Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

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Project Title	Maximizing Engagement in Community Based Care Coordination

Rationale for the Project

Defined by a PRISM score of 1.5 or above there are approximately 60,000 "high utilizers" in Washington's Medicaid population. About 60% are solely eligible for Medicaid, 40% are dually eligible for Medicaid and Medicare. On average, the combined medical and long-term care care spend for "Medicaid Only" clients is about $2,900 each month ($2,200 of which is for medical costs). For "Duals" the combined medical and long-term care total spend each month is around $4,100 ($2,400 of which is for medical, mostly covered by Medicare).

Beyond the sheer cost of their care, high utilizers have one thing in common that makes them an essential target for any transformation effort. Simply by the volume of their interactions with the health system they are more likely than any other group to be confused by professionals, over-medicated, suffer ill effects from uncoordinated care, and/or receive unnecessary treatments, hospitalizations, and emergency room visits.

Community Based Care Coordination addresses those problems. Each beneficiary is assigned a care coordinator who provides health coaching, community and health care service referral assistance, and links the efforts of the medical, mental health, substance abuse, long-term services and supports, and community social service delivery systems together to meet the beneficiary's healthcare needs. It is a promising practice for a number of populations, but for high utilizers it is especially impactful as a way to "move the needle," system-wide, on both cost and quality ---- provided sufficient numbers of people are engaged.

DSHS and Health Care Authority have built Washington's largest scale and most comprehensive care coordination effort to date, the Medicaid Health Home benefit, on the conservative estimate (based on pilot program experience) that every dollar invested in Health Home Care Coordination returns a dollar and a half in savings. Initial qualitative measures for Dual recipients have shown a reduction in Medicare-paid:

- Inpatient acute hospital admissions
- Avoidable emergency room visits
- Inpatient psychiatric admissions
- All cause hospital readmissions
- Nursing home admissions.

The effects for the Medicaid-only population are expected to be similar.

As was the case earlier this decade when DSHS and HCA collaborated with stakeholders to develop the HealthPath Washington proposal to CMS to improve care for Duals, HCA's current call for transformation proposals is likely to yield multiple care coordination or care coordination-like proposals. In particular, care coordination targeted to individuals with specific diagnoses or conditions, or who are served by a particular organization. That invites the question asked by a legislator at a recent committee hearing: "Who coordinates the coordinators?"

If multiple care coordination efforts are well-integrated at the regional level and collaboratively focused on the goals of improving the quality and efficiency of care coordination, along with maximizing engagement, then Washington is much more likely to see population-wide and system-wide benefits. This transformation proposal is to create a regional structure in which such coordination can occur and related infrastructure investments can be leveraged by multiple care coordination entities.

If such a structure is not created, the unintended result of many well meaning efforts would be a care coordination "system" that evolves in a manner that is as fragmented, siloed, confusing, and inefficient as the current health system.

Project Description

This project is focused on the five counties in the North Sound ACH region, but could easily be replicated in other regions. The table below identifies the number of high risk/high utilizing Medicaid clients in the North Sound area:

Count of Clients with PRISM Risk Score ≥ 1.5, by Dual Status

County	Medicaid Only	Some Dual Medicare Eligibility	Total
Island	420	314	734
San Juan	74	41	115
Skagit	971	716	1,687
Snohomish	4,994	3,405	8,399
Whatcom	1,614	1,270	2,884
Total	**8,073**	**5,746**	**13,819**

The goal of the project is to ultimately engage at least a third of the high risk/high cost population in high quality, effective Care Coordination, prioritizing maximum use of the Medicaid Health Home benefit while at the same time setting the stage for expanding care coordination to populations who are not eligible for the Health Home benefit. *Note: the Health Home benefit is currently not available in Snohomish county, so it will be essential that HCA and DSHS take steps to expand to that area.*

With pilot funding from the SIM grant, the North Sound ACH engaged a twenty-two member cross-sector group with interest in care coordination that was charged to:

> *"Create a plan that will facilitate enhanced collaboration and efficiency between care coordination programs, and maximum engagement of underserved populations, with the goal of maximizing our outputs, leveraging technology, and expanding best practices across the North Sound region, while also avoiding duplication of services to individuals or groups. It is essential that this plan can be supported by the five managed Medicaid plans in our region."*

This proposal is to operationalize selected elements from that group's recommendations that would integrate, add efficiency, and develop a care coordination "system" by creating a Regional Care Coordinator Network steering group (including Health Home Leads) that:

1. Links care coordination providers for distinct populations, possibly sharing the same HIE framework, to:
   a) Identify beneficiary populations/coordinate outreach and engagement of hard to reach populations

b) Determine which organizations serve each beneficiary group
c) Track a beneficiary's most current health plan, eligibilities, and care coordinator identity
d) Establish a Learning Lab to identify common Care Coordinator best practices, share resources, and training

2. Share technology solutions. Potentially including:
   a) A website that provides comprehensive regional resource lists
   b) A digital space for "Virtual Care Teams" to network and collaborate
   c) Further collaborative HIE development
   d) A website that allows that patient to grant health information access

3. Simplify administration
   a) Align care coordination administrative and regulatory requirements
   b) Advocate for a single common care plans that cross multiple entities
   c) Align performance metrics and mandates across sectors to reduce complexity and conflicts

This project would link care coordination efforts throughout the region and is a model that could easily be adopted in other regions. The Network would also facilitate integration of the emerging, allied skills of Community Health Workers and Long-Term Care personal care aides into the Care Coordination system.

Which Medicaid Transformation Goals[i] *are supported by this project/intervention? Check box(es)*

- ☐ Reduce avoidable use of intensive services **XX**
- ☐ Improve population health, focused on prevention
- ☐ Accelerate transition to value-based payment
- ☐ Ensure Medicaid per-capita growth is below national trends **XX**

Which Transformation Project Domain(s) are involved? Check box(es)

- ☐ Health Systems Capacity Building **XX**
- ☐ Care Delivery Redesign **XX**
- ☐ Population Health Improvement – prevention activities

Core Investment Components

- *Proposed activities and cost estimates ("order of magnitude") for the project.*

An investment in core staffing and administrative support would be necessary to facilitate and sustain the Regional Care Coordination Network steering group and operationalize related projects. A ballpark estimate for infrastructure development and maintenance would be 5% of the total expenditures for Care Coordination once engagement goals are reached -- approximately $400,000 annually based solely on Medicaid expenditures for Health Home Care Coordination. One-time IT infrastructure investments, cost as yet unknown, would be necessary during the demonstration period.

The Network infrastructure could be implemented almost immediately. Determining timeframes for IT investments would take more time than this proposal opportunity allows. Long-term sustainability would be from savings when engagement targets are reached.

Note: *Since Care Coordination is an established Medicaid service benefit under Health Homes and Washington is one of only two states with a shared financing agreement with Medicare, the mechanism for ongoing funding of care coordination direct services for both the Medicaid-only and Dual populations is already established. Consequently, this proposal is only for minmal underlying infrastructure to support client engagement and efficient operation by care coordination providers. Expansion of care coordination for populations not eligible for the Medicaid Health Home benefit would occur as other funders emerge.*

The goal is to engage at least 33% of high utilizers in Medicaid Health Home Care Coordination, with a linear ramp-up to that level over the next two years. If the Health Home benefit is extended to Snohomish County that would mean about 4,600 high utilizers would be engaged on a monthly basis in the North Sound region. Metrics for other populations would be added as other funders emerge.

At scale, this project would add a nickel to each dollar spent on the current Medicaid/Medicare Health Home intervention, which would change the ROI calculation for the Health Home benefit from $1.50 for every $1 spent to $1.50 returned for every $1.05 spent.

Project Metrics

The key overall metric is progress toward the target engagement level outlined above. The initial process metric would be to stand up the Regional Care Coordination Network group. Additional process measures would be based on a more detailed implementation plan that group would need to develop as a first order of business.