare and receiving services under HealthPathWashington. However, in some counties the result may be substantial overlap of the contract health plans, health home providers, and direct service providers that seek to support both beneficiaries under both programs. Where that proves to be the case, coordinating the design and implementation of the two programs will be key to forming a robust managed care base for system-wide comprehensive and integrated care.

For people who are solely eligible for Medicaid and served through Healthy Options, following guidance provided by SSB 5394 and the CMS State Medicaid Director Letter on health homes, HCA strengthened elements of the Healthy Options contract to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for the State Medicaid program. Key elements within Healthy Options contracts include requirements to:

- Establish a health home network that is qualified by the state and addresses the full range of health home services, consistent with the requirements of the Health Homes SPA
- Ensure primary care providers coordinate with community entities as well as DSHS services and programs, Department of Health, local health jurisdictions, and other HCA services/programs.
- Demonstrate care coordination capacity that encompasses categories of Medicaid services beyond traditional medical services.

For people who are dually eligible for Medicare and Medicaid, the parameters for expansion of capitated approaches to the delivery of Medicaid and Medicare services (including long-term services and supports and a full range of mental health and chemical dependency services were established by proviso in the current biennial budget, consistent with related language in the 1738 report of preliminary recommendations:

> *"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. "*

As part of the HealthPathWashington proposal, DSHS and HCA continue to work with Snohomish and King Counties, the federal government, labor partners and stakeholders to finalize the location, design and implementation steps toward a fully integrated approach to

purchase of health and support services through health plans for their shared populations. This strategy also includes the opportunity to provide health home services within that more integrated context. Referred to in HealthPathWashington as "Strategy 2," expanded delivery through health plans is set to start in January, 2014. The key milestones that have been reached or that remain are:

- Labor discussions on role of state workers (Sept-Nov 2012)
- Health Plans submit letter of intent (Nov 2012)
- County agreement on terms and conditions (Dec 2012)
- State/County Interagency Agreement (Dec 2012)
- County legislative approval (Dec 2012)
- Federal MOU signed (Jan 2013)
- RFP development (August-Jan 2012)
- RFP issued (February, 2013)
- Health plan applications due (March 2013)
- Apparently successful bidder identified (July 2013)
- Readiness review (Aug-Sept 2013)
- Contracts signed (Sept 2013)
- First enrollment period (Oct-Dec 2013)
- Coverage begins (Jan 2014). Enrollment will be phased in over five months.

<u>Where Washington Goes Next:</u> Modernizing and simplifying the current DSHS system of supports

In the report of preliminary recommendations, HCA and DSHS identified the key barrier to achieving integrated care that is presented by the current systems of service delivery:

> *"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."*

The chart below illustrates the degree of those combinations of need.

System	Mental Health Need	Substance Abuse Need	Co-occurring MH and SA Need	Population Size
Long-term services and supports *Adults age 18 to 64*	85.0%	20.6%	19.6%	21,087
Long-term services and supports *Adults age 65+*	66.6%	3.1%	2.7%	28,196
Services for the developmentally disabled	57.6%	3.3%	2.8%	18,897

Adults age 18 to 64				

SOURCE: DSHS Research and Data Analysis Division, October 2012

Successful statewide implementation of health homes through both health plans and within the fee-for-service environment will provide access to important service coordination for the 5% highest risk, highest need Medicaid enrollees. However, only about 10% to 15% of the shared DSHS and HCA populations would be engaged in demonstration of expanded delivery of a fully integrated benefit that includes long-term services and supports, mental health and chemical dependency services through capitated contracts with health plans, even under the most optimistic assumptions of enrollment The remaining 85% to 90% of the consumers with need for behavioral health and/or long term services and supports would continue to receive their care based on the uncoordinated patchwork of limited-purpose home and community-based waivers and Medicaid state plan authorities. That patchwork, and the infrastructure that has grown around it, does not support the kind of person-centered, coordinated care, alignment of financial incentives, and overall accountability that is key to achieving the HCA/DSHS vision of integrated care. To correct that, in the report of preliminary recommendations, HCA and DSHS identified steps to modernize and simplify the current DSHS systems of care in geographic areas without managed care plans or for people that opt-out of them. Substantial progress is simply not possible within the funding and delivery structures as they currently exist.

In order to hold health plans accountable for the care of dually eligible clients under their capitated contracts through HealthPathWashington, Strategy 2, substantial work has been accomplished to develop performance standards, establish outcome measures and create methods to tie portions of funding to those outcomes. That work represents the high-water mark in Washington's thinking about what integrated services would look like "on the ground." For the 85% to 90% of the overall population that is the subject of this report who will not have access to that approach to care, Washington needs to focus next on what can be done using other mechanisms to reach that high-water mark for all residents who could benefit from more integrated services.

To accomplish that, the preliminary HB1738 report called for an integrated DSHS benefit that responds comprehensively to individually assessed need:

- Assistance with daily living tasks and support to live in the setting of choice
- Skilled tasks and supportive community services
- Specialized services
- Individualized health action planning
- Measured use of consumer self-direction.

To be capable of meeting complex needs, as much as possible that benefit should support combinations of services that respond to the combinations of challenges presented by each consumer. For example, an individual with a need for long-term services and supports co-occurring with a mental health need and/or a substance abuse need should have access to a

benefit that is sufficient in scope to cover that complexity, ideally within a single care plan and service authorization scheme. Addressing complex needs on a consumer-centered basis requires reconfiguration of the basic delivery system that considers:

- Multiple points of entry, well- coordinated and streamlined with the ability to assess across the entire range of individualized need
- Standardized intake and screening protocols system wide with built in triggers for referral to specialty services
- Tiered levels of core services available to persons based on need. Core services would be strength- based and build on naturally occurring supports to promote less long-term reliance on more expensive services. Core services may include chemical dependency assessment, mental health Individual treatment, personal care, skilled nursing, nurse delegation, housing stabilization, assistive technology, medication management, respite, nutrition, personal emergency response
- Additional levels of specialized services to effectively serve high-risk beneficiaries with complex conditions or to address the unique needs of certain populations
- A primary, multidisciplinary case manager with general knowledge, skill, and authority to assess need and authorize a core set of client services
- Ability for the primary case manager to refer specialized professionals (RNs, MH, CD certified, those with expertise with certain populations) who are capable of assessing, authorizing, and developing specialized service and treatment plans for complex or high needs beneficiaries
- Ability to provide health home services, or link to health home services to coordinate community services with medical services for high cost/high risk beneficiaries
- Delivery by single organizations accountable to manage costs and outcomes.

Initial analysis has identified a potential alternative financing vehicle under the 1915(i) Medicaid Home and Community-Based Services Option[4] that could support better integration of funding for home and community-based services. Section 1915(i) provides an option for states to provide HCBS, including personal care, under the state Medicaid plan. States can use 1915(i) to provide a single Medicaid benefit package that incorporates services that otherwise would only be available through HCBS waivers (such as Washington's COPES or multiple developmental disabilities HCBS waivers) or demonstration projects. Under 1915(i), states have broad freedom to design a HCBS benefit package that can include services such as:

Homemaker services
Home health aide services
Adult day health services
Respite care
Services related to chronic mental illness
Personal care services
Habilitation services

[4] The services are specifically listed in section 1915(c)(4)(B) of the Act

Subject to federal approval, services may be added as part of the 1915(i) HCBS benefit. States also have more management flexibility than under other Medicaid sources of funding for HCBS. For example:

- States may serve individuals who have lower levels of disability than is required to qualify for care
- States are not required to demonstrate cost neutrality in comparison with the cost for equivalent levels of institutional services
- The benefit may be targeted to specific populations
- A full array of HCBS can be offered to individuals with mental health and substance use disorders
- States can tighten needs-based criteria for eligibility and can tighten service requirements if enrollment and/or costs exceed projections.

Like other Medicaid state plan options, however, 1915(i) services must be provided statewide and states cannot limit the number of eligible people who are served.

Greater integration of funding makes it possible to rethink the delivery system structure and unlocks the potential for cost risk/gain-sharing 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. Portions of virtually all of the major services financed under today's nine separate DSHS home and community-based program authorities (COPES, multiple developmental disabilities waivers, the Medicaid Personal Care Program, and the mental health Medicaid waiver).

Beyond the 1915(i) state plan option, another new Medicaid State Plan Option under Section 1915(k) of the Social Security Act, referred to as Community First Choice (CFC), provides home and community-based attendant services and supports with a 6% greater federal match contribution. Implementation of CFC would require offsetting investment in required client training and optional investment in services such as transition costs for rent, utility, security deposits and other necessities required to move from an institution, as well as supports that increase independence or substitute for human assistance. The potential for refinancing portions of the current delivery system using more federal funding is an attractive possibility that must be explored as part of the modernization effort.

While the goal is to explore how to use these new authorities in the most transformative manner to increase the ability to achieve improved outcomes and make the most efficient use of resources, it is not likely Washington would replace all of its current HCBS authorities. Optionally, the state could use 1915(i) to integrate the major, priority services that are needed by most clients, refinance other services using CFC to leverage increased federal funding, and

existing HCBS waivers could be modified to become a source for specialty, or "wraparound" services for specified populations. There are a broad range of options for how quickly to take next steps, including but not limited to:

- Incremental changes to create standard protocols for improved service coordination across professional disciplines including; medical, mental health, chemical dependency, and long-term services and supports.
- Broadly combining funding streams for all services currently provided by counties and let counties become accountable for managing costs and outcomes in a single contract.
- Establishment of local Accountable Care Organizations and/or Regional Health Authorities with combined funding streams that are responsible for integrating and coordinating all services including: medical, long-term services and supports, mental health, chemical dependency

As a note of caution, there are some significant details that need to be considered and addressed. Since both the CFC and 1915(i) options are entitlement programs, care must be taken to not only explore how to maximize their benefits, but to also assess ability to manage over the long term within expected budget constraints. In addition, as with any Medicaid program, there are legal and regulatory issues that may be challenging. For example, CFC includes a twelve month maintenance of effort requirement on related state expenditures. Some elements of the final CFC regulations appear to conflict with current state law on disqualifying crimes and worker qualifications. A key definition of what constitutes a "home and community-based setting" has not been finalized. The necessary feasibility work is largely in front of us and determining the exact nature and pace of change will require close collaboration with stakeholders, federal and local governments, the Office of Financial Management, our labor partners and the legislature. Key milestones in that process are:

The necessary feasibility work is largely in front of us and determining the exact nature and pace of change will require close collaboration with consumers and their families, service providers, federal and local governments, the Office of Financial Management, our labor partners and the legislature. Key milestones in that process are:

- Review of concept papers for 1915(i) and CFC-1915(k) and revised delivery system options with stakeholders (January 2013)
- Prepare options for a possible integrated home and community-based benefit structure 1915(i) state plan amendment, building from the performance expectations developed for health home services. (Jan –March, 2013).
- Prepare options for potential CFC – 1915(k) state plan amendment(Jan –March, 2013)
- Consult with advisory groups/stakeholders on planning/implementation (on-going)
- Identify options for delivery system changes (March-June, 2013)
- Assess financial and legislative feasibility (June – Sept, 2013)
- Decide whether to submit state plan amendments (Oct, 2013)
- Seek necessary legislative and budget approval (Jan, 2014)

- Implement changes (Beginning July, 2014)

Future considerations: **Medicaid expansion and behavioral health system changes**

If Washington exercises its option to expand Medicaid eligibility to 138% of federal poverty, Medicaid enrollment is expected to increase by 250,000 adults over four years, starting in 2014. The “expansion” population will have significant mental health and chemical dependency needs with 100% federal financing for the first three years, phasing down to 90% by 2020. As decisions are made about the Medicaid expansion, DSHS and HCA need to determine how to incorporate those additional resources into these integrated purchasing strategies.

Additionally, DSHS has launched a review of the adult behavioral health system, which will:

- Identify outcomes to measure the effectiveness of behavioral health services
- Identify evidence-based, research-based and promising practices to achieve those outcomes
- Assess the current state of the service system for delivering those
- Make recommendations on how to best promote, measure and sustain success.

The effort will contribute to defining the contribution behavioral health services can make to the goals shared by all of the populations that are the subject of this report:

- Improved health status.
- Increased meaningful activities, including employment and education.
- Reduced involvement with criminal justice systems.
- Reduced avoidable costs including hospital and emergency rooms, jails/prisons.
- Increased stable housing.

The work from the effort will inform the behavioral health outcomes and expectations HCA and DSHS will include in the three integrated purchasing strategies outlined in this report as they evolve under this implementation plan.

In Closing:

DSHS and HCA will continue to seize opportunities and move toward a shared vision of integrated care for vulnerable populations in close consultation with the Governor, legislature and our community partners. Our combined efforts will continue to set the pace for health reform implementation, with innovative approaches for restructuring the Medicaid program around the goal of high value, integrated services that better serve our shared clients.