Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WA2024MS0008O | WA-24-0023 | Washington State Health Home Program

Package Header

Package ID WA2024MS0008O
SPA ID WA-24-0023
Submission Type Official
Initial Submission Date 10/7/2024
Approval Date 10/09/2024
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID WA-24-0023

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2024	23-0027

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Executive Summary

Summary Description Including Goals and Objectives

Washington's original Health Homes SPAs were WA 13-0008 (approved June 28, 2013) and WA 13-17 (approved December 11, 2013). SPA WA 15-0011 (approved June 11, 2015) superseded both of these SPAs. SPA 16-0026 (approved March 31, 2017) superseded 15-0011, added a 20% Performance Incentive payment to increase Beneficiary engagement rates and expanded the Health Home program statewide adding King and Snohomish counties. SPA 18-0028 superseded 16- 0026, adds a 20% rate increase, and reduces the Performance Incentive payment to 5 %. SPA 23-0027 supersedes SPA 18-0028 to update language regarding appropriate provider types to reflect Care Coordination Organizations, to modify language to better align with current program policy, and to update rates. SPA 24-0023 supersedes SPA 23-0027 to update the final rule making Health Home Core Set(s) mandatory beginning in 2024.

Under Washington's approach, Health Homes are the bridge to integrate care within existing delivery systems for both managed care and Fee-for-Service beneficiaries. Washington's Medicaid delivery system integrates physical and behavioral health services statewide through its managed care program. Washington's Health Home program now serves managed care beneficiaries and beneficiaries who remain in the Fee-for-Service delivery system, such as full-dual eligibles and American Indian/Alaska Natives.

Washington has three high level goals to assess the effectiveness of its Health Home program: 1) Building care coordination capacity in all areas of the state; 2) Improve the beneficiary's self-management abilities; and 3) Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The Health Home program is designed as the central point for directing person-centered care through one-on-one interactions between the Health Home Care Coordinators and their assigned beneficiaries.

Beneficiaries are identified as having one or more of the chronic conditions on the chronic condition list and at risk for a second chronic condition using a tool that identifies those clients expected to have high future costs due to all their chronic conditions.

The Department of Social and Health Services (DSHS) generates and submits a list of eligible Health Homes beneficiaries to HCA. HCA then enrolls them into a Managed Fee-for Service Health Home Lead Entity (designated provider) or notifies the Managed Care Organization (designated provider) that one of their enrollees is eligible for Health Home services with a Health Home indicator on the 834 file. Lead Entities are permitted to serve as a CCO and must also subcontract with a wide-range of community-based Care Coordination Organizations (CCOs) to effectively manage the full breadth of beneficiary needs, increasing Washington's capacity to provide statewide Health Home services, especially in rural areas of the state.

There are six defined Health Home services, with each individual service further defined by embedded activities to make up the composition of the service.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2025	$0
Second	2026	$0

Federal Statute / Regulation Citation

Affordable Care Act, Section 2703, Section 1945
42 CFR §§ 437.10 and 437.15

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Medicaid State Plan

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CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
  - [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

Washington State Health Home Program

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[ ]	Health Homes Intro	( )	APPROVED
[ ]	Health Homes Geographic Limitations	( )	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	( )	APPROVED
[ ]	Health Homes Providers	( )	APPROVED
[ ]	Health Homes Service Delivery Systems	( )	APPROVED
[ ]	Health Homes Payment Methodologies	( )	APPROVED
[ ]	Health Homes Services	( )	APPROVED
[ ]	Health Homes Monitoring, Quality Measurement and Evaluation	( )	APPROVED

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- [ ] 1945A Health Home Program

Health Homes Monitoring, Quality Measurement and Evaluation

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	User-Entered		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The state will calculate regional, risk-adjusted, per member per month expenses in the target population in the baseline (FY2011), apply trend factors and estimate a projected per member per month figure. Cost savings will be calculated as the difference between actual and projected risk adjusted per member/per month expenditures. Cost savings for dual eligibles will be determined by CMS.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The state integrates Fee-for-Service claims data, managed care encounter data, beneficiary eligibility, enrollment and claims data for medical, pharmacy, mental health, substance use disorder, long-term services and supports, and Medicaid and dual eligible Medicare covered services in a secure web-based clinical decision support tool called PRISM. PRISM also pulls from other clinical assessment data within the state such as CARE. The state uses PRISM to support the beneficiary and the Health Home Care Coordinator to identify the unmet needs, gaps in care, clinical protocols required and current utilization of case management, medical and behavioral health services. Use of these tools enables the Health Home Care Coordinator to better coordinate care and ensure that the beneficiary's complex needs are met, and will assist the state in monitoring cost and utilization data to ensure program goals are met.

The state has developed Health Information Technology (HIT) through OneHealthPort (OHP), who HCA contracts with to consult on maintaining a statewide Health Information Exchange (HIE). HCA is developing the Medicaid Health Profile clinical data repository, with clinical data passed through OneHealthPort HIE using the Continuity of Care Document (CCD) and the Admit/ Discharge/Transfer Document (ADT) transaction sets. Updates to the Medicaid clinical data repository to refine or to correct identified data collection errors occur whenever a need is identified.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- [ ] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [ ] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [ ] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [ ] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.