**ADDENDUM to**

**State of Washington**
**Washington State Department of Social & Health Services**
**Washington State Health Care Authority**

**Proposal to the Centers for Medicare and Medicaid Services**

**State Demonstration to Integrate Care for Dual Eligible Individuals**

*This addendum is specific to Washington's HealthPathWashington Strategy 1: Health Homes (Managed Fee-for-Service Financial Alignment Model)*

- *Please clarify how Strategies 1, 2 and 3 in Washington's proposal interact. What is the timeframe for starting Strategy 1?*

  Response: Although Washington proposed implementing multiple financial alignment demonstration strategies in the same geographic area in the proposal submitted to CMS, ultimately there was an agreement between CMS and Washington to limit the geographic area for the Managed Fee-for-Service Financial Alignment Demonstration to all counties in the State, with the exception of any counties in which Washington receives approval from CMS to implement the Capitated Financial Alignment Demonstration. If a beneficiary moved from an area of the state where the Managed Fee-for-Service Demonstration was operating to an area of the state where the Capitated Demonstration was operating, it is possible they could move from enrollment in the Managed Fee-for-Service to the Capitated Demonstration or vice versa. Washington is not pursuing implementation of Strategy 3 as a duals demonstration project but will continue to explore modernization options under its Medicaid systems. The proposed start date for the Managed Fee-for-Service Demonstration is April 1, 2013, and the Demonstration will be rolled out geographically through November 2013.

- *Will the State require health home providers to have formal arrangements with community and institutional based providers such as hospitals, community mental health centers, etc. to ensure that proper referrals are being made to the health home?*

Response: Yes to ensure coordination of all necessary Medicare and Medicaid services, signed subcontracts or Memoranda of Agreement (MOA) will be required of qualified Health Home Networks. Per Washington's proposed health home requirements, the Health Home Network Lead Entity must maintain MOA with essential partner organizations that are part of the Health Home Network and subcontracts with Care Coordination Organizations that hire Health Home Care Coordinators to provide the new health home services. The network must include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency and medical services. Examples of entities that may be part of a health home network include Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging (AAA), Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays (including those covered under Medicare) when applicable. The Health Home Care Coordination Organization must all coordinate with primary care providers, specialty care managers and other providers based on beneficiary needs.

- *What type of communication/education (roll-out plan) does the State expect to initiate prior to implementation?*

Response: The state envisions a multi-pronged approach to communication, education and outreach including:

- Educating the larger provider community and advocacy organizations about health homes, who is eligible and potential benefits for beneficiaries
- Written communication to beneficiaries, including correspondence & brochures
- Website information
- Use of fact sheets & graphics geared to beneficiary audience

- Use of webinars

The state will develop enrollment education and outreach materials designed to ensure beneficiaries are meaningfully informed about the benefits of participating in health homes services. Materials will be translated into languages required under both applicable Medicare and Medicaid rules and the State will partner with local organizations serving minority and underserved populations to increase the likelihood of reaching beneficiaries whose first language is not English. In addition, materials will be available in alternative formats such as large font if requested by a beneficiary. Other planned outreach activities include regional meetings, direct mailings, posters, and the ability for local organizations, providers and hospitals to refer potentially eligible beneficiaries to a qualified health home network.

Mailings and enrollment materials will be aligned with Washington's regional roll-out schedule. Washington plans to auto-enroll eligible beneficiaries in qualified Health Home Networks through Washington's existing MMIS system ProviderOne. Once they are enrolled, the beneficiary will receive more complete health home information, such as a Health Home booklet, which will detail the opt-out process, how to request changes, and a description of the new benefits if they elect to remain enrolled. The lead entity of the Health Home Network is charged with working with beneficiaries to assign where care coordination will take place for each individual within the network. Health home enrollment does not equate to payment or delivery of a health home service. Beneficiaries must elect to receive health home services by completion of a Health Action Plan. If the beneficiary does not choose to engage in developing a Health Action Plan, he/she will not be considered enrolled.

Additional outreach will be performed by qualified Health Home Networks. The Health Home Lead Entity will assign enrolled beneficiaries to one of their subcontracted Care Coordination Organizations to perform outreach and engagement activities. A beneficiary will elect whether or not to receive health home services and remain enrolled

in a health home. Beneficiaries may change Care Coordination Organizations within the network or discontinue health home services at any time.

The state works actively with information and assistance partners including Senior Information and Assistance, Aging and Disability Resource Centers, the Statewide Health Insurance Benefits Advisor (SHIBA), and advocacy organizations to ensure they are aware of options for the beneficiaries with whom they work. The state will also be informing Medicaid providers about health home services and eligibility so they are able to refer eligible individuals. Health Home Networks are also expected to develop relationships with hospitals and emergency departments who will also make referrals.

- *How does Washington envision the qualified Health Home Network will integrate primary and behavioral health services for all health home enrollees including those with and without mental health conditions?*

  Response: The state does envision the health home provider will integrate primary, behavioral health and long term services and supports for health home enrollees based upon individualized needs. The integration will occur through:

  - Assisting beneficiaries to access needed services and to self-advocate Provide coaching and education to increase beneficiaries' skills and confidence in managing their chronic conditions
  - Use of health risk screening tools that identify physical health, mental health, functional supports and chemical dependency needs
  - Signed subcontracts/memoranda of agreement across organizations/agencies to ensure referrals, communication and ongoing coordination
  - Standardized training and technical assistance to Health Home Network providers to ensure understanding of expectations
  - Use of PRISM, a web-based clinical decision support tool that integrates information across all service domains (including primary and behavioral health) for both Medicare and Medicaid paid services

- Communication of Health Action Plan goals to service providers as permission from the beneficiary allows

As entities that authorize mental health services and manage the contracted mental health provider network, RSNs will be an essential partner within qualified Health Home Networks to ensure the coordination of service delivery and to assist the beneficiary in achieving his/her identified Health Action Plan goals. Qualified Health Home Networks and RSNs will be expected to implement procedures to share pertinent information regarding the care of beneficiaries to facilitate care coordination and achievement of Health Action Plan goals, reduce duplication and ensure protection of beneficiary confidentiality and rights. It is anticipated that RSNs may also provide Health Home Lead Entity functions and/or health home coordination functions in some qualified Health Home Networks

- *Please describe how under Strategy 1 Washington will meet the demonstration requirement of ensuring a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable.*

  Response: The State will meet the requirement to provide Demonstration participants with assistance in exercising grievance and appeals rights as applicable under Medicare and/or Medicaid. Individuals in this Demonstration will continue to receive services including primary, acute, pharmacy, mental health, chemical dependency, long-term services and supports and developmental disability services through existing Medicare and Medicaid service delivery systems. If a beneficiary requires help to identify where to turn for assistance with a grievance or appeal, the health home coordination will be a first point of contact for information sharing and providing assistance.

  The State and CMS will leverage existing State and Federal resources to further assist individuals with grievances and appeals. These resources include mental health ombudsman, care managers in long term services and supports and developmental

disabilities, the Statewide Health Insurance Benefits Advisor (SHIBA), the Office of the Insurance Commissioner, and 1-800-MEDICARE. These resources will provide responses to beneficiary questions on the Medicare and Medicaid grievances and appeals processes.

- *Does Washington intend to include beneficiaries with end-stage renal disease (ESRD) in this demonstration? Does Washington intend to include beneficiaries receiving hospice services in this demonstration?*

  Response: Washington intends to include the ESRD population in the Managed Fee-for-Service Demonstration. Washington intends to exclude beneficiaries receiving hospice services from the Managed Fee-for-Service Demonstration.

- *Will the health home perform any prior authorization or other similar functions for the delivery of Medicaid services?*

  Response: No

- *Are Alaska Natives/American Indians eligible to receive health home services?*

  Response: Yes, eligible beneficiaries who are Alaska Natives/American Indians may always elect to enroll in health homes. Washington does not auto-enroll this population into any service and agreed in the stakeholder feedback process to not auto-enroll this population in health homes or Financial Alignment Demonstration models.