

To: Jessica May, CMS Project Officer

From: Bea Rector and Kathy Pickens Rucker, Project Directors DSHS and HCA

Date: May 14, 2012

Re: HealthPathWashington: A Medicare Medicaid Integration Project – Changes to the Final Proposal Based Upon Feedback from the Public Comment Period

Today, Washington State will submit to your agency its final design plan, *HealthPathWashington: A Medicare Medicaid Integration Project*. The final design plan is the result of ten months of collaboration between the Health Care Authority and the Department of Social and Health Services' Aging and Disability Services Administration and extensive engagement with individuals, who receive, provide, administer, and advocate for services provided by these programs.

During the draft design plan public comment period (March 12-April 13, 2012), the state received over 200 pages of written comments from more than 60 organizations and individuals. Overwhelming support was expressed for the state's proposed approach to integrate care using multiple strategies. In the nine working days between receipt of the comments and submission of the final plan, comments were organized into categories including: 1) general statements for which no change to the draft was requested; 2) questions that the state will work to answer with additional input from stakeholders as more detailed implementation steps are taken; 3) additional clarification and specification considerations for implementation; 4) considerations related to the communications plan; 5) considerations for the consumer protections section; and 6) considerations for changes to the final design plan. The stakeholder feedback was extremely valuable and many revisions were made to the final plan in response to the feedback.

The state will continue to work with our HealthPathWashington Advisory Team and other interested parties as we move from design to implementation planning. This memo provides an overview of the key changes and clarifications made from the draft to the final demonstration proposal. This memo is organized into four discrete sections; overall themes that apply to the proposal as a whole and then those that apply to each of the three integration strategies described in the proposal. This is not an inclusive list of all the changes made to the final design plan, but an overview of changes made as a result of themes found in the comments received.

Themes applying to the overall proposal

1. Need for more specificity and details related to implementation.

Information was added to the document to clarify it is a high level overview of the planning process and the integration strategies proposed by Washington State. As implementation planning continues, additional detail and specificity will be available. Where possible, additional detail has been included within the final proposal. Additional clarity around the role of the new advisory team and the types of

activities they and other interested parties will have an opportunity to provide feedback on was added to the final proposal.

2. A need for more robust and specific description of beneficiary/consumer protections.

Washington State recognizes and embraces the need for strong consumer protections. A significant revision was made to the consumer protections section (Dii) of the proposal to address themes identified in the public comments received. This includes additional detail in areas of: continuity of care, network adequacy and provider access, enrollment assistance, integrated grievance and appeal process, rights and responsibilities, beneficiary support and integrated beneficiary information. In addition, greater emphasis was put on the need to ensure services are delivered in a culturally competent manner with materials available in multiple languages and alternative formats. In the design and implementation of integration strategies Washington will:

- build on the foundation of current consumer protections;
- work with CMS to create an integrated appeal and grievance process for beneficiaries that will include the most beneficiary advantageous protections offered in the current Medicare and Medicaid programs;
- request CMS provide funding for enrollment/options counseling assistance to help beneficiaries make fully informed choices;
- continue engagement with stakeholders during implementation planning to ensure adequate protections are achieved.

3. Highlight need for culturally competent service delivery.

A number of changes were made within the document to ensure the goal of providing culturally competent service delivery is clearer within the document, including adding the expectation to the integrated care vision.

4. Need to provide background of the current service delivery systems and the strengths that exist in those systems.

The background section (A) was rewritten to provide a high level overview of the state's partnerships, experience, strengths and innovations made in the areas of medical, long term services and supports, mental health, chemical dependency and services to individuals with developmental disabilities.

5. Concern that chemical dependency was not emphasized enough in the document.

In the draft proposal the term "behavioral health" was used to refer to mental health and chemical dependency. We believe this may not have been well understood by the reader. Behavioral health references have been replaced to specifically call out both mental health and chemical dependency. In addition, substance use disorder has been added to the list of chronic conditions for health homes services.

6. Clarifications about how the proposal may impact Tribal members.

The final design plan includes three clarifications related to tribes and tribal members: 1) consistent with state Medicaid policy, tribal members will not be passively enrolled into any strategy; 2) the state is working with Tribes to develop a tribal-centric health home model; and 3) specific language added to section (Di) to highlight engagement activities that have taken place with tribes during the planning process.

7. List individuals and groups that participated in engagement activities during the design planning process and include additional detail on how the state will include stakeholders and other interested parties during implementation planning.

The proposal includes additional appendices (J, K and L) that describe the state's engagement activities, who participated, and the HealthPathWashington Advisory Team participants. Additional language was also added throughout the document to make clearer the State's commitment to continue to seek input from stakeholders and other interested parties throughout the demonstration project.

8. Provide additional detail about opportunities for Medicare savings.

The final proposal contains a new appendix (Q) outlining the Medicare savings potential of each strategy.

Themes applying to Strategy 1: Health Homes

The state received a large number of comments supporting the creation of clinical integration at the local service delivery level through community based organizations that have established relationships with beneficiaries. In addition, recognition of the need for high touch care coordination for this population was wide spread among those who provided public comment. In response to comments received, the state has created a second revised draft of the health home qualifications document, appendix U. It was not possible to complete the work necessary to finalize the document prior to the submission of the final design proposal. The state will continue work on the application/qualification process and payment methodologies with input from stakeholders.

1. Need for additional clarity to ensure health homes are high touch and role of direct care workers.

Language has been added to clarify the role of direct care workers and the types of in-person activities expected by the qualified health home providers. The state is also requesting funding from CMS to help support training, fidelity and monitoring functions for dual beneficiaries enrolled in health homes.

2. Need to provide additional information for why the state is choosing to target health homes to the high cost/high risk population, its relevance to the duals population, and publish the PRISM risk score methodology.

Two appendices were added to the proposal (D and F). One provides background on the PRISM risk score algorithm. The second more clearly articulates the clinical and cost reasons the state is targeting this intervention to a population that is at significant risk of experiencing poor health outcomes associated with hospitalization or use of other costly health care services.

3. Need to broaden the list of chronic conditions and not rely solely on PRISM risk score for eligibility.

The state has revised the list of chronic conditions based upon public comment and a review of claims data in appendix U. The state also included examples of additional criteria for health home eligibility in the final proposal. Public comment received made clear that additional criteria is necessary for individuals that may not have a claims history due to: 1) being new to Medicaid/Medicare; 2) not having historic access to an adequate provider network or having cultural or geographic issues impacting utilization; and 3) to ensure access to health home services for individuals who are experiencing a recent transition from an institutional facility or a new acute episode that is resulting in inpatient hospitalizations. The additional criteria will be finalized after the PRISM risk scores are calibrated to the duals population and prior to submission of the 2703 State Plan Amendment in the summer/fall of 2012.

4. Many organizations requested they be named in the list of entities that could be part of a health home network.

The state chose not to name specific entities due to a number of factors including diversity in: 1) population, density, providers and geography of the state that will influence the development of effective health home networks; 2) the needs of the population will vary by age, conditions and where they are already engaged in the provider network; 3) the state will be qualifying health homes and there will be a contractor selection/procurement process; 4) the lead entity will vary by service delivery system (FFS/Managed care) and local health home provider network.

Themes applying to Strategy 2: Integrated Service Delivery Using Financial Capitation Through Health Homes

1. Concern about the feasibility of the aggressive implementation timeline proposed for strategy 2 –fully integrated service delivery using financial capitation through health plan(s).

The revised proposal reflects a change in implementation date of strategy 2 to January 2014. Consistent with the stakeholder feedback received, we believe this delay in implementation start date will provide the additional time needed to:

- ensure careful consideration of state plan selection and readiness review criteria;
- develop plans to build adequate, quality networks;
- work to fully engage county legislative authorities as required by budget proviso;
- work with beneficiaries to better understand integrated care options; and
- continue engagement with stakeholders during implementation planning.

2. Revise county/health plan selection criteria.

There were many questions raised in the public comment period about the authorizing budget proviso language that requires counties to agree to terms for strategy 2. A copy of budget proviso language is included in the final proposal as a new appendix (G). The state is working closely with county governments and the Association of Counties to create a process and timeline to move forward continued discussions with counties and their legislative authorities. In addition, the county/health plan selection criteria appendix H was revised to reflect the following:

- Elimination of any minimum population size by county or multi-county region.
- Additional information about the development of the state specific selection criteria and that a health plan must be an apparently successful bidder in the completion of a procurement process that will occur beginning in November 2012.

Themes applying to Strategy 3: Modernization and simplification with partial capitation

The state received many comments in support of integrating care outside of full service capitation particularly due to the voluntary nature of strategy 2 and the geographic and population diversity of the state.

There were no significant changes made specifically to strategy 3. The changes made to the overall proposal impact all three strategies. Many of the comments received on strategy 3 related to implementation details and questions that will be the focus of the work moving forward.

We look forward to continued collaboration with CMS and our stakeholders in the months ahead as we negotiate with you to implement our demonstration proposal.

