



Low Income Health Program Overview

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Today's topics

- Medicaid budget
- Who we serve
- Services provided
- Managed care
- Approaches to care
- Physical & behavioral health integration
- Medicaid transformation demonstration

VISION

A healthier Washington.

MISSION

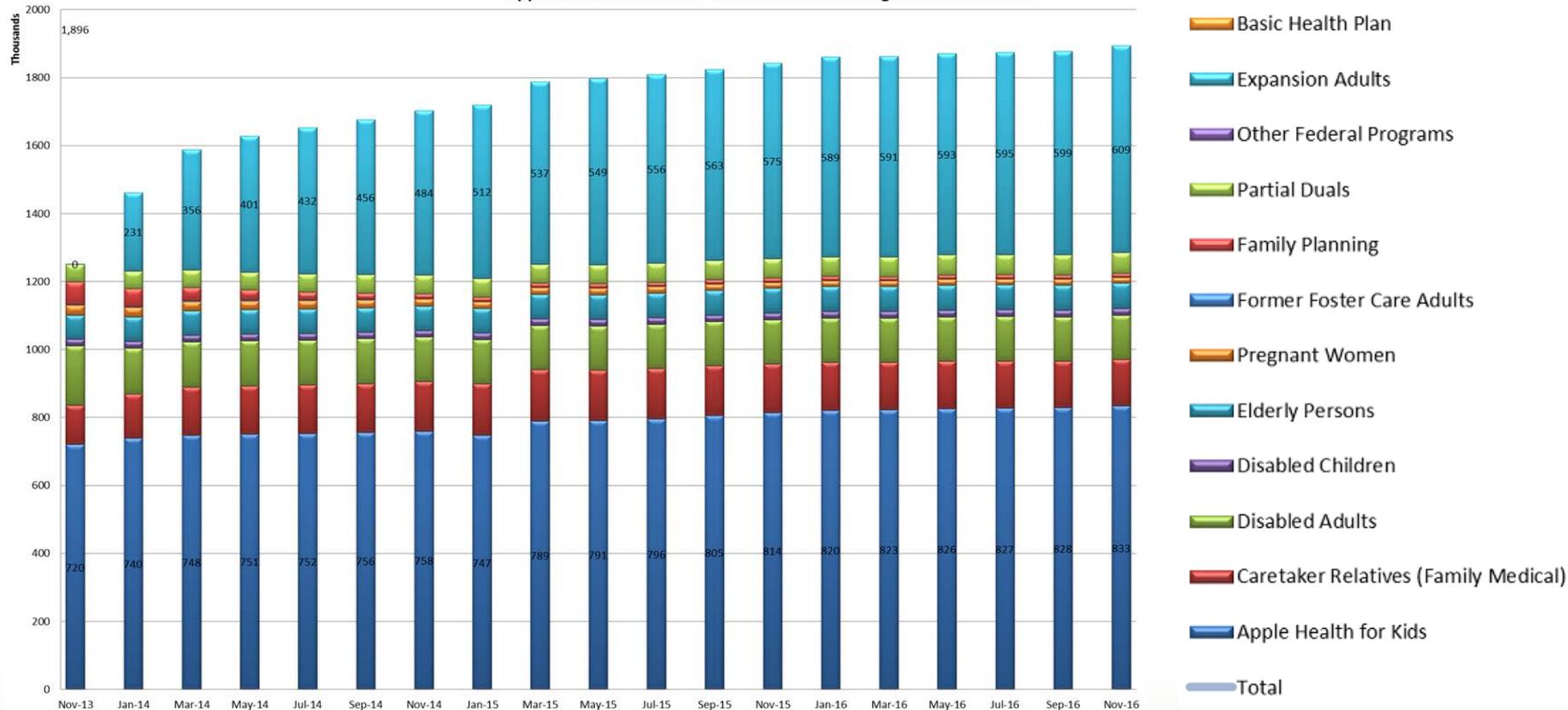
Provide high quality
health care
through innovative
health policies and
purchasing strategies.

VALUES

People First
Innovation
Respect
Public Service
Collaboration
Service Excellence
Leadership
Stewardship

Washington's uninsured rate has dropped from 14% to 5.8%

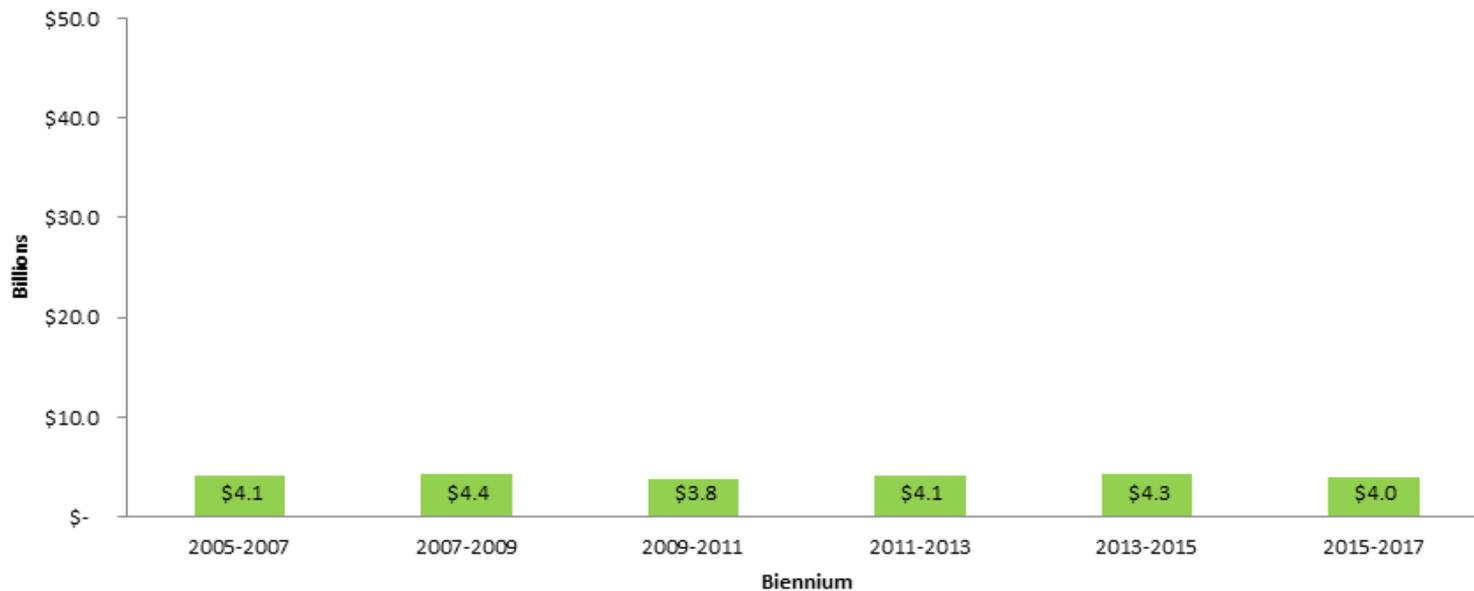
Apple Health Enrollment November 2013 through November 2016



Source: American Community Survey, U.S. Census, September 2016

Medicaid budget and enrollment (05-17)

HCA's GF-S Budget



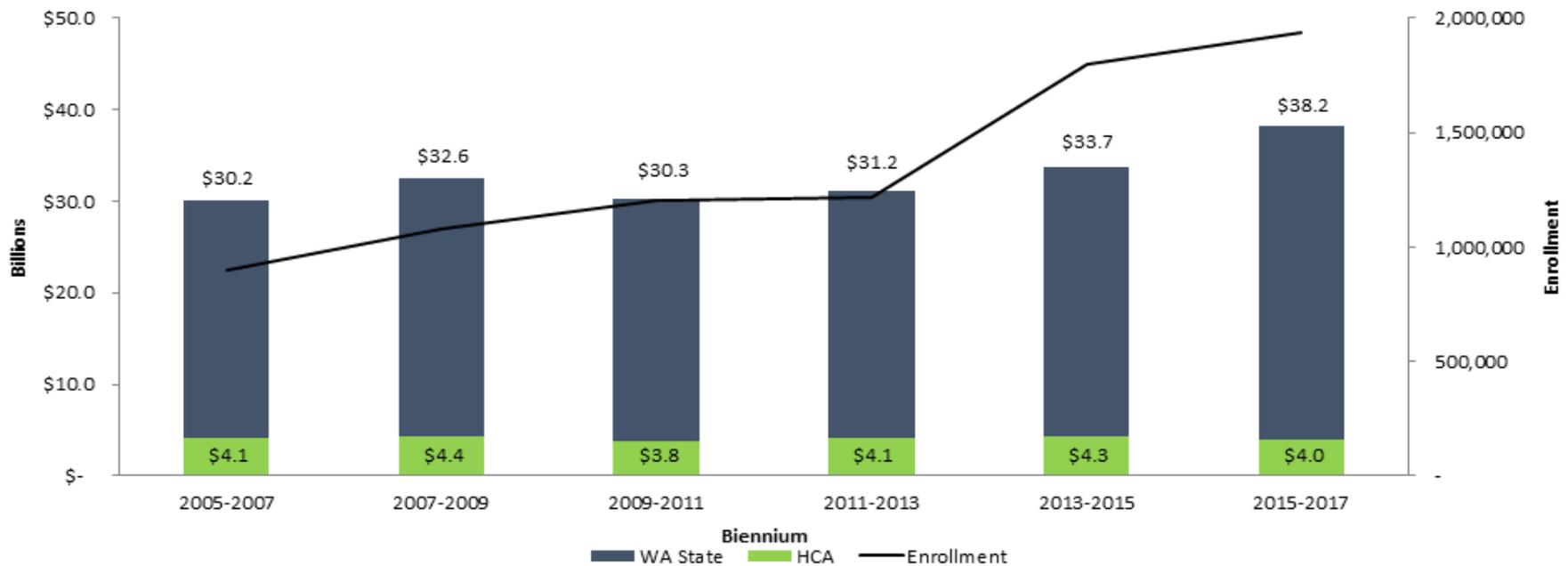
Medicaid budget and enrollment (05-17)

HCA's GF-S Budget vs. Statewide GF-S Budget



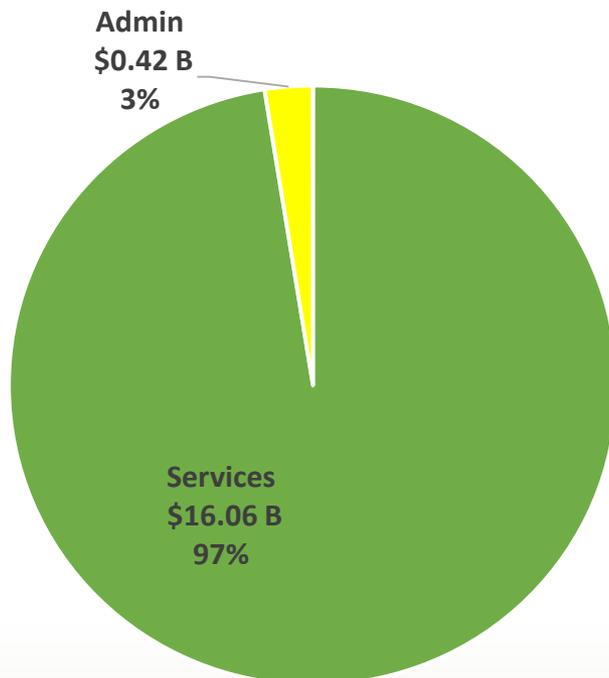
Medicaid budget and enrollment (05-17)

HCA's GF-S Budget vs. Statewide GF-S Budget



Medicaid budget

- The majority of HCA's Medicaid budget is for client services funded through federal Medicaid and Children's Health Insurance Program grants.



2015-17 Biennium

Services	\$ 16.06 billion	97%
Administration	\$ 0.42 billion	3%
Total Medicaid Budget*	\$ 16.48 billion	100%

Sources: Agency Financial Reporting System (AFRS) Allotments
October 2016 Forecast

* Excludes Health Benefit Exchange \$0.11 billion budget

Medicaid

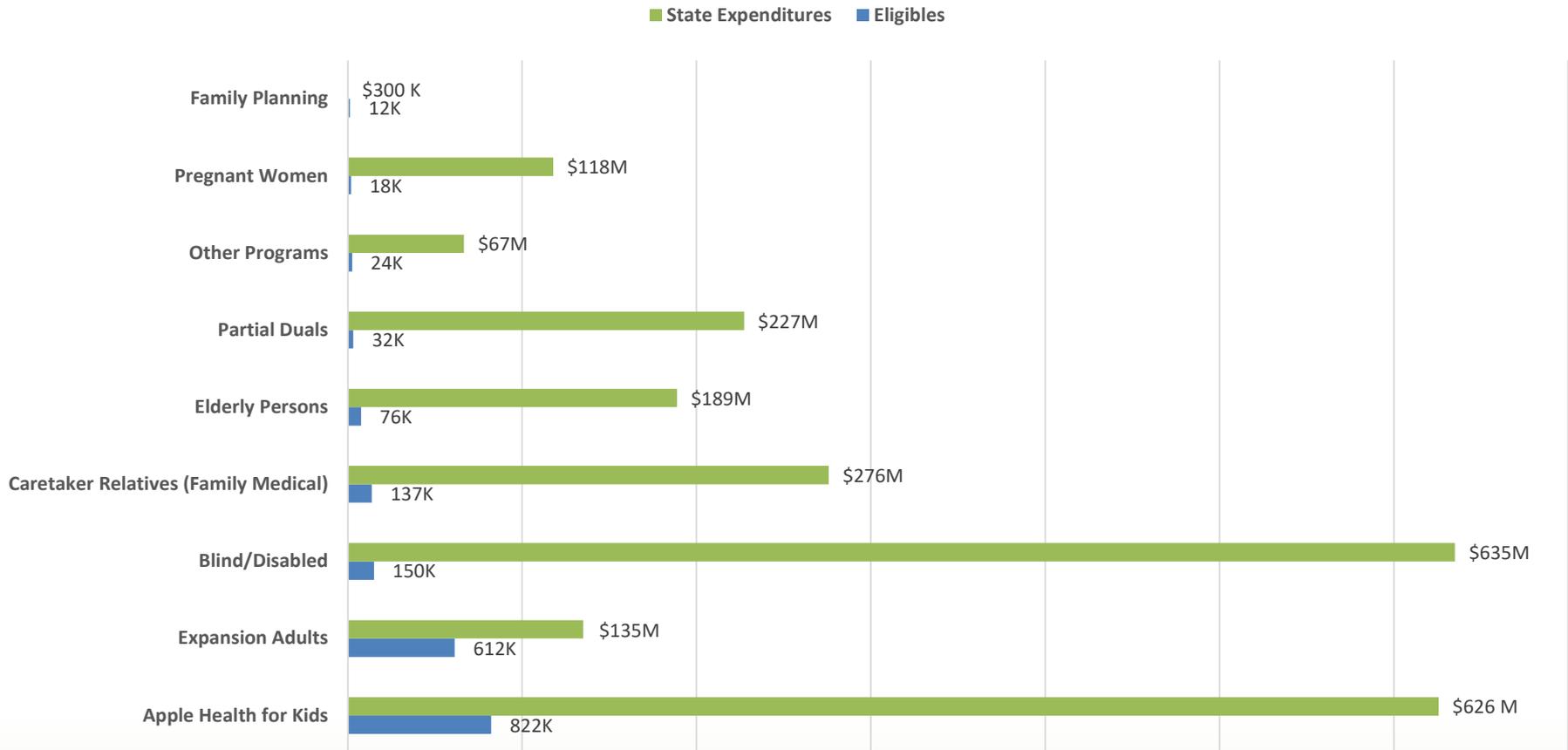


- Purchases health care for 1.9 million people
 - 8 in 10 Apple Health clients are enrolled in Managed Care
- Most – 1.55 million – receive care through five Managed Care Organizations (MCOs)
- \$8 billion annual spend
- Populations served include children, pregnant women, disabled adults, elderly persons, former foster care adults, and adults covered through Medicaid expansion

Medicaid clients served

An average of 1.9 million clients are served per month in FY 2017.

SFY 2017 State Expenditures Only



Source: October 2016 Forecast

Notes: Presumptive SSI clients are included in Expansion Adults

Other Programs include State-only Children Health Program, Alien Emergency Medical, Medicaid Buy-In

Managed Care

Managed care contracting principles

Goals

- Provide comprehensive services through collaborative care coordination and integration
- Maintain a network capable of ensuring access
- Control the cost of care

Managed care rates: budget proviso

2nd Engrossed Substitute House Bill 2367, Section (1)(b)

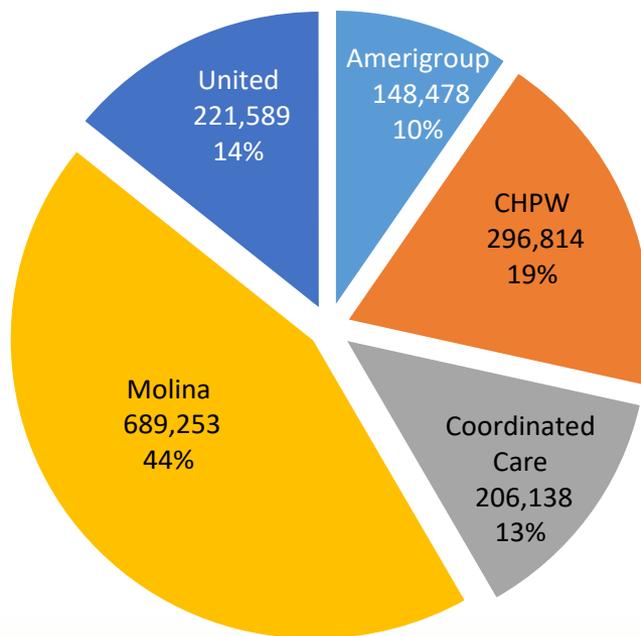
- “\$121,599,000 of the general fund-state appropriation for FY 2017 is provided solely for holding Medicaid managed care capitation rates flat at CY 2016 levels in state FY and CY 2017”

Update

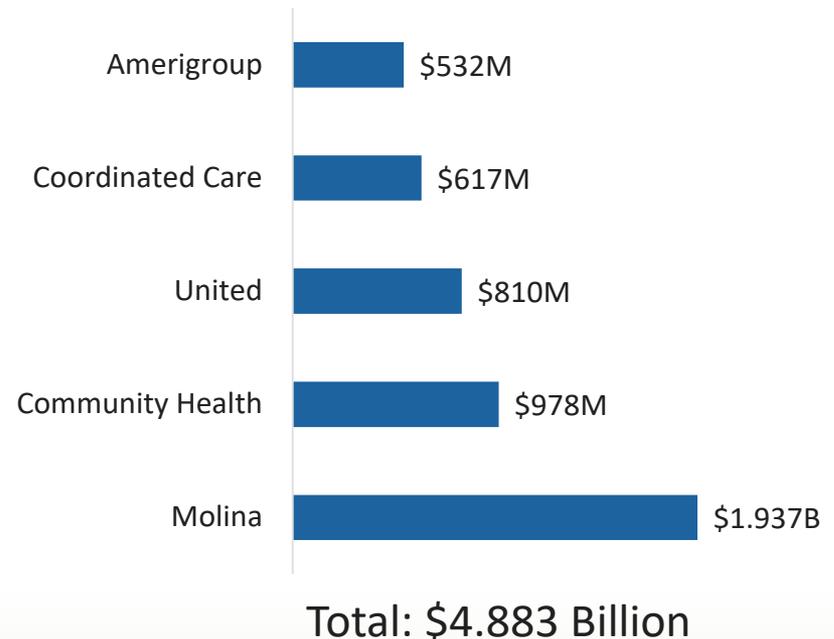
- Engaged with OFM, Medicaid forecast work group, managed care plans to come up with strategies
- Obtained independent actuarial analysis, support, and recommendations
- Office of the State Actuary obtained an actuarial review
- Progress update to Joint Select Committee on Health Care (July 2016)
- Legislative report submitted Oct. 1, 2016

Managed care distribution by MCO

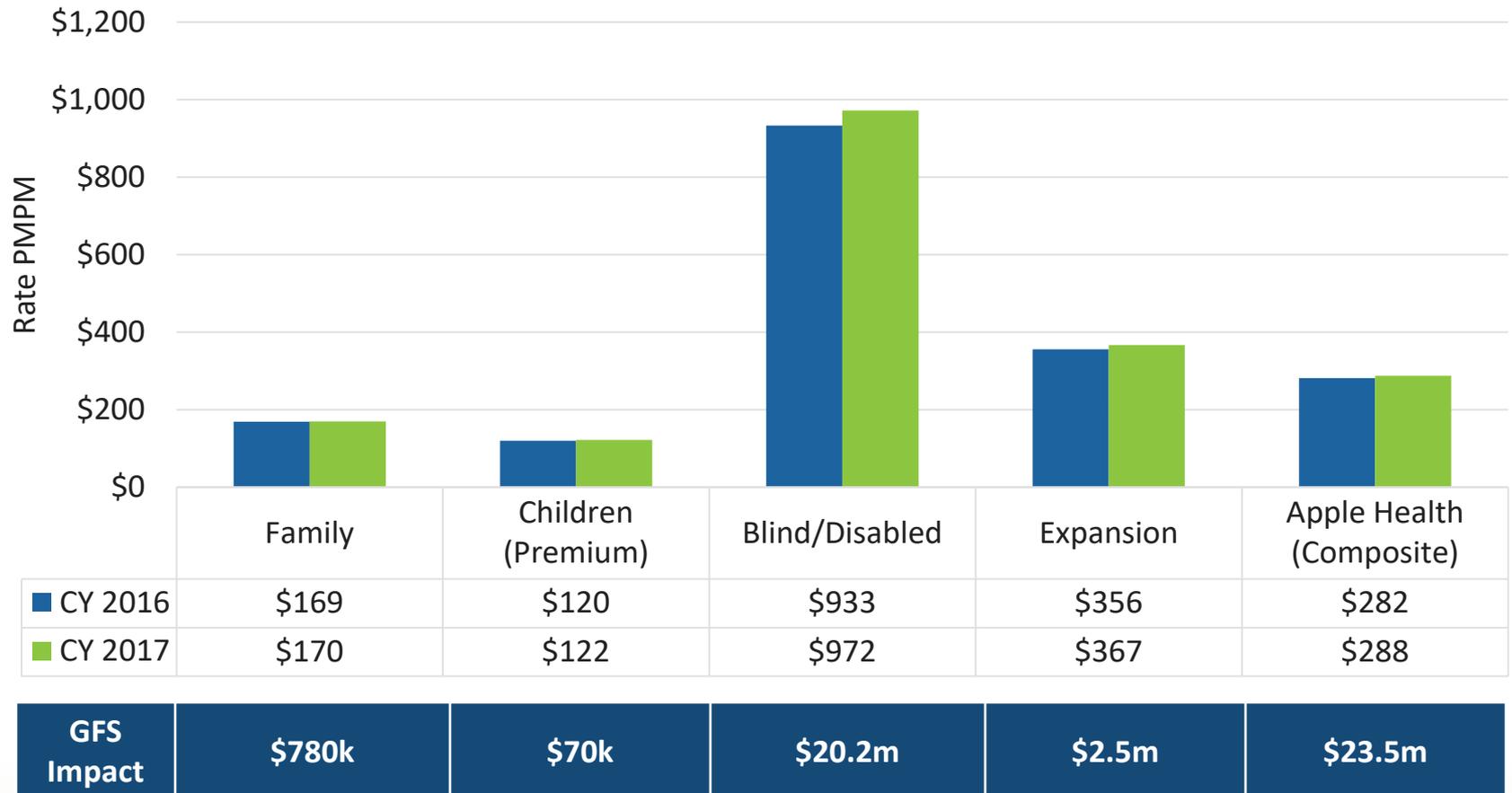
Managed care enrollment by MCO



Estimated paid premiums CY 16

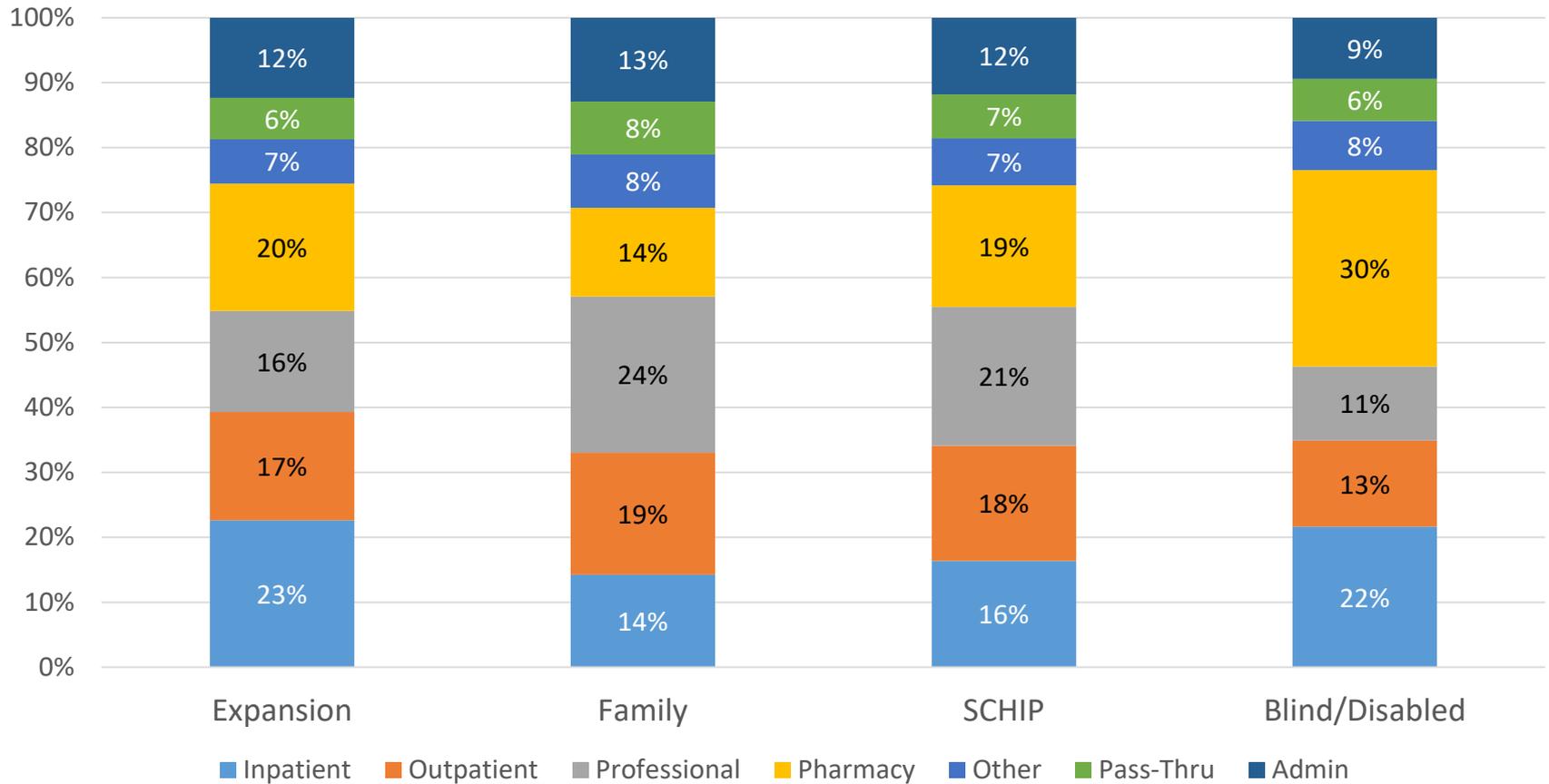


Impact of CY 2017 rates



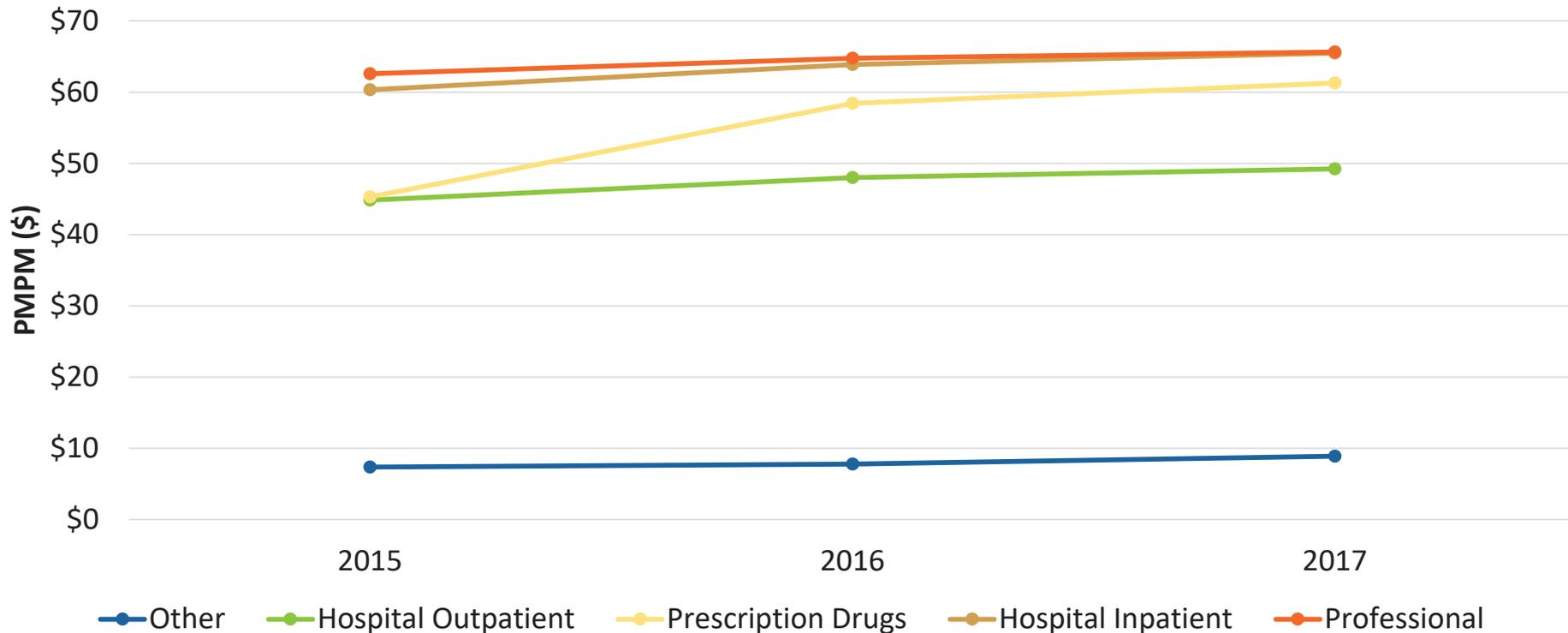
Source: CY 2017 Final Milliman Rate Appendix A-2 – October 28, 2016

Managed care rate components



Managed Care PMPM Changes by Service Experience

CY 2015 – CY 2017



Notes:
 PMPM changes depict service experience, holding membership constant.
 Pass-thru and admin not included
 Premiums include DCR/LBW
 "Other" contains Private Duty Nursing, Home Health, DME/Supplies, Ambulance, Prosthetics, etc
 2015 PMPM adjusted for Expansion recoupment

Approaches to Care

Value-based purchasing

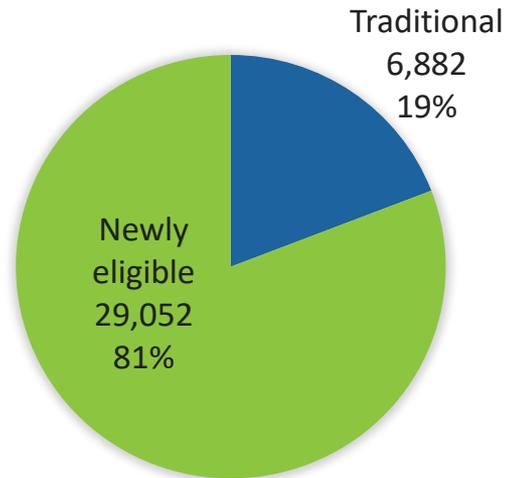
Quality improvement – 1% withhold

- Approximately \$53 million*

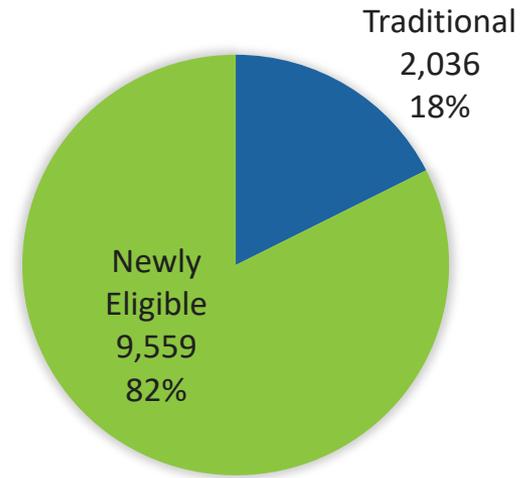
Quality measures

- Comprehensive diabetes care (2 measures: HbA1c control & high blood pressure control)
- Controlling high blood pressure
- Antidepressant medication management (2 measures: acute phase treatment & continuation phase treatment)
- Childhood immunizations
- Well-child visits
- Medication management for people with asthma (2 measures: ages 5-11 & ages 12-18)

Medicaid expansion impact on treatment for opioid use disorder



Diagnosis of Opioid Use Disorder by Coverage



Utilization of MAT by Coverage

Health Home program

Demonstration Year One results from CMS' independent evaluation of dual eligible enrollees

- Positive feedback on role of care coordinators
- Decline in inpatient admissions from 186 to 160 per 1,000 user-months
- Medicare savings of 3%, resulting in estimated \$10 million shared savings payment to state
- Net of program costs, should return GF-S of \$1-5 million per year

The case for integration

For patients with depression

- 10+ studies of collaborative care models for depression have been shown to improve clinical outcomes, employment rates, functioning, and quality of life; and they are cost-effective compared with other medical interventions

For patients with serious mental illness

- Integrated, on-site delivery of primary care was feasible, promoted greater access to primary care and preventive care, and resulted in a significantly larger improvement in health status than usual care

For patients with substance abuse-related comorbidities

- Trials reported improvements in medical care, quality of care, and patient outcomes. Two programs found to be cost-neutral... no significant decline in annual costs for a subsample of patients with comorbidities

Integrated managed care: legislation

2SSB 6312

- Changed how the state purchases mental health and substance use disorder services in the Medicaid program
- Directed the state to fully integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care by 2020
- Directed the state to integrate mental health and substance use disorder services through Behavioral Health Organizations (BHOS) as an interim step to 2020
- Created a pathway for regions to fully integrate early, starting in April 2016

Integrated managed care: Clark & Skamania counties

Goals

- Ensure continuity of care access to care for all clients
- Ensure behavioral health providers received timely and accurate payments
- Reduce administrative burdens and align as much as possible the processes and procedures for behavioral health providers

Observations

- Continuity and access to care was achieved for clients
- Most providers able to process managed care transactions for timely payment
- Improved coordination for clients with physical and behavioral health conditions
- WSH discharges occurring at a slightly faster rate – 3.25 more discharges per quarter
- Region has remained on average 3 beds under census for 9 months
- Early warning system created new process at the county jails to track individuals who self-report behavioral health conditions upon booking

Integrated managed care: what's next

June 2017

- Southwest Washington (Clark & Skamania counties) “early adopter” region first-year results using standard RDA measures

January 2018

- North Central Region (Chelan, Douglas, Grant counties): mid-adopter”

2018-2020

- Other regions engaged in discussion with HCA about implementation of integrated managed care: Pierce, Thurston, Mason, King counties

Savings from fully integrated managed care 2015-2017 biennium

Original Estimated Savings by Region

- Pierce County: \$12.8 million GF-S
- King County: \$24.2 million GF-S
- Southwest Washington: \$7 million GF-S

Updated Savings Projection based on final established CY 2016 Managed Care Integration Factors

- Southwest Washington: \$2 million GF-S

Medicaid Transformation Demonstration

Legislative directives for transformation

E2SHB 2572 (2014)

- Transforming the Health Care Delivery System

2SSB 6312 (2014)

- Fully Integrated Medicaid Managed Care

SHB 1879 (2015)

- Integrated Medicaid Managed Care for Foster Children

2ESHB 2376 / Subsections 213 (1)(d-g) (2016)

- Appropriation for Medicaid Transformation Demonstration Waiver Initiatives

Medicaid Transformation Demonstration

- Five-year demonstration of innovative strategies to improve health outcomes and use resources wisely
- Authorizes up to \$1.5 billion in federal investments with no further/ongoing GF-S commitments
- Three initiatives:

Transformation through
Accountable
Communities of Health
Up to \$1.1B

Long-term Services
and Supports
\$175M

Foundational
Community Support
Services
\$200M

Initiative 1: Transformation through ACHs

ACHs will coordinate and oversee regional projects

- Each ACH will apply for transformation projects, and incentive payments, on behalf of partnering providers within the region.
- Projects will be assessed based on achievement of defined milestones and metrics.
- ACHs will decide on distribution of incentive funds to providers for achievement of defined milestones.
- Each region will choose at least 4 transformation projects from the toolkit; 2 of which are required.
 - *Bi-directional integration of care*
 - *Addressing the opioid use public health crisis*

Medicaid transformation goals

Over the five-year demonstration, Washington will:

- Integrate physical and behavioral health purchasing and service delivery
- Convert 90% of Medicaid provider payments to reward outcomes
- Implement population health strategies that improve health equity
- Provide targeted services that address the needs of our aging populations and address the key determinants of health

Budget neutrality

Federal expenditures

- Must be at or below what they would be without the waiver

“Without Waiver” vs “With Waiver”

- State must measure projected “without waiver” (WOW) expenditures against “with waiver” (WW) expenditures
- Difference between WOW and WW expenditures creates the budget neutrality “room” within which federal funds are made available

Measurement

- Budget neutrality is measured annually but enforced over the five-year lifetime of the demonstration

Federal funding sources

Designated state health programs (DSHP)

- State or locally funded health care programs which serve low-income and uninsured people and are not otherwise eligible for federal matching funds
- CMS must approve designation and use of programs as DSHP
- Programs leveraged as a DSHP will continue to operate just as they would if they were not a designated DSHP

Intergovernmental transfers (IGT)

- Transfers of public funds between governmental entities (e.g., from a county or public hospital to the state)
- Source of funding must be reviewed to ensure it meets federal requirements for permissible transfers
- Public/governmental entities that are eligible, willing and financially able to contribute funds through an IGT will partner with regional Accountable Communities of Health to develop transformation project plans

Allocating funds for projects

Considerations in building the allocation model:

- Number of Medicaid beneficiaries served
- Relative impact of the proposed project (e.g., capacity building activity vs. opioid use intervention)
- Number, type and scale of projects undertaken in a given region

Model submission

- Model will be submitted by March 10 as a protocol to be approved by CMS

Budgeting & payments

- Model will guide budgeting by ACH region
- Actual payments to providers will be made upon achievement of defined milestones

Managing risk

Demonstration does not create entitlements for future state obligations

- Would require legislative authority through budget appropriation or statute
- Current appropriation authority for all three demonstration initiatives

State controls the pace and scope of financing

- Federal funds are claimed through DSHP and IGT
- Funds are issued upon completion of agreed milestones

Financial executor

State-contracted vendor

- Provides centralized management and accounting for transformation project incentive funds
- Avoids variation in payment arrangements across Accountable Communities of Health
- Provides central accountability to state for managing transactions
- Responsible for distributing incentive dollars to providers participating in transformation projects once milestones are achieved

Independent assessor

State-contracted vendor

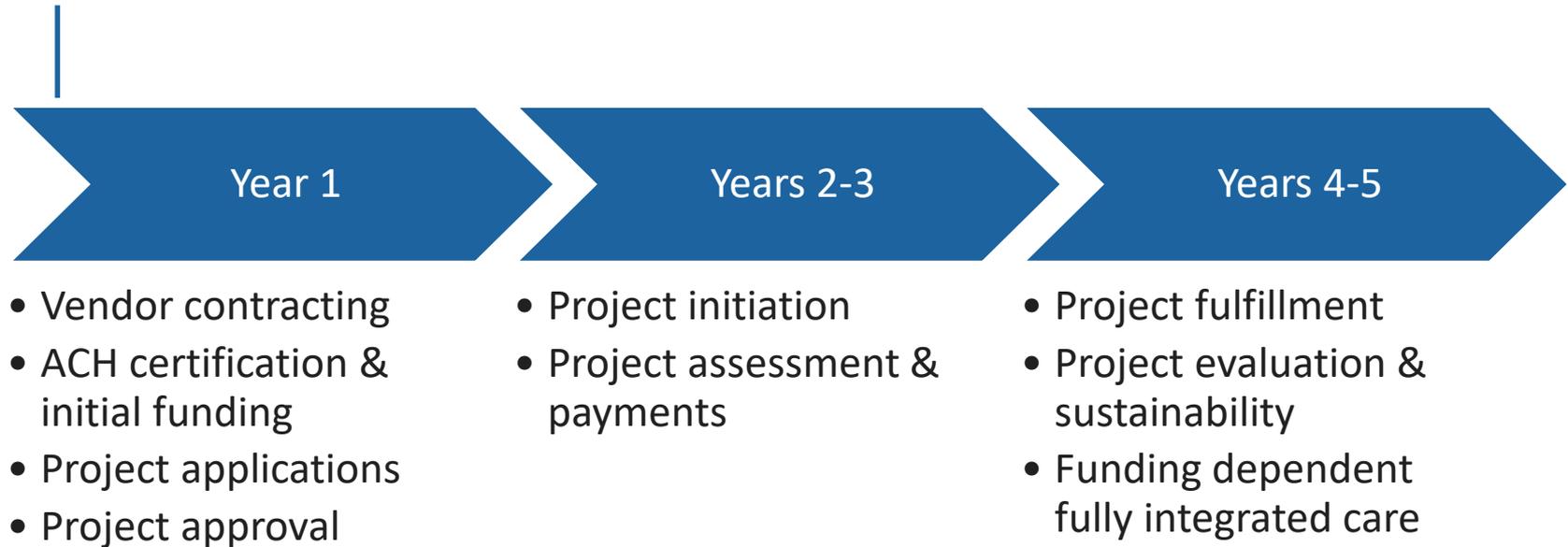
- Will serve as independent assessor for delivery system reform activities under the demonstration
- Cannot have an affiliation with Accountable Communities of Health or their partnering providers

Independent assessor responsibilities

- Reviewing Accountable Communities of Health Project Plan applications
- Providing recommendations to state regarding approval, denial, or recommended changes to ACH Project Plans
- Assessing project performance throughout the demonstration

Timeline

Protocol development
(60-120 days)



Value-based payment milestones →

Process measures → Outcome measures

Demonstration public forums

Purpose: Inform and invite dialogue with the public in each of the nine ACH regions

Proposed Schedule

- February 8, Tacoma
- February 22, Seattle
- February 25, Vancouver
- March 1, Mt. Vernon
- March 11, Tri Cities
- March 12, Spokane
- March 15, Wenatchee

Questions?

More Information:

<http://hca.wa.gov>

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