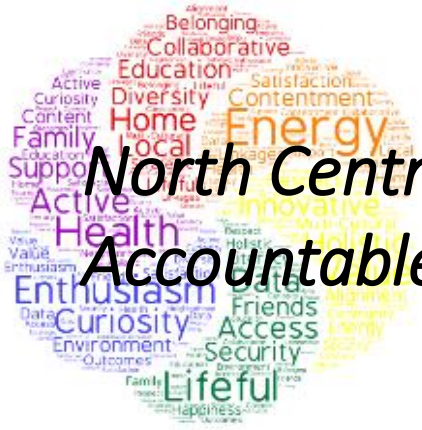

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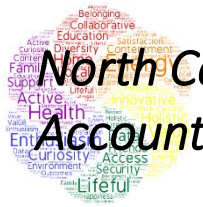
Demonstration Decisions

What will North Central Washington Do as Part of the Medicaid Demonstration?

Barry Kling, *Governing Board Chair*
Linda Parlette, *Executive Director*
Christal Eshelman, *FIMC Project Coordinator*
John Schapman, *Program Manager*



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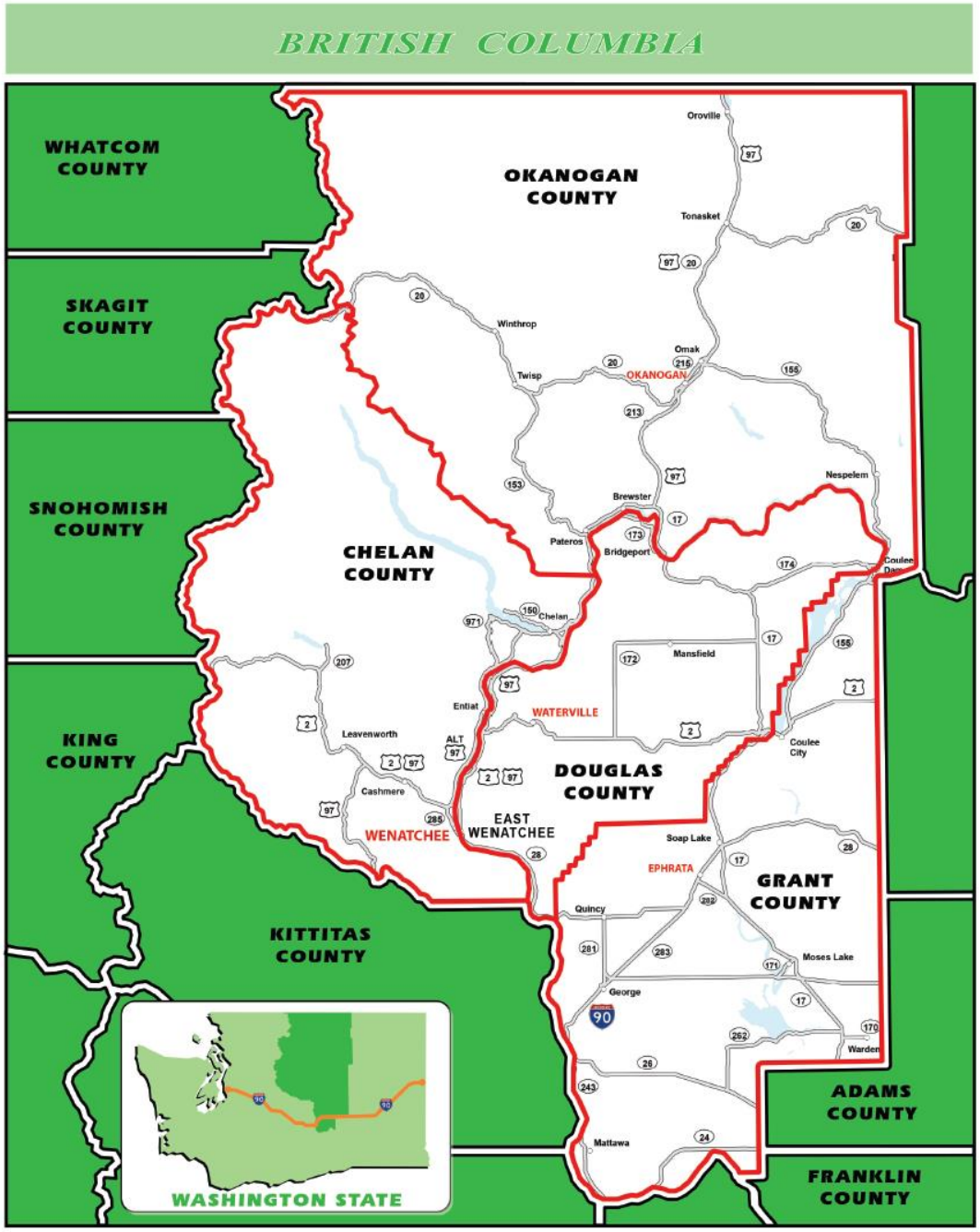
Demonstration Decisions

This presentation will:

- **Outline the Medicaid 1115 Demonstration (formerly known as the Waiver)**
- **So that you can provide informed input**
- **Because the ACH Governing Board must decide which projects to adopt under Initiative 1 of the Demonstration**

To inform those choices, the ACH Governing Board is collecting input from partners and community members in each of our counties.



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Medicaid Demonstration Project

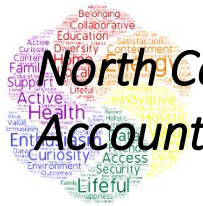
Through a five-year demonstration, Healthier WA will use up to $1.5Billion to address three initiatives aimed at transforming Medicaid to improve quality and control costs:

Initiative 1: Transformation Through Accountable Communities of Health

Initiative 2: Long-term Services and Supports to Enable Older Adults to Live At Home Longer

Initiative 3: Supportive Housing and Supported Employment

Of the $1.5Billion available through the Demonstration, **$1.125Billion will be available to address Initiative 1**.



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Initiative 1

Transformation through Accountable Communities of Health

Delivery System Reform

- Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.

Transformation Projects

Initiative 2

Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

Benefit: Medicaid Alternative Care (MAC)

- Community based option for Medicaid clients and their families
- Services to support unpaid family caregivers

Benefit: Tailored Supports for Older Adults (TSOA)

- For individuals "at risk" of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria
- Primarily services to support unpaid family caregivers

Initiative 3

Targeted Foundational Community Supports

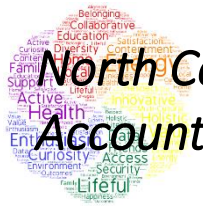
Benefit: Supportive Housing

- Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do ***not*** include Medicaid payment for room and board.

Benefit: Supported Employment

- Services such as individualized job coaching and training, employer relations, and assistance with job placement.

Medicaid Benefits/Services



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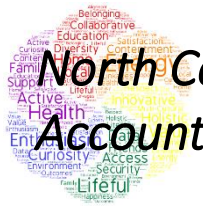
NC ACH's Initiative 1 Projects

- **Substantial funding will be available for those projects**
- **But probably not enough to do all of them well in a sustainable way that will persist after the Demonstration is over.**
- **It is NC ACH's policy to push resources out to providers and other community partners, not to build an ACH empire.**
- **The ACH's role will include picking projects, planning them along with providers and community partners, and tracking their implementation and results.**
- **We welcome your help to select projects for our region.**



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The Demonstration Toolkit

- **The Demonstration Toolkit outlines requirements and options for Initiative 1**
- **The Toolkit includes <u>3 Domains</u>:**

  Domain 1: Health Systems and Community Capacity

  Statewide efforts in which ACHs must participate.

  Domain 2: Care Delivery Redesign

  Regional Projects: 1 required, others optional

  Domain 3: Prevention and Health Promotion

  Regional Projects: 1 required, others optional

Every ACH must choose at least one optional project in Domain 2 and one in Domain 3.

Medicaid 1115 Demonstration

Initiative 1: Care Transformation

- Domain 1: Health System and Community Capacity
  - ACH must participate in statewide efforts.
- Domain 2: Care Delivery Redesign
  - ACH must deliver 1 or more optional projects.
  - Required: BH-Primary Care Integration
- Domain 3: Prevention and Health Promotion
  - ACH must deliver 1 or more optional projects.
  - Required: Address Opioid Crisis

Initiative 2: Better Medicaid In-Home Options for Older Adults

Initiative 3: Housing and Employment Supports

ACH Responsibilities

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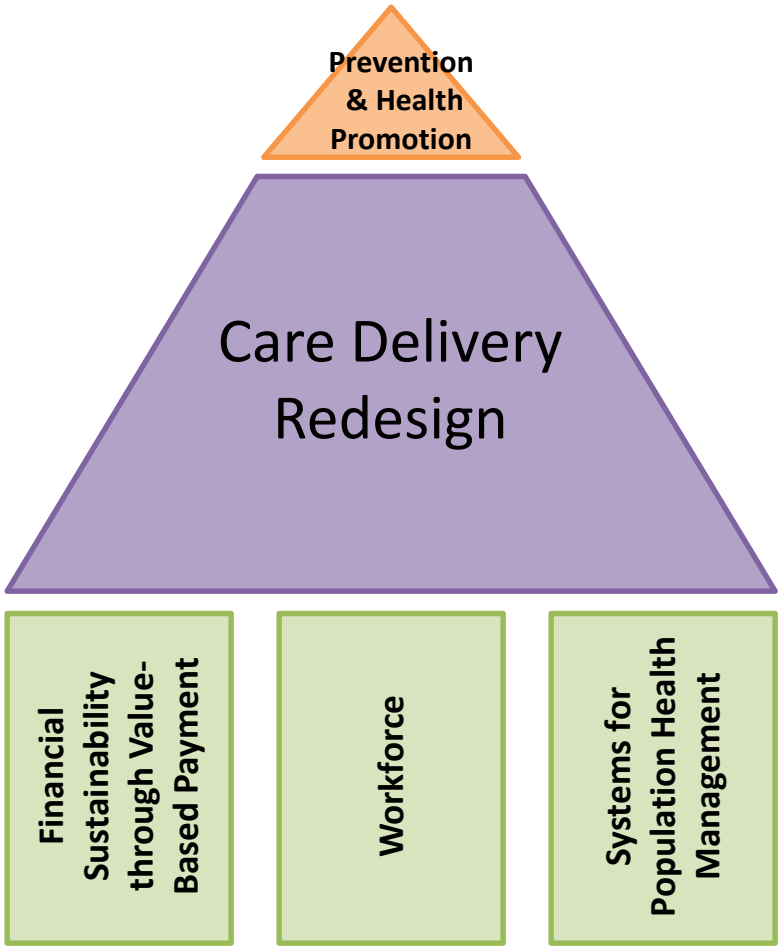
Initiative 1 Overview



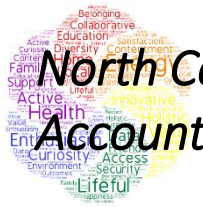
Domain 3: Prevention and Health Promotion
- Addressing the opioid use public health crisis
- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Domain 2: Care Delivery Redesign
- Bi-directional integration of care and primary care transformation
- Community-Based care coordination
- Transitional Care
- Diversion interventions

Domain 1: Health Systems and Community Capacity Building
- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

Funding Among the Domains

- **Overall funding allocations for our region are not yet available from HCA, but it is sensible to expect a few million dollars annually in 2018-2021.**
- **This is not a grant program. There will be up-front money for start-up, but much of the project funding must be earned by reaching performance targets.**
- **By far the highest funding priority for ACHs will be given to Domain 2, Care Delivery Redesign.**
- **This is not surprising – more than anything else, Healthier Washington is about improving care for Medicaid patients.**
- **Domain 3, Prevention and Health Promotion, is mostly about better care for people who already have opioid addiction or chronic disease – it isn't mostly about primary prevention for people not yet sick.**
- **There are some options for primary prevention, but these are unlikely to produce cost results within 5 years.**



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More details on each Domain

- **Next we'll briefly look at Domain 1, which involves statewide and regional efforts on foundational aspects of the care delivery system.**
- **We don't have to choose specific projects within Domain 1 – the ACH has a role, along with the state, in all three Focus Areas in Domain 1.**
- **After looking at Domain 1 briefly, we'll move on to more details about Domains 2 and 3 – because for those Domains, we must make some choices about which projects to implement.**

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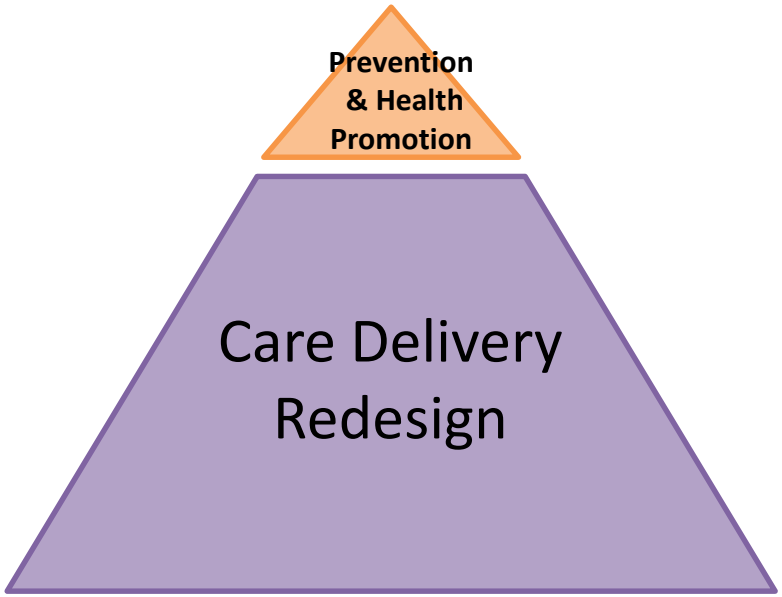
Initiative 1 Overview



Domain 3: Prevention and Health Promotion
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Domain 2: Care Delivery Redesign
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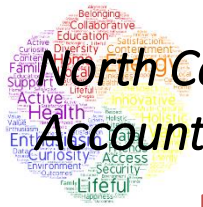
Financial Sustainability through Value-Based Payment

Workforce

Systems for Population Health Management

Domain 1: Health Systems and Community Capacity Building
- Financial sustainability through value-based payment
- Workforce
- Systems for population health management



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****REQUIRED****

Healthier Washington

DOMAIN 1: Health Systems and Community Capacity Building

Domain 1 addresses the core health system capacities to be developed and enhanced. Three required focus areas are to be implemented and expanded across the delivery system. Each of these areas will need to be addressed progressively throughout the five-year timeline. State agencies will provide leadership but the ACH will have a role in each focus area.

Focus Areas

1. Financial Sustainability through Value Based Payment
2. Workforce
3. Data Systems for Population Health Management

Domains 2 and 3 – Project Choices

- **In the following slides, we'll look at Domains 2 and 3.**
- **In each of these Domains, there is one required project and a few optional projects.**
- **We must choose at least one of the optional projects in each of these Domains.**
- **We can choose more than one optional project in each domain if we want, though it may be wiser to focus on a few projects than to attempt several.**
- **For each Domain, we'll provide summary slides and then a slide explaining each of the projects – required and optional.**

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Initiative 1 Project Options Summary

Domain 2: Care Delivery Redesign

REQUIRED:

- Bi-directional integration of care and primary care transformation

OPTIONAL:

- Community-Based care coordination
- Transitional care
- Diversion interventions

Domain 3: Prevention and Health Promotion

REQUIRED:

- Addressing the opioid use public health crisis

OPTIONAL:

- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

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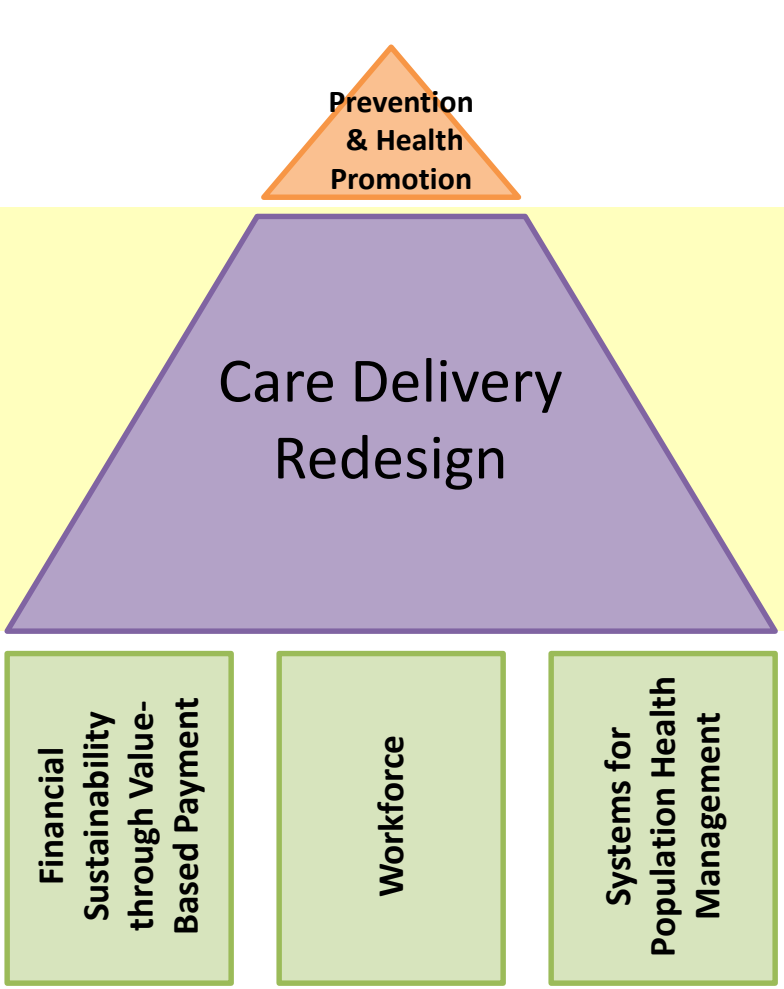
Initiative 1 Overview



Domain 3: Prevention and Health Promotion
- Addressing the opioid use public health crisis
- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Domain 2: Care Delivery Redesign*
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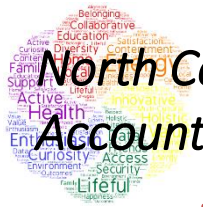
- Community-Based care coordination
- Transitional Care
- Diversion interventions

Domain 1: Health Systems and Community Capacity Building
- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

*** Domain 2 will receive highest funding priority at the regional level among the Domains.**



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****REQUIRED****

Domain 2

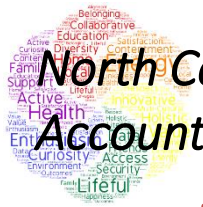
PROJECT 2A: Bi-Directional Integration of Care and Primary Care Transformation

Rationale:

This project is meant to produce Medicaid services that better address the social determinants of health and integrate physical and behavioral health care. NC ACH's Whole Person Care Collaborative is expected to be a central vehicle for work in this project.

Approaches

- Promote enhanced primary care models that address whole patient care, including integration of physical and behavioral care.
- Collaboration of Primary Care and Behavioral Health through some combination of the following:
  - Off-site, Enhanced Collaboration;
  - Co-located, Enhanced Collaboration
  - Co-located, Integrated Collaboration



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****REQUIRED****

Domain 2

PROJECT 2A: Bi-Directional Integration of Care and Primary Care Transformation

Important Challenge:

Medicaid and Medicare are moving to Value Based Payment and fully capitated care. Provider organizations must undergo major changes to survive under the new system, while surviving in the meantime under the old. An important aspect of this project is to support provider organizations in this transformation.

OPTIONAL

Domain 2

PROJECT 2B: Community-Based Care Coordination: Pathways HUB, an Evidence-Based Model

The Pathways HUB model does not replace current providers of care coordination (such as Health Homes) but provides an “air traffic control” function that allows one care coordinator to manage services for each patient, instead of having many coordinators approaching the same patient in an incoherent manner.

The HUB provides a well tested data system to coordinate and share the information needed by providers and care coordinators.

The HUB does not provide care coordination; it only coordinates the coordinators and usually pays for care coordination services.

The HUB can draw on different levels of care coordinators to serve patients with needs of different complexity.

OPTIONAL

Domain 2

PROJECT 2B: Community-Based Care Coordination *(Optional)*

Key Points About the HUB:

Primary care providers need an efficient way to connect patients with community resources that can help address the social determinants of health. Things like homelessness, transportation and food insecurity. Most providers cannot afford, under Medicaid payment, to hire expanded care teams. The ability to connect a patient through the HUB to community resources (with follow-up by care coordinators) could make this feasible in the real world of primary care. For this reason, the HUB has the potential to enhance the financial sustainability of Whole Person Primary Care.

An important challenge is to increase training programs for Community Health Workers and other potential care coordinators.

OPTIONAL

Domain 2

PROJECT 2C: Transitional Care

Rationale:

Transitional services provide opportunities to eliminate avoidable admissions and readmissions. Points of transitions out of intensive services/settings (such as prisons, hospitals and nursing homes) and into the community are critical intervention points in the care continuum.

Approaches:

- Interventions to Reduce Acute Care Transfers
- Transitional Care Model (TCM)
- The Care Transitions Intervention (CTI)
- Care Transitions Interventions in Mental Health

****OPTIONAL****

Domain 2

PROJECT 2D: Diversion Interventions

Rationale:

Transitional services provide opportunities to eliminate avoidable admissions and readmissions to hospitals and jails. Points of transitions out of intensive services/settings and into the community are critical intervention points in the care continuum

Approaches:

- ER Diversion
- Community Paramedicine
- Law Enforcement Assisted Diversion (LEAD)
- Options for pts accessing EMS for non-acute conditions

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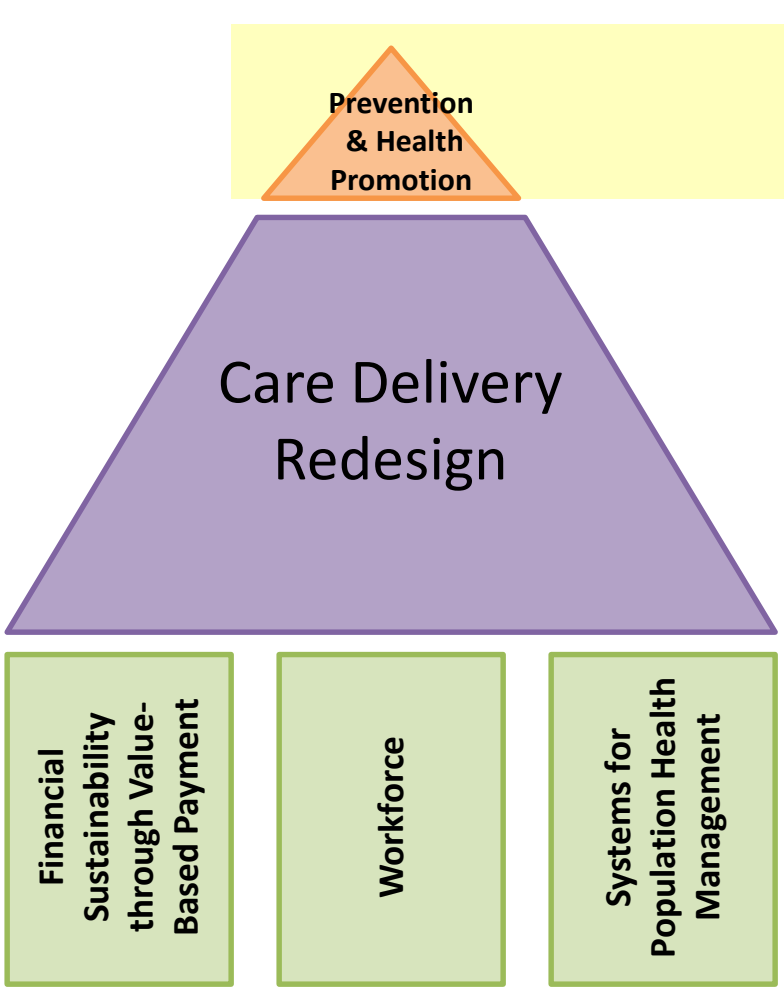
Initiative 1 Overview



Domain 3: Prevention and Health Promotion
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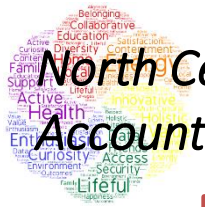

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****REQUIRED****

Domain 3

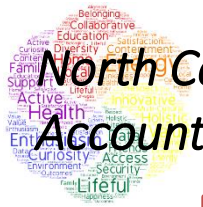
PROJECT 3A: Addressing the Opioid Use Public Health Crisis

Rationale

Opioid use disorder is a devastating and life-threatening chronic medical condition. Access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved.

Examples of Evidence-based Approaches

- AMDG's Interagency Guideline on Prescribing Opioids for Pain
- Substance Use during pregnancy: Guidelines for screening and Management
- 2016 Washington State Interagency Opioid Working Plan
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan
- CDC Guideline for prescribing opioids for chronic pain



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****REQUIRED****

Domain 3

PROJECT 3A: Addressing the Opioid Use Public Health Crisis

Goals:

1. **Prevent Opioid misuse** and abuse by improving prescribing practices
2. Expand **access** to opioid **dependence treatment**
3. Intervene in opioid overdoses to **prevent death**
4. Use **data** to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

OPTIONAL

Domain 3

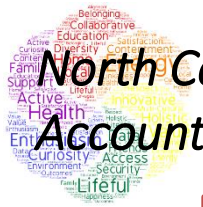
PROJECT 3B: Maternal and Child Health

Rationale

- More than half the births in WA are covered by Medicaid.
- Home visits have been demonstrated to improve maternal and child health.

Evidence-based Approaches

- Home visiting model for pregnant high risk mothers (Nurse Family Partnership, Early Head Start Home-based Model)
- Improve regional well-child visit rates (Bright Futures)
- Improve Preconception Health and Health Care (Family Planning Pathway)



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****OPTIONAL****

Domain 3

PROJECT 3B: Maternal and Child Health

Goal:

Support **healthy** pregnancies, mothers, and children through **home visits,** increased **well-child visit** rates, and **family planning**

OPTIONAL

Domain 3

PROJECT 3C: Access to Oral Health Services

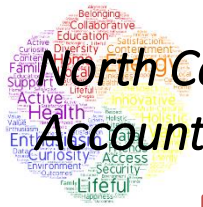
Rationale

- Oral disease has been referred to as a "silent epidemic" and has been associated with increased risk for serious adverse health outcomes.

- Some initiatives have focused on oral health needs, but few have been focused on adult oral health services. Most were aimed at children.

Evidence-based Approaches

- Oral Health in Primary Care – integrating oral health screening, assessment, intervention, and referral
- Mobile/Portable Dental Care



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Domain 3

PROJECT 3C: Access to Oral Health Services

Goal:

Improve **dental health** and access to **oral heath services** for adults

OPTIONAL

Domain 3

PROJECT 3D: Chronic Disease Prevention and Control

Rationale

- Chronic health conditions are prevalent among WA Medicaid beneficiaries, and are continuing to increase
- Disease prevention and effective management are critical to quality of life and longevity
- Right now we often do not do a good job of managing chronic disease, in part because of a lack of effective care coordination.
- This project could be integrated with Project 2A on Whole Person Care and with the Pathways HUB Model (2B).

Evidence-based Approaches

- Chronic Care Model

OPTIONAL

Domain 3

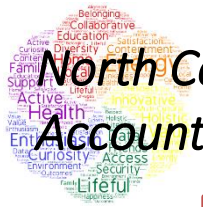
PROJECT 3D: Chronic Disease Prevention and Control

Chronic Care Model

The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are:

- The community
- The health system
- Self-management support
- Delivery system design
- Decision support
- Clinical information systems.

Evidence-based practices under each element, in combination, foster productive interactions between informed patients, who take an active part in their care, and providers with resources and expertise.



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OPTIONAL

Domain 3

PROJECT 3D: Chronic Disease Prevention and Control

Goal:

Integrate health systems and community approaches to improve **chronic disease management, Prevention** and **control**

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Initiative 1 Project Options Summary

Domain 2: Care Delivery Redesign

REQUIRED:

- Bi-directional integration of care and primary care transformation

OPTIONAL:

- Community-Based care coordination
- Transitional care
- Diversion interventions

Domain 3: Prevention and Health Promotion

REQUIRED:

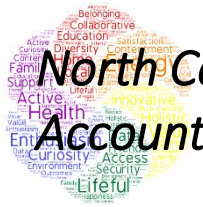
- Addressing the opioid use public health crisis

OPTIONAL:

- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Some Projects Interact

- **In thinking about which projects to select, it is worth noting that some project interact.**
- **For example, an effective Pathways HUB would help with diversion (by providing better care coordination that can sometimes prevent homelessness and untreated substance abuse problems that often lead to imprisonment or unnecessary ER visits).**
- **An effective HUB would also provide for better transitions from inpatient facilities and prisons into the community.**
- **It may make more sense to focus on a few over-arching projects like the HUB and care redesign, rather than picking out narrower projects which will be addressed (at least in part) by broader care system improvements.**



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Questions?

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