CONCEPT PAPER – GLOBAL MEDICAID TRANSFORMATION WAIVER

PREFACE

The year is 2020. John is an Apple Health enrollee, now 27 years old and living in the north Puget Sound area of Washington State. As a teenager, his parents worried about his mood swings, but attributed it to adolescence. To fit in, John started smoking in high school. At 22, he seemed to have found his passion and was doing well in his first year of community college, pursuing an IT certification. During a visit to an urgent care clinic following multiple infections, John was diagnosed with Type 2 diabetes. He didn't have a consistent primary care provider and wasn't sure how to manage his illness, so maintaining his blood sugars became an ongoing challenge.

During his second quarter of community college, John began to experience extreme mood and behavior changes. This change seemingly came out of nowhere, stunning his family and friends. After a particularly frightening blow-up, he was hospitalized and diagnosed with bipolar disorder.

During his discharge from the hospital, John and his family were surprised to learn he qualified for Apple Health, and successfully signed him up with hopes that his health care needs would be met. After his release, John was diligent at first about following his discharge plan—taking his medications, meeting with his therapist as well as a primary care physician (PCP). Though he continued to see his PCP to manage his diabetes, he did not understand the importance of talking about his ongoing mental health treatments or prescribed medications. As a result, John's PCP remained in the dark about this co-occurring disorder.

For a little while, John was doing much better. However, he soon discovered that when he took his medications as prescribed, the side effects would often make him feel even worse—so sometimes he wouldn't take any of them. Before long, John's life—and his family's life—became a roller coaster. Multiple case managers were attempting to help John navigate a delivery system designed primarily for episodic interventions for acute and chronic illness, and crisis, but that was leading to some serious unintended consequences. Everyone wanted to help, but John wasn't getting any better.

John experienced intermittent periods of stability, but a cloud of anxiety and depression never fully dissipated. Meanwhile, John was not consistent with his medication and appointments. John's family felt he was getting lost in a web of well-meaning providers and interventions that were targeted to the presenting symptoms and not his whole person needs. Unbeknownst to John, the lack of communication between his providers often resulted in duplicate lab tests and, at times, the prescribing of more medications than he needed. John dropped out of school and remained unemployed. He continued to struggle with his weight and would drink heavily to self-medicate on his bad days. During manic episodes, John became agitated and reclusive, eventually alienating himself from his friends and avoiding his family.

John's parents arranged to pay his rent directly to his landlord so he could remain housed, but because John had become so withdrawn and unwilling to accept their help, they were unable to do more. John was frustrated with having so many different providers and felt overwhelmed by the frequency of appointments. He did not

feel that he had any control over his own care or future. There were plenty of people telling John what was best for him, but no one to really listen or, more importantly, to ask John what he really wanted.

Halfway through the year, John has been to the emergency room five times for physical and mental health concerns. Each time the hospital has been paid for stabilization services while he awaits the next in an array of costly health interventions.

Washington's systems have failed John. We are left with a burning question: Could we have done better?

In this document, Washington proposes a concept to change the system for John and others served within the Medicaid system.

INTRODUCTION

Washington State will seek approval from the Centers for Medicare and Medicaid Services (CMS) for Section 1115 waiver authority to implement a Demonstration Project that engages and supports Medicaid clients, providers, and communities in achieving improved health, better care, and lower costs (the triple aim).

An approved Medicaid waiver will (1) provide flexibility and expenditure authority to fund nontraditional services for targeted populations, and (2) use past and anticipated future federal savings for strategic investments that:

- Bend the Medicaid cost curve by two percentage points[1] below national trends.
- Reduce institutionalization in acute care hospitals, psychiatric hospitals, and nursing facilities.
- Improve population health.[2]
- Accelerate payment reform to pay providers for better health outcomes.[3]

Health Systems—The term "health systems" is used throughout this document to reference a transformed delivery system skilled at providing person-centered services that promote and facilitate whole person care and support the interdependence of health and human services—medical, mental health, substance use disorder, and long term services and supports offered under Medicaid, as well as other human services such as housing and employment.

A transformed system recognizes that many of the activities that impact health outcomes—and the ability and willingness of individuals to actively engage in health improvement—occur outside the four walls of traditional medical providers. A transformed system supports these activities.

This effort will redefine the federal-state relationship in Washington's Medicaid program and embody our shared commitment to support the triple aim. Washington is already a leader in Medicaid reform and is dedicated to driving our delivery system toward providing whole-person care that emphasizes recovery and consumer choice while recognizing the important influence of social determinants of health.

This concept paper represents the first step in a statewide discussion about how this global waiver will drive health system transformation. We are committed to engaging Tribal partners, clinical partners, health plans, local government, local public health organizations, and the general public in Medicaid reform. Over the next few months, there will be opportunities to share ideas and comments through a series of webinars, workgroups, and public forums.

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[1] Washington State Health Care Innovation Plan, www.hca.wa.gov/hw/Documents/SHCIP_InnovationPlan.pdf. The state aims for annual health care cost growth to be 2 percent less than national health expenditure trend by 2019.

[2] The Washington State Common Measure Set for Health Care Cost and Quality Report, page 6, December 2014. For population health measures agreed upon by the Performance Measures Coordinating Committee, see http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and 5732/1519; Cross System Performance Measures, http://leg.wa.gov/JointCommittees/ABHS/Documents/2014-07-18/Jane%20Beyer%20DSHS%20Cross-System%20Performance%20Measures%20-%20State%20Agency%20Selections%20for%20Initial%202016%20Contract%20Negotiation.pdf

[3] As part of the State's Health Care Innovation Plan, the state aims for 80% of payments to providers to be on the value-based continuum by 2020.

BACKGROUND

Two years ago, Washington received a $1 million planning grant from the Center for Medicare and Medicaid Innovation (CMMI), under the State Innovation Model (SIM) program. Over the following eight months, more than 1,100 stakeholders participated in the development of a bold vision for health system change captured in the State Health Care Innovation Plan, first published in December 2013. The plan set policy direction for system transformation across multiple payers and delivery systems and called for the development of Accountable Communities of Health as a key resource and convener for local change. Shortly thereafter, the Governor proposed and the Legislature adopted two landmark pieces of health reform legislation that put the vision into statute and helped launch "Healthier Washington," an effort that spans the whole state and is well underway.[4]

Healthier Washington is now supported through a $65 million Round 2 model[5] test grant from CMMI that extends through January 2019. This represents a significant down payment on the vision of Healthier Washington and finances key initiatives that invest in Washington's infrastructure to support multi-payer and population health transformation over the next four years. However, while grant financed activities are building essential comprehensive analytic capacity, developing new payment models, launching Accountable Communities of Health, and building an educational hub for supporting practice transformation, they are in and of themselves not enough to assure full adoption of change and engagement in care delivery and value-based purchasing by the providers who serve Medicaid clients. The concept proposed for the Medicaid Transformation Waiver addresses this void and assures the sustainability of these changes beyond the five-year waiver demonstration period.

Washington is among the leading states for successful implementation of the Affordable Care Act; cutting the rate of its uninsured population in half. This success has been driven in large part by the expansion of Apple Health (Medicaid) which covers an additional 550,000 newly eligible adults, most of whom previously lacked health insurance. This is a remarkable step forward, but one that will not achieve Washington's goal of improving health without concentrated attention on transforming the system to deliver better whole-person care and improved outcomes at a lower cost. With over 1.7 million enrollees—over 25% of Washington's population—Apple Health is a significant player in the Healthier Washington journey.

Prior to the Medicaid expansion, Apple Health implemented significant changes to increase its operational efficiency and effectiveness. The program is now almost fully reliant on managed care health systems for the delivery of physical and behavioral health services. Furthermore, Washington continues to be a leader in national efforts to shift reliance for long-term supports and services (LTSS) from expensive institutional settings to cost-effective home and community-based services—options that better meet the needs and are preferred

[4] Engrossed Second Substitute House Bill 2572 (2013)—"Better Health Care Purchasing"; Second Substitute House Bill 6312 (2013)—"Treating the Whole Person".

[5] The State Innovation Models Initiative Model Test Awards provide financial and technical support over a four-year period for states to test and evaluate multi-payer health system transformation models. States must produce and implement a detailed and fully developed proposal capable of creating state-wide health transformation for the majority of care within the state, http://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/.

by clients. Over the last 20 years, the state has rebalanced the LTSS system and achieved substantial federal savings by shifting 82 percent of spending on nursing homes in the 1991-1993 biennium to 38 percent in the 2013-2015 biennium. Washington is 2nd in the nation in providing quality long-term care to seniors and people with disabilities, and only 34th in the nation for LTSS costs. However, we cannot rest on our laurels. Rapidly changing demographics will generate escalating demand for LTSS as the 65 and over population is set to double over the next 20 years. The projected growth of this population will increase LTSS and all other health care costs significantly. Washington must build on past achievements to expand options for providing care to individuals in community settings.

> Amy is 43 years old. She experienced an extremely difficult childhood, including poverty and physical abuse. This led to a series of struggles in adolescence and adulthood—substance use, teen pregnancy, school failure, abusive relationships, depression and social isolation. Amy remains jobless and is chronically homeless.
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> In the health care system, Amy is perceived as a difficult patient. Although she is often in the emergency department and has been hospitalized three times in the last two years, she is a frequent "no show" for appointments. She is distrustful of providers, and does not follow prescribed care plans.
>
> Improving Amy's access to and engagement with behavioral health care and community supports will be critical for improving her health outcomes and quality of life.

Since 2003, our managed care and LTSS interventions have resulted in significant federal savings of approximately $5.8 billion.[6] However, having never operated its Medicaid program under a Section 1115 waiver, Washington has had little opportunity to reinvest the federal savings accrued from prudent investments in delivery system efficiencies and improvements. Through the global waiver approach proposed in this concept paper, Washington seeks a fractional reinvestment of these federal savings into the future of our program.

The global Medicaid Transformation waiver will increase Washington's ability to fully implement the policy direction set by the Governor and legislature designed to complement the Round 2 CMMI grant investments that address critical barriers to high value care in Washington State. The case for change is summarized below:

Current System		Transformed System
Fragmented clinical and financial approaches to care delivery	→	**Integrated** systems that deliver whole person care
Disjointed care and transitions	→	**Coordinated** care and transitions
Disengaged clients	→	**Activated** clients
Capacity limits in critical service areas	→	**Optimal access** to **appropriate** services
Individuals impoverish themselves to access needed Long Term Support Services (LTSS)	→	**Timely supports delay or avoid need** for Medicaid LTSS
Inconsistent measurement of delivery system performance	→	**Standardized performance measurement** with **accountability** for improved health outcomes
Volume-based payment	→	**Value-based** payment

Figure 1: This graphic represents the challenges under the current system. A global Medicaid waiver demonstration aims to respond to these barriers and provide the necessary tools to achieve a transformed system.

[6] Please refer to Figure 3.

Apple Health consumers and their families rely on a health delivery system that supports improved outcomes. They require better integrated care that coordinates physical care, behavioral health care services, and social supports. They depend on responsive services in community settings that maximize their ability to control daily decisions that affect them. Bottom line, they need a Medicaid program that is more accountable and stream-lined, while producing reliable outcomes. This is the primary aim of Washington's pursuit of a global waiver.

Key Strategies for Medicaid Transformation

The flexibility available through expanded federal waiver authority provides an opportunity to address underlying health care delivery challenges through strategic investments in delivery system reform. For Washington, a global waiver enables the state to transition from fragmented systems of care and social supports to a sustainable, high-quality, integrated health system that improves the care experience and outcomes for Medicaid enrollees. It will blend a set of strategies to collectively build a stronger, healthier system for all Apple Health clients.

These specific, interconnected strategies give Washington the ability to actively engage and support Apple Health clients, providers, caregivers, and communities in achieving improved health, better care, and lower costs:

Fully integrated managed care systems for physical and behavioral health services

Consistent with statutory guidance, bi-directional care delivery (where behavioral health services are brought to primary care settings and vice versa), will be standard practice across the state. This ensures that Apple Health clients can routinely be served in the most appropriate setting of their choice, whether in a primary care office or a behavioral health setting. Multidisciplinary care teams will interact more effectively through integrated financing and delivery system models that support whole-person care and recovery.

> Liz has been caring for her mother Eva with increasing intensity over the last 3 years, as Eva's memory loss has become more significant. At first Liz thought her mother was just forgetful, until last year when Eva became increasingly anxious and panicky when she was left home alone for extended periods of time. As Eva's support needs have grown, Liz's stress level has risen dramatically.
>
> Without help to sustain her ability to care for her mom in her home, Liz is considering placing Eva in a care facility. Liz knows that she would need to find a place that will accept Medicaid when her mother's limited savings are exhausted.
>
> If she had access to respite services, support groups, and other resources to assist with her mother's care needs, Liz could continue to care for her mother stay safely in her home.

Clinical-community linkages with mutual accountability for results

Leveraging new community capacity through Accountable Communities of Health, Medicaid will support care transformation that goes beyond the four walls of a provider setting. Workforce capacity development, payment policies focused on paying for value and workflow redesign will allow care delivery to interact with social and physical environments in which clients live and work. New benefit design will help clients recover through outreach and engagement services, supportive housing, and supported employment.

Targeted long-term services and supports, enabling individuals to delay or avoid more costly services
The state proposes creation of two new service packages that support individuals facing the decision to impoverish themselves (also called "spend down") to qualify for Medicaid long-term services and that would provide targeted family caregivers support services to individuals eligible for Medicaid. The practice of spend down results in diminished assets and prevents individuals from retaining resources necessary for basic home maintenance and other costs associated with remaining in their homes. This approach allows qualifying individuals to receive targeted long term services and supports such as family caregiver supports. It delays full Medicaid eligibility, preserves quality of life for our aging population, and reduces costs for the state and federal government.

INVESTMENT DOMAINS AND MEASURING SUCCESS

The state is proposing four investment domains that advance Washington's strategies for sustainable Medicaid transformation. Within each domain is a list of correlated transformational activities. Together, the domains and respective transformational activities create a portfolio of investment areas to support the necessary capacity building, service flexibility, and comprehensive reform needed to achieve Washington's Medicaid Transformation vision. Figure 2 provides short descriptions of the domain areas as well as some example transformation activities that begin to develop our portfolio approach.

The list of example transformational activities is not intended to be exhaustive. Instead it represents potential areas for investment that Washington believes will enable success and align with priorities elevated by Tribes and stakeholders throughout the Healthier Washington stakeholder process. Over the coming months, a transformation activity toolkit will provide specific parameters around investments to ensure effective programs and services are implemented statewide.

Investments in transformation activities will prioritize evidence and research-based interventions. Like many of the examples provided, selected transformational activities have been previously tested to demonstrate desirable outcomes and a high likelihood of successful replication. Promising practices that show potential for desirable outcomes based on a well-established theory of change or preliminary analysis, particularly for ethnic minority and Tribal communities where evidence-based practices have not been fully researched will also be considered. We also see opportunity to recognize and support regions in addressing regional capacity gaps to carry out statewide priorities and succeed in carrying out the fidelity of the models.

Figure 2. Medicaid transformation domains and corresponding activities.

The success of the transformational activities and, ultimately, delivery system reform investments will be measured through pre-identified milestones and metrics that leverage statutorily required standardized statewide measures. The achievement of the milestones and metrics will enable further investment over the course of the five-year demonstration. While the details of these milestones and metrics are still under development, there are four principal measure areas that will define ultimate success for Medicaid transformation at the end of the five year demonstration period. All investment areas under the waiver will be structured to support these desired outcomes:

- Bending the Medicaid cost curve two percentage points below national trends.
- A reduction of institutionalization in acute care hospitals, psychiatric hospitals, and nursing facilities.
- Improved population health.
- Accelerating payment reform to pay providers for better health outcomes.

What is DSRIP?

Delivery System Reform Incentive Payment, or DSRIP, can provide a targeted source of funds for transforming Medicaid—supporting providers in changing how they provide care.

DSRIP: *Not* a Grant Program

DSRIPs are performance-based incentive programs with funding tied to advancing the overall vision for the state; the intended result is long-term federal savings in Medicaid spending. Over the course of a demonstration project, DSRIP activities must show measurable improvements in outcomes and must demonstrate how these improvements can be sustained once DSRIP funding ends.

States have flexibility to design Delivery System Reform Incentive Payment (DSRIP) programs to address the unique challenges facing their delivery system and Medicaid population.[7] Washington proposes a DSRIP program as a tool for investing in transformation activities that align with previously identified strategies and investment domains, and are directly linked to measurable outcomes. These activities will need to show federal savings over the course of the five-year waiver demonstration. This is particularly important to ensure that the state does not spend more under the authority of the waiver than it would have spent without the waiver. Through close monitoring of transformation activities, data will be collected to validate proof of concept and return on investment and support continued investment over the five-year demonstration. Effective care models and practices will be sustained after the five-year waiver demonstration through value-based purchasing within Medicaid managed care contracts; other investments in non-Medicaid reimbursable services by plans, providers, state and local government; or by the private sector. In addition, by demonstrating the cost-effectiveness of the tested transformation activities, the State can seek renewed waiver authority from CMS to continue paying for care models after the five-year waiver demonstration.

[7] To date, seven states have instituted a DSRIP program. In order of implementation, they are: California, Massachusetts, Texas, New Jersey, Kansas, New Mexico, and New York. The program continues to evolve and several other states are now in various stages of developing DSRIP initiatives.

COORDINATION OF TRANSFORMATIONAL ACTIVITIES

As a condition of receiving DSRIP federal financing for transformational activities, CMS requires the State to assure accountability, investment fund management, transparency and reporting, and sustaining ongoing transformation beyond the waiver demonstration. This will be accomplished through mutually supportive transformational activities at the regional and state levels. At the regional level, to coordinate delivery system reform activities, the State will further strengthen its partnership with Accountable Communities of Health (ACHs). These regionally organized public-private collaboratives will align priorities, actions, and investments to facilitate and support their memberships to develop and sustain more accountable and integrated care delivery—with improved overall health for Washingtonians. By design, ACHs serve geographic regions that align directly with Washington's regional services areas for Medicaid purchasing. As such, they enable shared responsibility and coordination across managed care systems, providers and the community services that impact the social determinants of health.

ACHs will serve as the coordinating entities to develop applications for DSRIP financing within their region that align with the key waiver investment areas, satisfy State expectations and Medicaid transformation priorities, and also address regional capacity for providers to participate in transformation (and ultimately thrive in a value-based purchasing environment). Collectively, ACH members will be responsible for supporting each other to assure achievement of regional milestones and metrics.

Each ACH will provide critical real-time information to the State and participating members, including managed care systems, to identify local area gaps, needs and priorities, and facilitate improved coordination and delivery of Medicaid services. They will administer and distribute regional investments under DSRIP. They will also act as primary points of accountability for the State to achieve the goals of the waiver.

Prior to distribution of DSRIP investments, the State will ensure the readiness and competency of ACHs to administer and coordinate investments and transformational activities. The state is currently developing ACH designation criteria that will consider the capacity and member participation needed for an ACH to act as a regional waiver coordinating entity. Allocation of DSRIP funds over the five-year demonstration period will be contingent on performance tied to the milestones and performance measures. While the state will work to build in sustainability of the DSRIP investment through developing value-based purchasing and payment approaches, ACH members also will be charged with designing an effective reinvestment strategy that will define, measure, and capture shared savings resulting from DSRIP financed interventions.

ACH members will be asked to co-invest in the evidence-based interventions, with a 10 percent share of costs by Year 3 and a 50 percent share of costs by Year 5. Each ACH will be expected to design a shared contribution schedule that aligns with the level of gain or benefit from DSRIP-financed transformation activities. The ability for communities to co-invest will support sustainability beyond the demonstration, allow for funding tied to creative financing mechanisms,[8] and provide further flexibility for initiatives not eligible for Medicaid financing.

[8] Creative financing mechanisms could include Pay for Success models and/or social impact bonds.

At the state level, key transformational activities will be implemented, such as: supportive housing and supported employment service, investments in outreach and engagement, and activities designed to delay or reduce the need for Medicaid long term services and supports. These statewide programs will provide a foundation to improve coordination and delivery of Medicaid services. They will enhance effective linkage of coordinated physical and behavioral health, long term services and supports, and other social supports. They will also provide access to services that are essential to more effectively engage Medicaid clients in improving their health.

Washington is committed to sustaining waiver-financed initiatives through value-based payment models and reinvestment of federal savings. For reinvestment strategies to be successful there is a significant interplay between community factors, business and competitive needs, budgeting processes and rate setting; this will require further discussion. This waiver will promote that ongoing discussion at the community and state levels while instituting a structure that requires shared investment by Year 3.

FEDERAL REQUIREMENTS

Section 1115 waivers are generally approved for a 5-year period and must be budget neutral to the federal government—meaning that, over the course of the waiver, federal Medicaid expenditures will not be greater than they would have been without the waiver. To build its DSRIP investment pool, Washington is proposing to leverage a portion of savings accrued to the federal government as a result of State strategies previously employed to constrain the rate of Medicaid spending. Through providing managed care choices for 90 percent of Apple Health enrollees, and rebalancing the long term care system from nursing homes to community based settings, Washington has achieved federal savings of more than $5.8 billion dollars since 2003. The State projects increased federal cost avoidance through 2020 that will raise that figure to approximately $14.9 billion dollars.[9] In an era of unprecedented growth in the Medicaid caseload, Washington proposes a federal investment of $3 billion to support the transformation activities financed through the waiver over the 5-year waiver demonstration.

Non-Federal Share

To access federal funding for delivery system transformation, the State will be expected to fund the non-federal share, meaning it must match any federal investment with an equal state or local share. This is significant because it determines the amount of funding the state can receive to finance transformational activities.

There are a few strategies for the state to satisfy this requirement including: through state general funds, designated state health programs (DSHPs) or intergovernmental transfers (IGT).

For all funding sources, the dollars leveraged for the non-federal share cannot already be used for federal claiming. The state is currently in the process of identifying a list of eligible DSHPs to propose to CMS.

Savings have been achieved through policy and programmatic changes in both Medical and Long-term Support Services (LTSS), with approximately 85 percent of the savings coming from Medical services. Medical services savings were calculated by estimating the average per-member-per-month cost (PMPM) growth rate of all

[9] Estimates reflect trend projections based on an autoregressive integrated moving average (ARIMA) estimator applied to historical per member costs in calendar years 1998-2002.

medical services over calendar years 1998-2002. To account for changes in caseload composition, these growth rates were calculated separately on five coverage groups (Non-Disabled Children, Non-ABD 'Classic' Adults, Disabled, Aged, and historical sub-populations who transitioned to the ACA Expansion Adults). The Medical Projected Trend is then estimated by multiplying actual and projected CY2003-2020 caseloads by simulated PMPM costs which are based on an assumed continuation of 1998-2002 PMPM growth rates. This then is compared to actual and forecasted program costs over this same time period. Conceptually this exercise is attempting to capture the difference between maintaining the 1998-2002 cost structure into the future versus our realized costs structure influenced by various policy and programmatic changes—all simulated on our actual caseload experience.

On the LTSS side, a conceptually similar yet different methodology was employed. For LTSS, the federal savings have been achieved via a rebalancing of care toward more community-based settings. Therefore, we estimated the average of the distribution of clients into the various LTSS settings (Adult Family Homes, Assisted Living, Adult Residential Centers, In Home Care, Managed Care, and Nursing Homes) for the same time period CY1998-2002. This estimated distribution was applied to the overall LTSS population for CY2003-2020 (actual and forecasted) to create an alternative distribution of the population among these various LTSS modalities. Multiplying this simulated distribution by the PMPM cost in each modality provided an alternative total program cost that could then be compared to the actual program cost to generate our federal savings estimate.

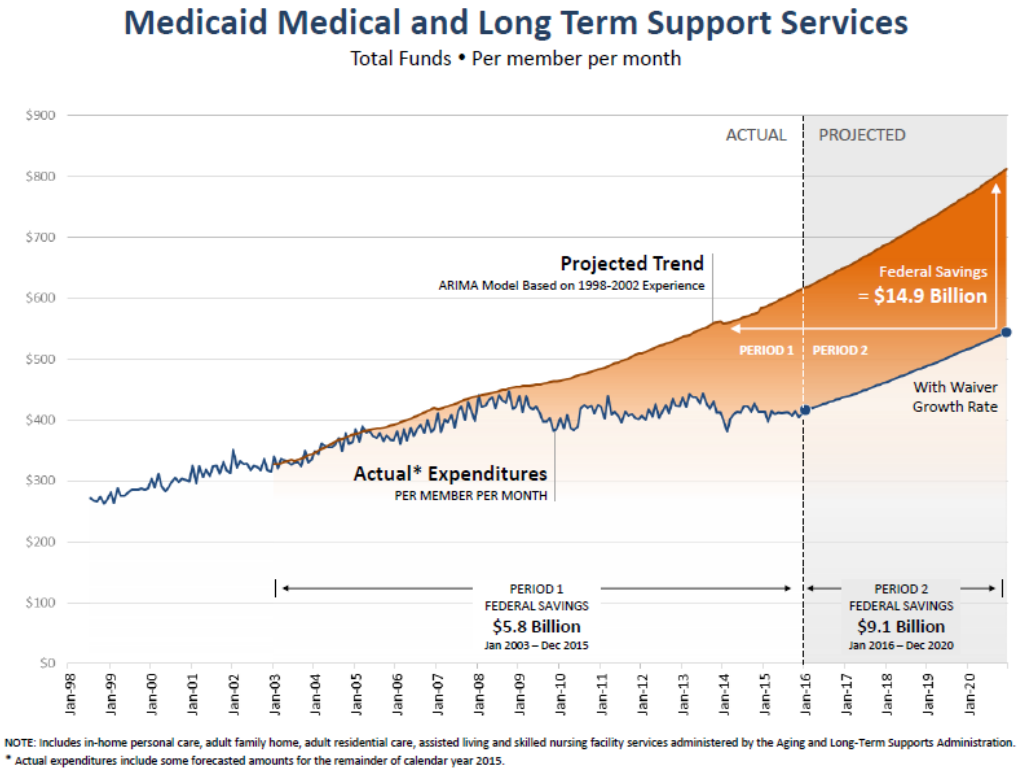


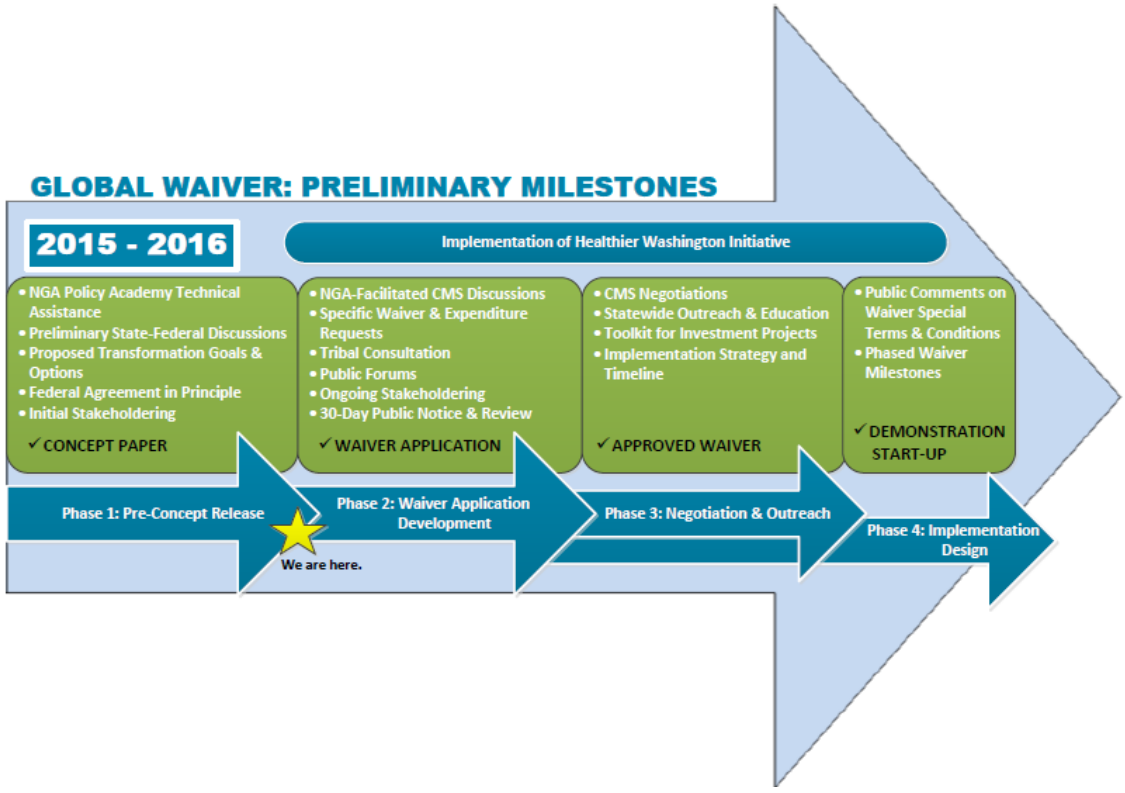
Figure 3: Projected Medical and LTSS Medicaid expenditures with and without waiver.

ENGAGEMENT OPPORTUNITIES

Help us make Medicaid transformation and a Healthier Washington a reality. Your questions and suggestions will help us build and refine the vision and key strategies as we develop the waiver application. Further details of how we can achieve Medicaid transformation and what that will look like will be developed over the next few months together with our stakeholders, providers, local and Tribal governments, and state agency partners. There will be numerous opportunities for input and collaboration, beginning with a webinar scheduled for Monday, June 15. We will be scheduling at least two public forums, and meeting with stakeholders throughout the summer. Prior to a waiver application submission, there will be a 30-day public comment period.

A unique government-to-government relationship exists between the federally recognized Tribes in Washington and the State. In furtherance of this partnership and recognizing there is more work to come, the state will solicit advice through consultation with the Tribes, Tribal Organizations, Indian Health Programs, and Urban Indian Organizations on the development of a draft waiver application.

For additional information and engagement opportunities, please visit the Medicaid Transformation webpage and sign up for updates through the Feedback Network, www.hca.wa.gov/hw. Additionally, you are encouraged to send questions, comments to medicaidtransformation@hca.wa.gov.



AFTERWORD

Five years following his diagnosis of bipolar disorder, John finds himself re-enrolled in community college, pursuing that no longer distant dream of receiving an IT certification. Shortly after recovering from his last hospital stay, John was connected to a supported employment program that is now providing regular assistance and support services to ensure his academic and career progress.

John now feels more capable of managing his health, has more control over his life, and can focus on what is important to him. Although John remains diagnosed with bipolar disorder and Type 2 diabetes, and is still a regular smoker, these are no longer total impediments to his life. He has a greater understanding of his diagnoses and is able to better manage his condition in partnership with his care team. With just one single care plan, John no longer feels completely overwhelmed. Additionally, he knows that there are plenty of other services available if he ever needs them. He has even set a goal to reduce his smoking and is optimistic that he will be successful. John may continue to experience episodes of depression and mania in the future, but now he feels empowered about how and where he receives his care. He has found a set of providers who work to understand what is important to him; they have developed a person-centered care plan including a medication regimen that helps control his symptoms without disabling side effects. As a result John is taking his medication regularly. When he has bad days or questions about his care, he knows there is someone he can call who understands all his needs as well as his goals.

Over five years, the reclusive, overweight 22 year-old has transformed into a motivated young professional, hardly distinguishable from his peers. John and his family speak regularly. Without the added strain of John's unmanaged bipolar disorder, their relationship has greatly improved, and now when he calls it is not because he is in a crisis.

The once paralyzing symptoms and accompanying stigma of a mental health diagnosis is now being leveraged as an opportunity. John volunteers once a week at the local Community Mental Health clinic as a peer support specialist, helping others just like him understand how to work as part of a coordinated, connected care team to prioritize and reach their health goals, even with a serious mental illness. For John, this work is tremendously important. As he transitioned out of the hospital, a peer specialist was a huge factor in facilitating John's successful path forward by helping to break down barriers and working with him on engaging with other services. That lived experience showed John that recovery was possible and how significant it was to have a peer involved in his care.

Recovery was no easy path. However, it was a path in which there was support from the entire community. An interdisciplinary team of health care professionals and peer support specialists has been with John through the ups and downs, ensuring that his physical and behavioral health needs are met. While a carefully coordinated treatment regimen was important, his access to career training and supported employment has made all the difference between an almost certain track to permanent disability to one that is likely to maintain his quality of life and ability to achieve his goals. A transformed, accountable, and connected system provided the necessary supports and incentives to allow John to recover fully. Statistics tell us that compared to someone with a similar diagnosis; John has avoided at least two psychiatric inpatient stays and seven emergency room visits over the

last two years. His average annual cost of care would have been $12,000 for those two years; instead it has been $5,500. Today, John receives the care he needs in addition to the support that keeps him headed toward his life goals. There will be ups and downs, but John and his family now have a community supporting them and a delivery system that has been transformed to be better connected, person-centered, and focused on the overall 'health' of the patients it serves, not just the treatment of illness and disease.

Apply John's story to the thousands of others like him who today fall through the cracks, ending up incarcerated or institutionalized, and on a fast track to permanent disability. There are significant personal and societal costs to doing nothing. A global waiver is the chance to ensure that newly eligible or longer term Medicaid beneficiaries don't have to endure the status quo approach that results in a shortened life span or permanent disability, with an exhausted family left in its wake. It is the opportunity to form partnerships for meeting individual and family needs, a pressing case that we have heard from our safety net providers for decades. It also forces action and accountability at a local level where it is most likely to succeed. The year is 2015—we cannot accept a 2020 that resembles the status quo.