Ensuring Value of Managed Care

For Kentucky Legislative Committee

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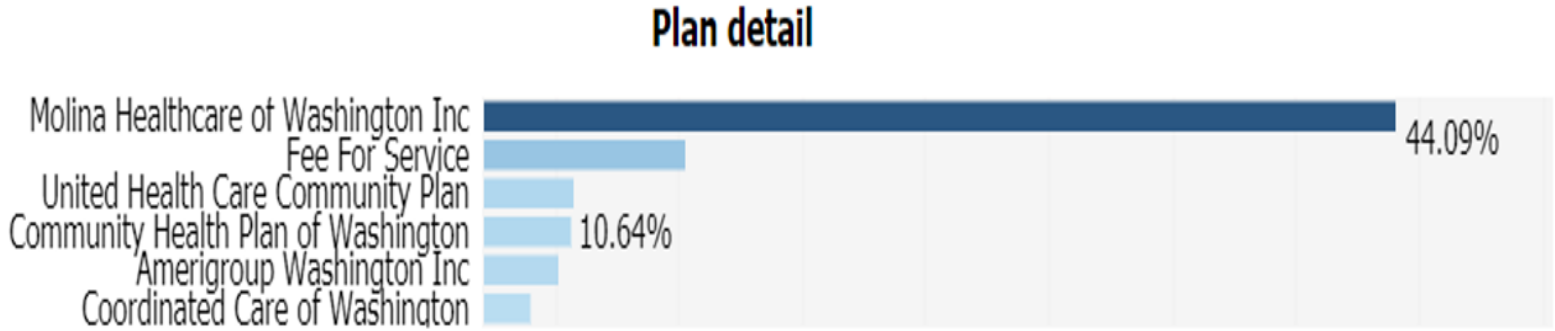
Washington State Health Care Authority

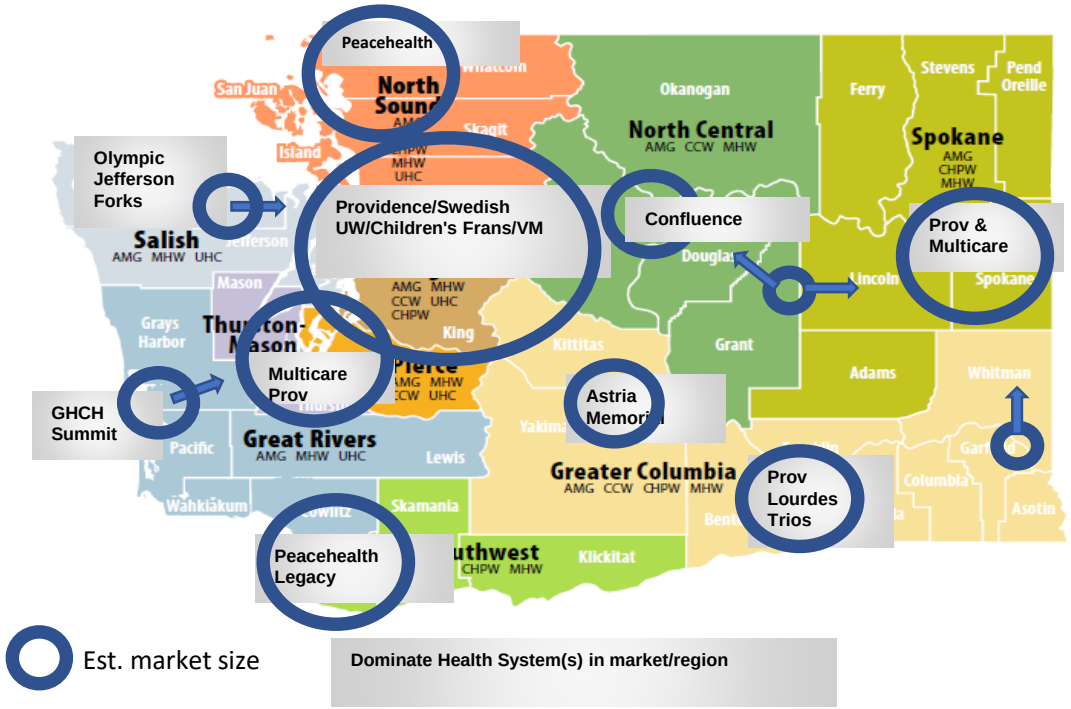
Summary

- WA State snapshot
- Why managed care?
- Importance of behavioral health integration
- Costs, rates
- Quality, member satisfaction, Network adequacy, rural health
- Equity, Medicaid transformation waiver and Accountable Communities of Health
- Framework for the future

Medicaid Managed Care in WA



- ~2.1 million Washingtonians enrolled in Apple Health (Medicaid) and approximately 86.6% are enrolled in managed care.
- Five Medicaid Managed Care Plans are contracted with the state to deliver physical and behavioral health
  - Molina Healthcare of Washington, Community Health Plan of Washington, UnitedHealthcare, Coordinated Care, Amerigroup
  - Coordinated Care also manages care for children involved in the foster care system statewide
- Most Medicaid Clients are enrolled
  - Medicaid only clients receive full medical and behavioral health benefits through managed care
  - Dual-eligible clients receive behavioral health benefits through managed care
  - American Indian/Alaska Native can opt out
  - LTSS and I/DD carved out; but systems must work together

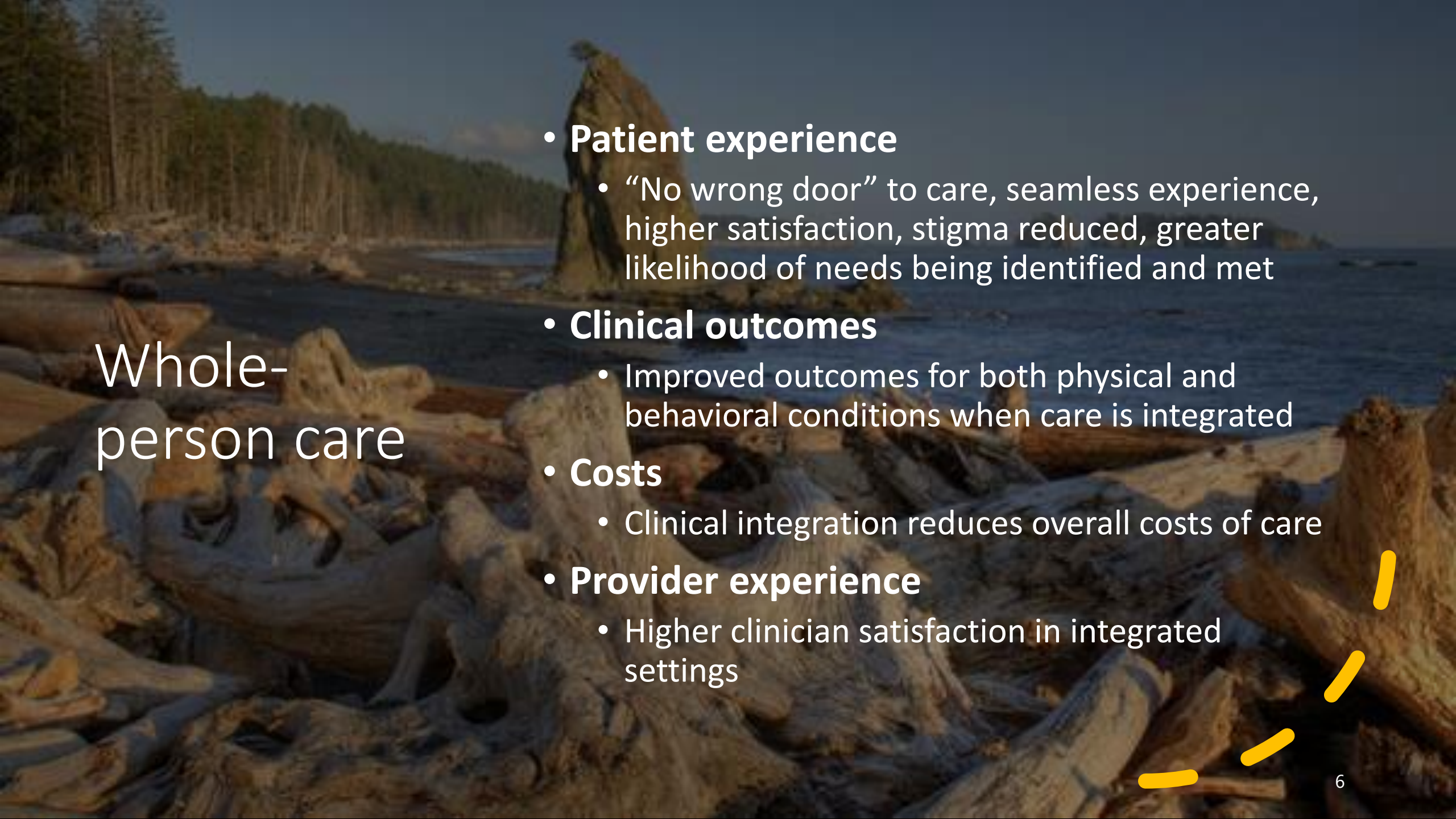


History in WA – why managed care?

- In response to serious access issues, the state moved the first major population groups (pregnant women and children) into managed care starting in 1993. This improved access to care, especially for primary and specialty care.
- In 2012, the second major expansion occurred to add the non-dually eligible Aged, Blind and Disabled (ABD) population and expanded to the five managed care plans we have today.
- 2014 Medicaid expansion
- 2016-2020 Integrated Physical and Behavioral health

Role of Managed Care Organizations in Washington

- Facilitate care management
- Clinical and service quality
- Build provider networks
- Engage & partner with communities
- Leverage data and technology
- Monitor & maintain compliance
- Achieve predictability for spending
- Test new ways of purchasing ~ behavioral health



Whole-person care

- **Patient experience**
  - "No wrong door" to care, seamless experience, higher satisfaction, stigma reduced, greater likelihood of needs being identified and met
- **Clinical outcomes**
  - Improved outcomes for both physical and behavioral conditions when care is integrated
- **Costs**
  - Clinical integration reduces overall costs of care
- **Provider experience**
  - Higher clinician satisfaction in integrated settings

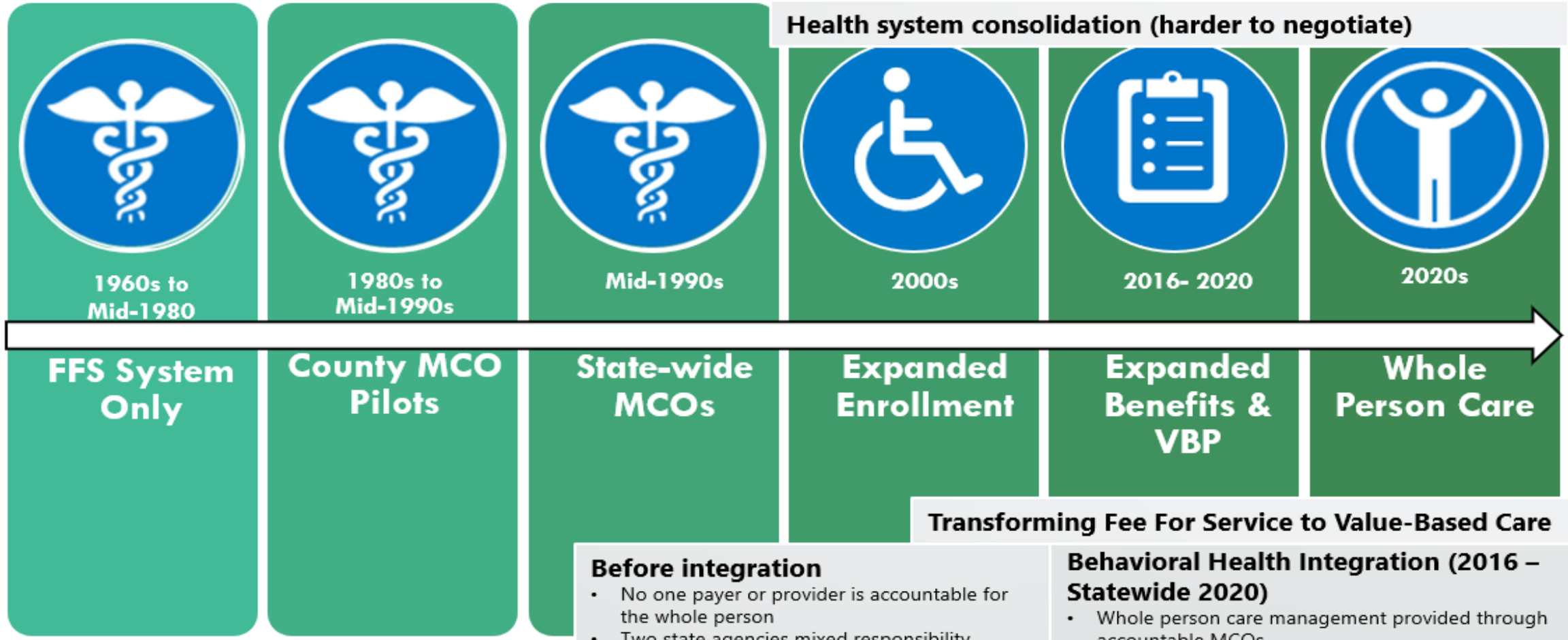
Timeline to full integration – System changes prior to Covid

Managed care expansion (2012 – 5 MCOs)

ACA – expansion and IM --- Public Option 2020 (+++MCOs covering more of state)

DSNP (Medicare/Medicaid (+++Medicaid MCOs covering state)

Health system consolidation (harder to negotiate)



Transforming Fee For Service to Value-Based Care

Before integration

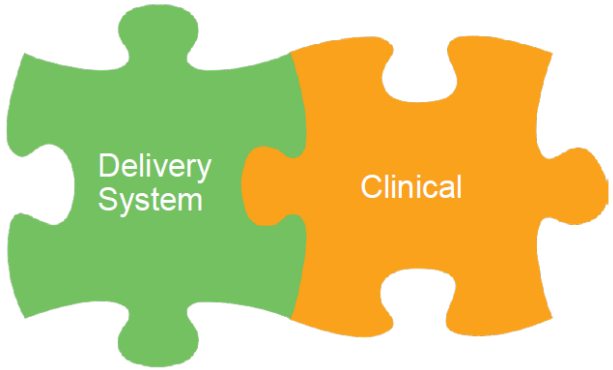
- No one payer or provider is accountable for the whole person
- Two state agencies mixed responsibility
- Access to Care standards in place

Behavioral Health Integration (2016 – Statewide 2020)

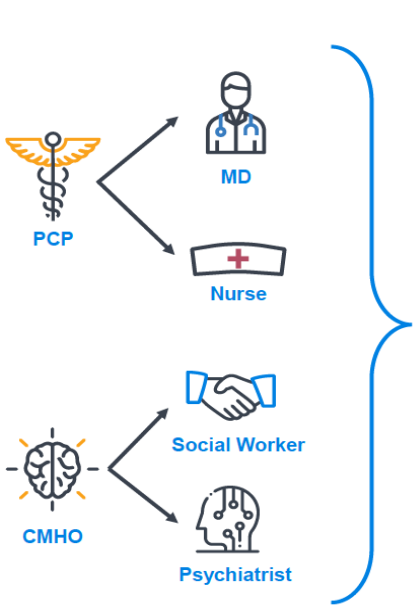
- Whole person care management provided through accountable MCOs
- One state agency responsible (HCA)
- Eliminates access to care standards
- Full continuum for physical and behavioral health, including crisis services - building out community-based health system

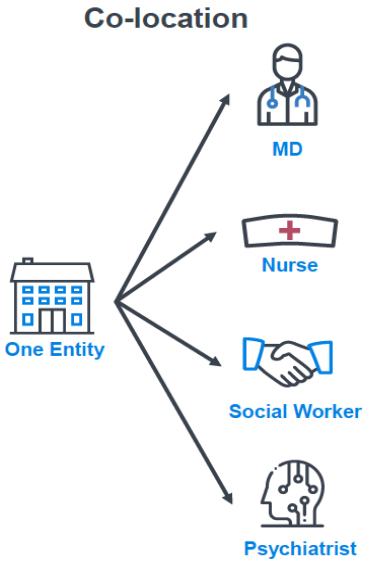
Behavioral Health Integration

- Clinical integration



- System integration





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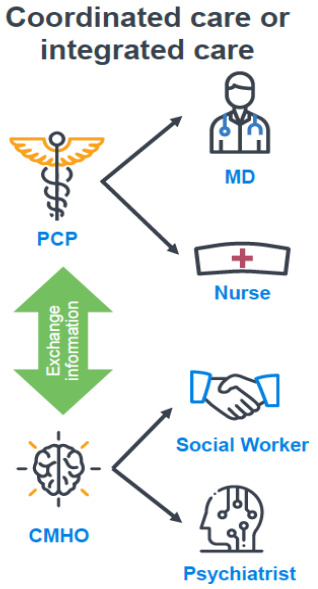
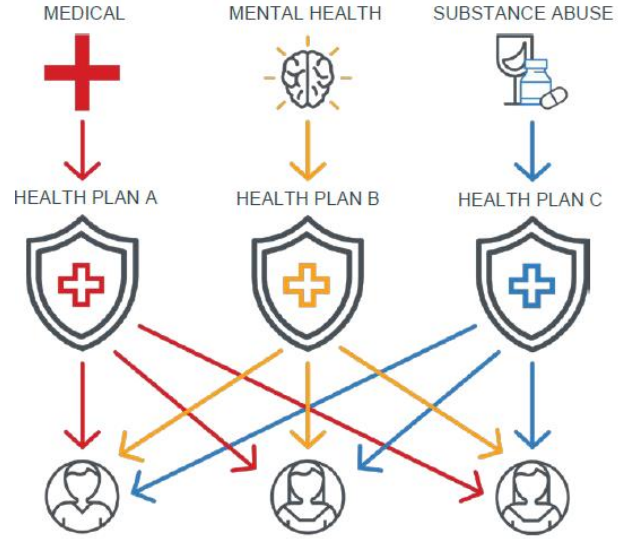
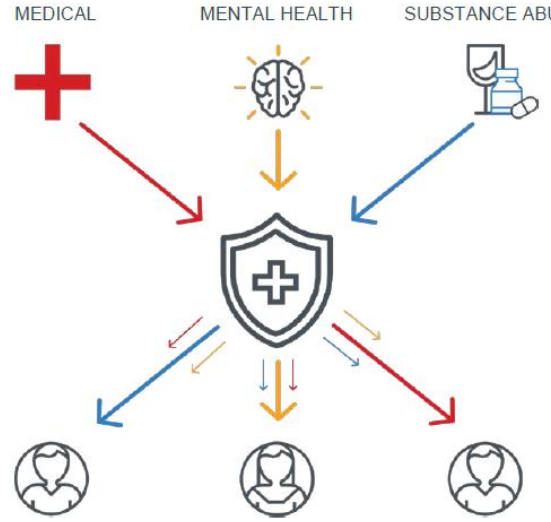
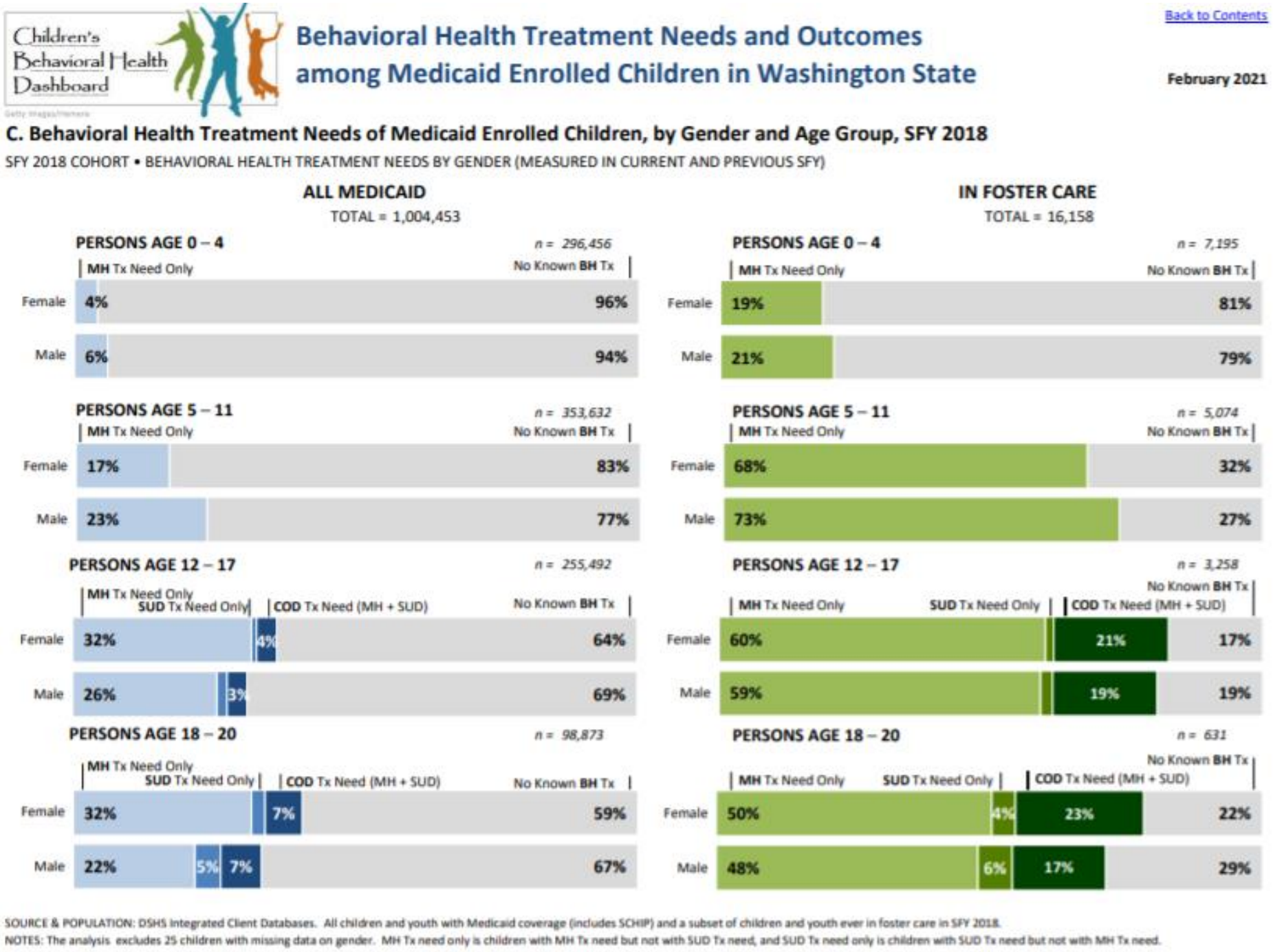






Integrated managed care – Behavioral Health Dashboard

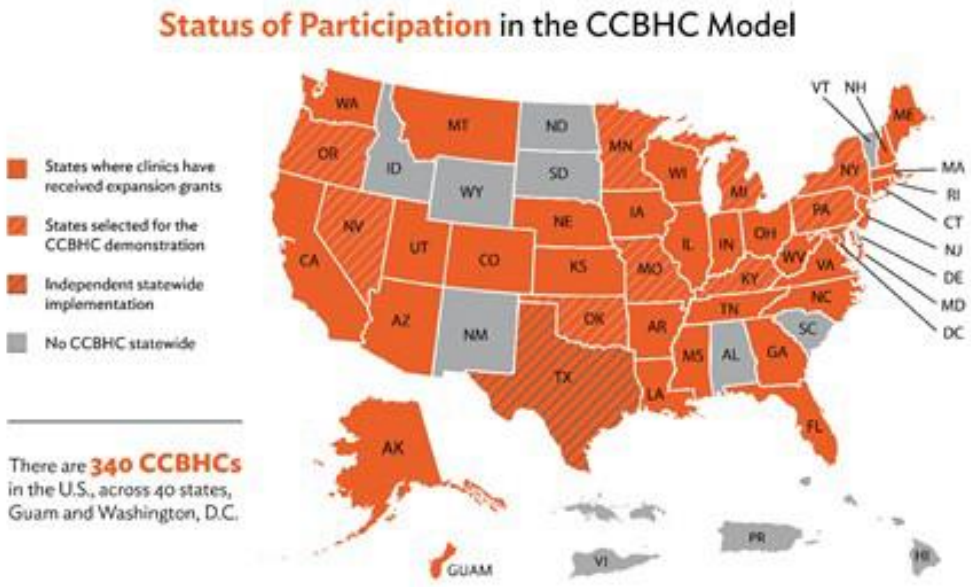


Future of BH: Workforce, CCBHC

Certified Community Behavioral Health Clinic (CCBHCs) must meet stringent criteria related to timeliness of access, care coordination, quality reporting, staffing and scope of services. In return, they receive Medicaid payment based on a prospective payment system (PPS). PPS in its many variations provides a critical financial foundation across the safety net.

Without changes to the current financing model, BHAs will likely face financial challenges. This could lead to the state losing these essential safety net providers. Specifically, HCA is working toward:

- Protecting and expanding workforce capacity to respond to growing pandemic and post-pandemic
- demand for mental health care, risk of suicide and substance use, and surging numbers of opioid related deaths
- Improving health outcomes for complex, highcost Medicaid populations that live with multiple chronic health conditions including behavioral health disorders
- Expanding and ensuring access to comprehensive, integrated behavioral health treatment and recovery supports which includes crisis response, integrated physical and BH care, residential treatment, etc.
- Creating a sustainable payment model tied to value and based on the cost of providing essential safety net services



Behavioral health integration savings

- Medicaid patients with behavioral health conditions account for nearly half of total Medicaid expenses.
- Costs are 60-75% higher compared with people with NO behavioral health condition.
- Milliman (our actuary) reports ~5% savings achievable over time through:
  - Improvements of co-occurring chronic physical conditions
  - Fewer ER visits and shorter inpatient stays

Figure 9: Health Care Spending Relative to the Washington State Gross Domestic Product, 2014-2019 (Current Dollars)

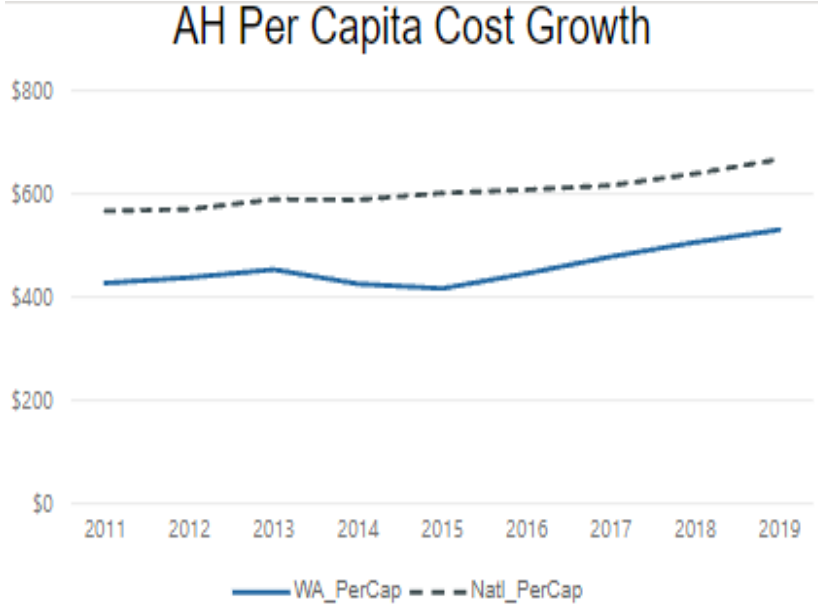
	WA State-Purchased Health Care Annual Spending (Medicaid and PEBB)		WA State Health Care Average Monthly Eligible Members (Medicaid and PEBB)		WA State GDP		State Purchased Hea Care Spending as Percentage of State G	
2014	$9,315,362,455		1,801,946		$442,201,300,000		2.11%	
2015	$10,169,822,206	9% Change	2,002,550	11% Change	$470,329,300,000	6% Change	2.16%	3% Change
2016	$11,203,779,829	10% Change	2,068,114	3% Change	$491,358,200,000	4% Change	2.28%	5% Change
2017	$12,012,782,916	7% Change	2,077,690	0% Change	$524,814,600,000	7% Change	2.29%	0% Change
2018	$12,466,265,652	4% Change	2,043,530	-2% Change	$565,831,000,000	8% Change	2.20%	-4% Change
2019	$12,884,935,557	3% Change	2,010153	-2% Change	$599,607,700,000	6% Change	2.15%	-2% Change

To see additional information on Medicaid and public employee spending as well as graphs of spending over time, go to **www.WACommunityCheckup.org/Highlights/** and select Health Care Spending in Washington State.

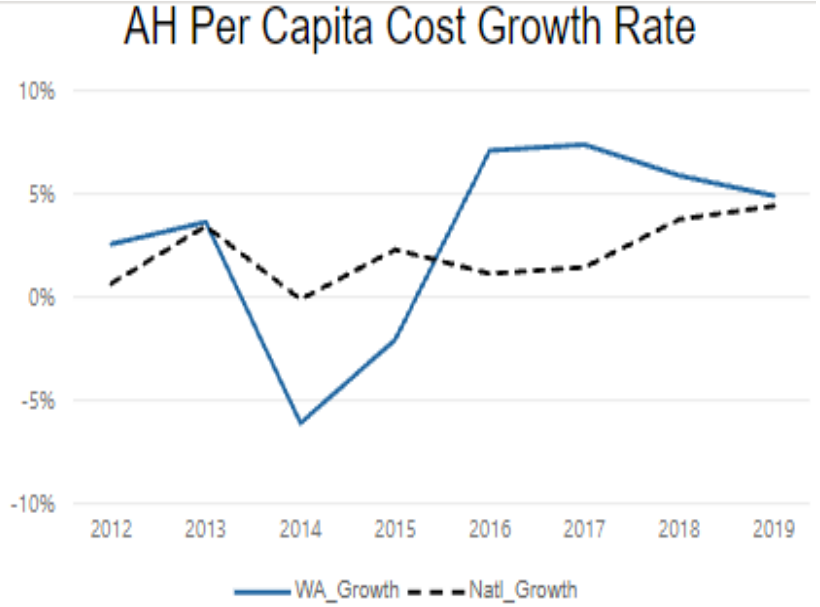
Medicaid costs have remained low compared to State GDP

MC Helps Control Growth in Spending

WA Per Cap has remained lower than national average – pharmacy costs are a major driver – but hard to compare due to new program adds



Year	AH Growth	AH PerCap	Nat Growth	Nat PerCap
2011		$425		$565
2012	2.5%	$436	0.6%	$568
2013	3.6%	$451	3.4%	$587
2014	-6.2%	$423	-0.2%	$586
2015	-2.1%	$414	2.2%	$599
2016	7.0%	$444	1.1%	$606
2017	7.3%	$476	1.4%	$614
2018	5.8%	$504	3.7%	$637
2019	4.8%	$528	4.4%	$665



Washington State Health Care Authority

Cost Centers and Service Categories

Inpatient (IP) Hospital

- IP Medical
- IP Newborn
- Maternity
- Mental Health / Substance Abuse
- Other IP

Outpatient (OP) Hospital

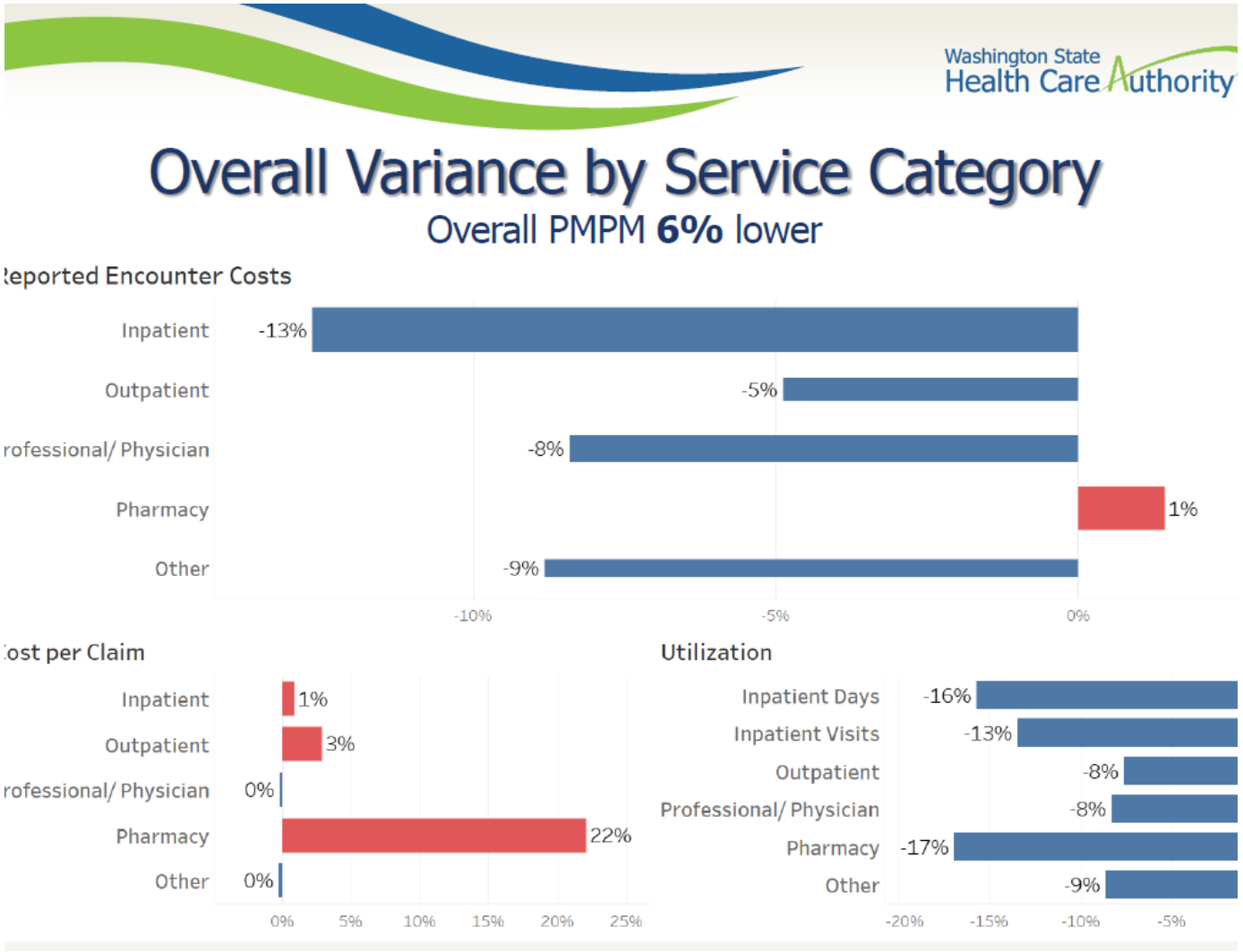
- Behavioral Health
- Drugs
- Emergency Room
- Radiology/Labs
- Surgery
- Other OP

Physician/Professional

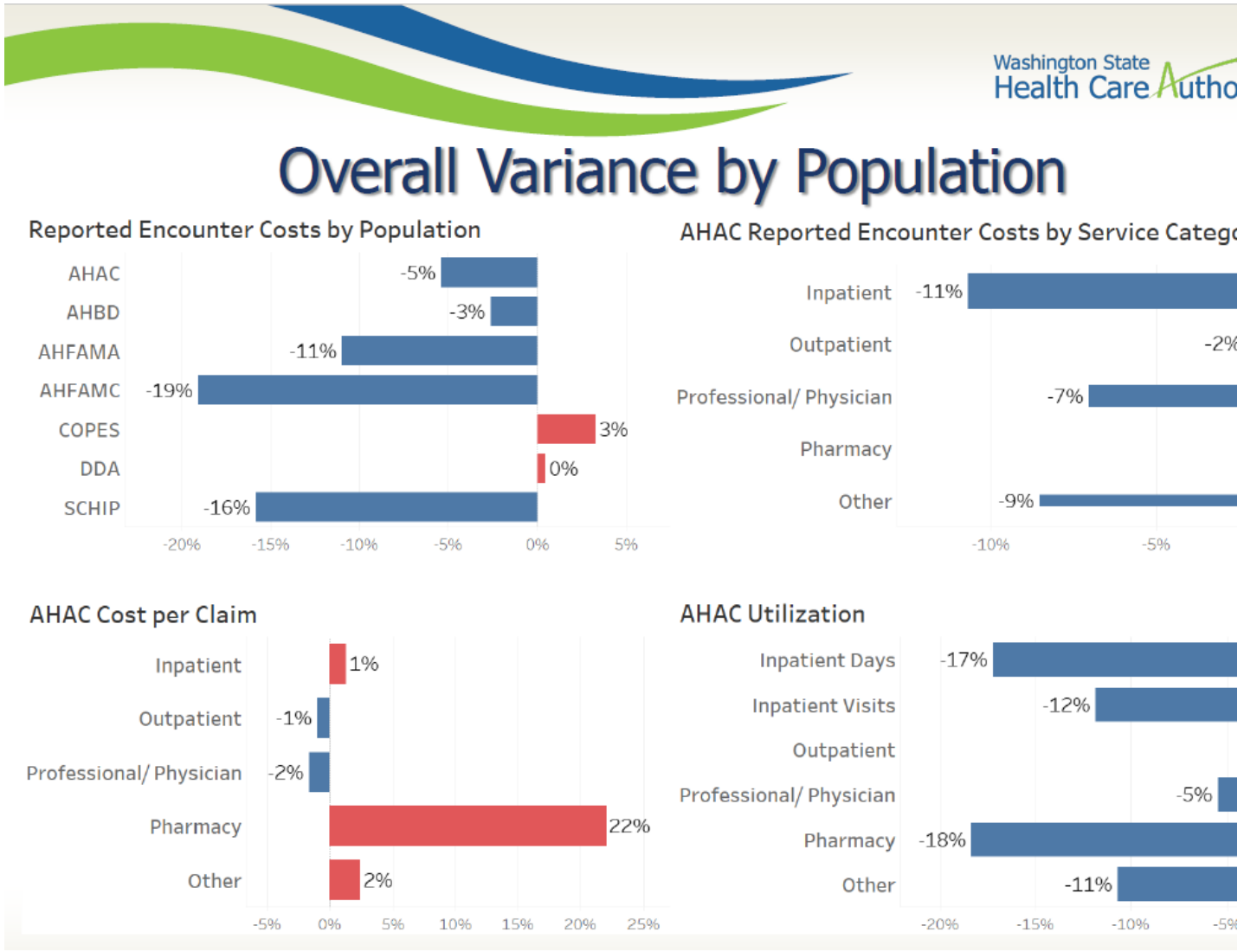
- ER Visits
- Hospital Visits
- Immunizations
- Inpatient Delivery (Cesarean)
- Inpatient Delivery (Normal)
- Maternity (Non-delivery)
- Office Visits
- Pathology
- Radiology
- Surgery (IP/OP)
- Surgery (IP/OP) Anesthesia
- Other Professional Services

Service utilization and costs (-6%) decreasing during Covid.

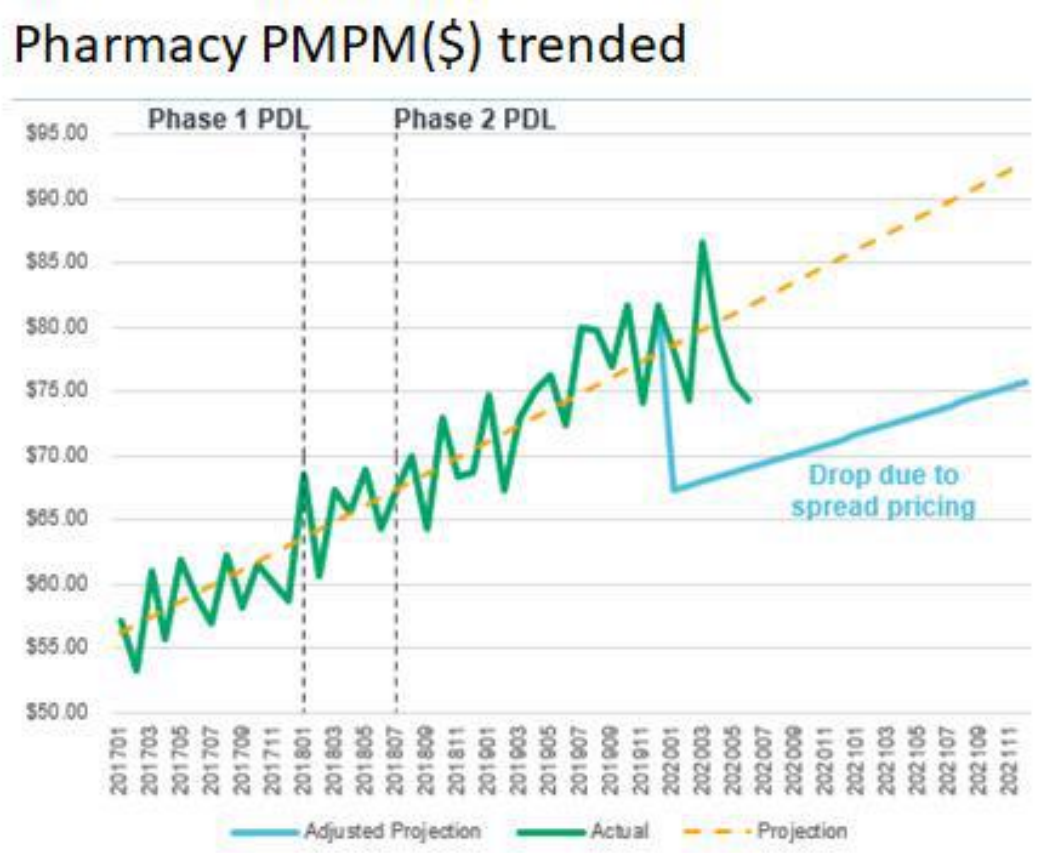
Pharmacy utilization also down (-17%) but script costs increased 22% for an overall 1% increase



Utilization decrease consistent across all sub-population



Rx costs: innovation possible in managed care



- **Pharmacy Costs and PBM contracts (5.11 and 6.23)**
- Apple Health-Prescription Drug List (PDL).
- Prohibition against ‘spread pricing’ agreements with their Pharmacy Benefit Managers (PBM)s. This requires the contractors’ PBMs to charge only what they paid to pharmacies for dispensing.
- Our actuary, Milliman, reports these savings as “significant cost decreases for generic drugs (54.2% factor achieves a 45.8% cost decrease) and marginal cost decreases in brand and specialty drugs (99% factor achieves a 1% cost decrease)”. These costs showed a significant trended drop in the PMPM, that resulted in a significant estimated more than $100M cost avoidance.
- Significant oversight of the MCO contracts required, including review of compensation exhibits between the MCO and their PBM.
- High-cost drugs can be carved out and excluded from the contracts. These drugs are used to treat rare diseases and are not likely to be equally distributed across the contractors. The identified drugs are considered fee-for-service and will be paid by HCA. The list of drugs may be found in Section 17.4.3.16.5 Table 1.

year	Drug Class	MCO Scripts/1000	All Other Scripts/1000	MCO Days/Script	All Other Days/Script	MCO Cost/Day
Total		**8,895.7**	**8,804.9**	**29.0**	**30.3**	**$3.43**
2021	**Total**	**8,895.7**	**8,804.9**	**29.0**	**30.3**	**$3.43**
	CYTOKINE AND CAM ANTAGONISTS	22.0	20.6	29.8	29.8	$238.99
	ANTIDIABETICS	398.2	442.0	38.0	41.1	$7.92
	ASTHMA AND COPD AGENTS	473.3	481.8	27.3	27.6	$4.82
	ANTIPSYCHOTICS / ANTIMANIC AGENTS	285.4	333.8	30.0	29.2	$7.21
	ANTIVIRALS	88.9	102.7	23.2	24.6	$24.52
	ALL OTHER (GROUPED FOR DISPLAY)	1,608.4	1,570.1	23.4	25.9	$1.24
	SUBSTANCE USE DISORDER	186.6	191.1	17.0	16.7	$13.95
	ADHD / ANTI-NARCOLEPSY	331.0	221.6	29.4	29.8	$3.91
	ONCOLOGY AGENTS	16.4	15.3	27.8	30.0	$71.82
	DRUG CLASS DOES NOT APPEAR ON AHPDL	354.4	347.6	26.9	25.7	$3.25
	RESPIRATORY AGENTS	1.8	1.1	30.1	29.0	$492.95
	ANTICONVULSANTS	556.1	527.6	28.6	31.3	$1.71
	ENDOCRINE AND METABOLIC AGENTS	309.2	234.4	29.6	39.8	$2.47
	MULTIPLE SCLEROSIS AGENTS	3.2	2.9	29.4	29.5	$203.12
	ANTICOAGULANTS	47.5	48.1	28.2	34.1	$10.86
	[illegible] HYPERTENSION AGENTS	1.2	1.6	29.5	30.1	$351.99
	[illegible]	406.8	387.6	10.7	10.7	$2.45
	CONTRACEPTIVES	165.4	127.2	56.5	53.8	$1.08
	[illegible]	188.3	179.8	23.9	23.2	$2.20
	ANALGESICS	749.3	773.9	17.3	18.2	$0.72
	GASTROINTESTINAL AGENTS	167.6	175.3	22.2	22.6	$2.49
	ANTIDEPRESSANTS	924.1	894.5	39.3	37.5	$0.24
	ANTIHYPERTENSIVES	614.0	706.5	46.2	46.4	$0.30
	ATOPIC DERMATITIS AGENTS	4.4	3.8	27.8	27.0	$67.83
	DIGESTIVE AIDS	4.3	4.2	28.7	29.7	$55.29
	OPHTHALMIC AGENTS	82.9	89.0	21.1	22.5	$3.93

Top Rx

- By utilization and cost

Actuarial soundness: *a blessing and a curse – but really a value for the health system*

Actuarial Standard of Practice 49

Definition of actuarial soundness

Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

Managed care rates allow for innovation

Managed Care Efficiencies

States seek to purchase value from their managed care organizations

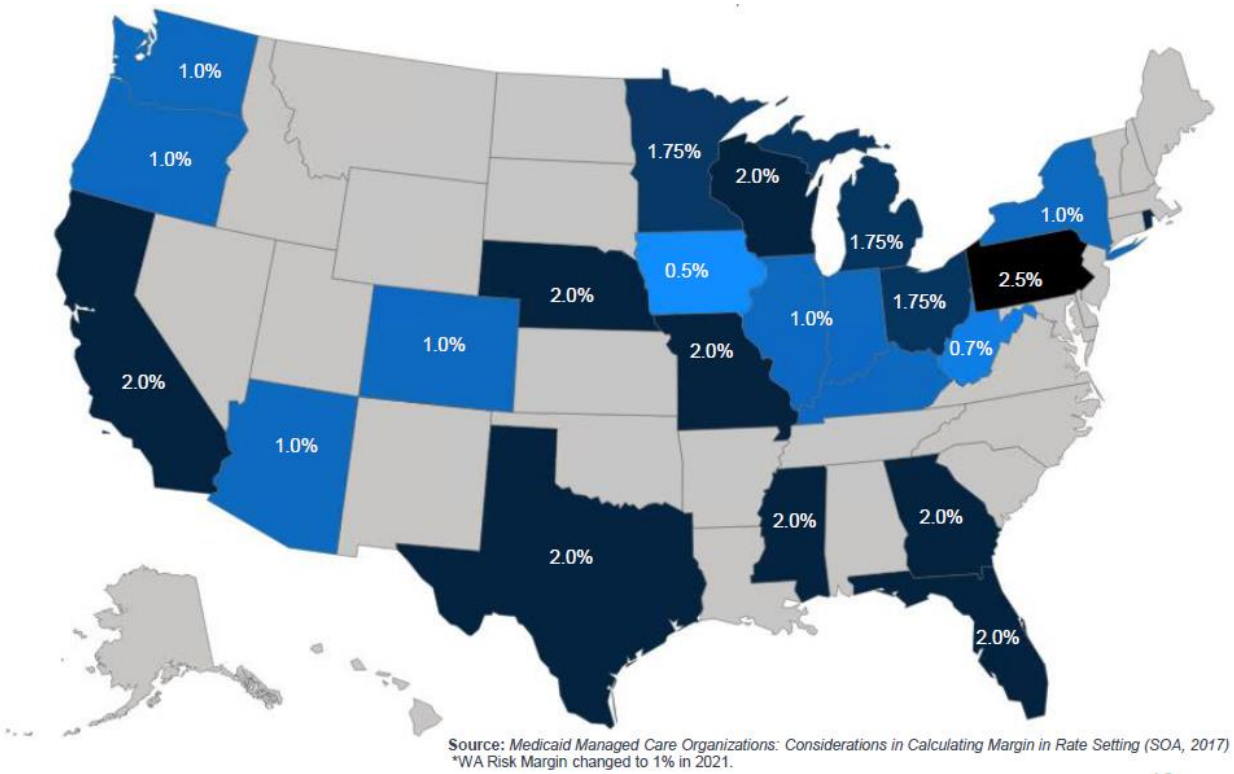
- Capitation rates are permitted to include adjustments for assumed cost savings due to managed care plan activities
- This enables a state to prospectively recognize the benefit of managed care activities, and include savings in budget and forecasting activities.
- The onus is on managed care organizations to achieve the savings reflected in the capitation rates.

Managed care flexibilities include In-lieu of services, value-added benefits and quality improvement investments

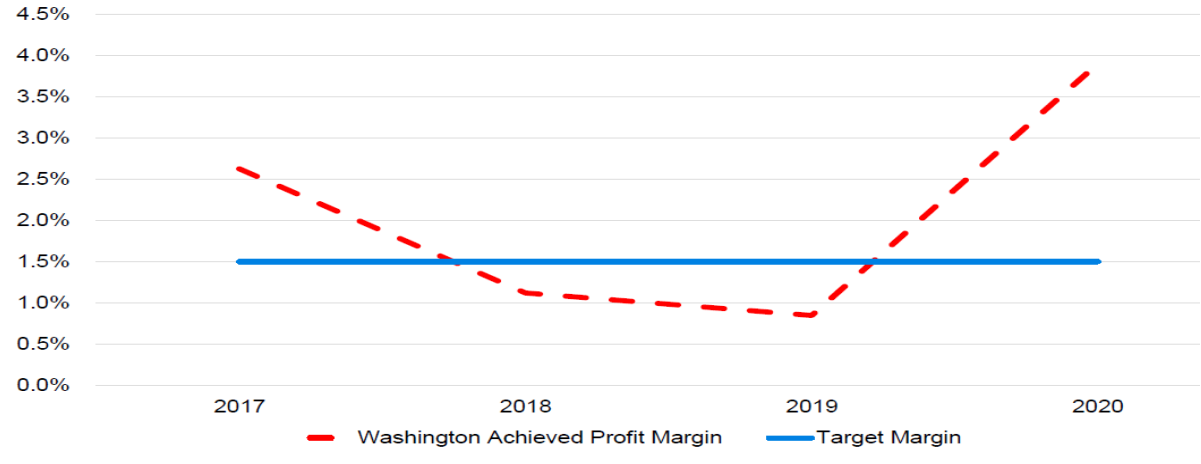
BENEFIT CATEGORY AND DESCRIPTION	FEDERAL RULES	IMPLICATION PERMISSIBLE TO INCLUDE IN MLR	BENEFIT EXAMPLE
In-Lieu-Of Services: Services or settings that are "in lieu" of services or settings covered under the State plan, are determined by the State to be a medically appropriate and cost-effective substitute, and are defined in the MCO contract.	**42 CFR 438.8 Medical Loss Ratio** Definition of incurred claims includes direct claims paid to providers for services covered under the contract AND services the MCOs voluntarily agree to provide meeting the requirements of 438.3(e). **42 CFR 438.3(e)(2)** Permits MCOs to offer services or settings that are in lieu of services or settings under the State plan.	Yes. A benefit that is paid to a provider through a direct claim **can** be included in incurred claims and in the numerator of the MLR. The utilization and actual costs of in-lieu-of-services **can** be included when determining MCO capitation payment rates.	Short term inpatient stays in institution for mental disease (IMD) Medically-tailored meals as substitute for home health aide visit Home visits and parenting classes for pregnant mothers as a substitute for prenatal visits
Value-Added Services: Clinical services or settings reimbursed through direct claims process that MCOs voluntarily agree to cover but are not covered under the State plan or are in excess of the amount, duration, or scope of those listed in the contract.	**42 CFR 438.8 Medical Loss Ratio** Definition of incurred claims includes direct claims paid to providers for services covered under the contract AND services the MCOs voluntarily agree to provide meeting the requirements of 438.3(e). **42 CFR 438.3(e)(1)** Permits MCOs to voluntarily offer services in addition to those covered under the State plan.	Yes. A benefit that is paid to a provider through a direct claim **can** be included in incurred claims and in the numerator of the MLR. The costs of value-added services **cannot** be included when determining the capitation payment rates.	Adult vision/eyeglasses Additional non-emergency transportation rides Sports physicals Shower grab bar Respite care Acupuncture Chiropractic visits Durable medical equipment
Activities That Improve Healthcare Quality: Activities that improve health outcomes, prevent hospital admissions, improve patient safety, and promote health and wellness as defined consistent with CMS guidance. Also referred to as Health Care Quality Improvement (HCQI) Activities.	**42 CFR 438.8 Medical Loss Ratio** Numerator of the MLR includes MCO expenditures for HCQI activities that meet the requirements of 45 CFR 158.150(b) and are not excluded under 45 CFR 158.150(c). **45 CFR 158.150(b) HCQI Requirements** Outlines the requirements to be counted as HCQI activities (see Appendix for full details below).	Yes. MCOs **can** include non-benefit services that are not provided through direct claims when they meet the definitions of 45 CFR 158.150(b). States can use the guidelines in 45 CFR 158.150 as a litmus test for whether an enhanced benefit meets the requirements of an HCQI activity. Some states choose to place overall dollar limits on member incentives for healthy behaviors.	Tobacco cessation programs Weight Watchers Gift cards as rewards for healthy behaviors Home delivered meals Stroller, car seat, diapers, playpen as rewards for prenatal care/healthy behaviors Health promotion activities (cooking class) Housing assistance

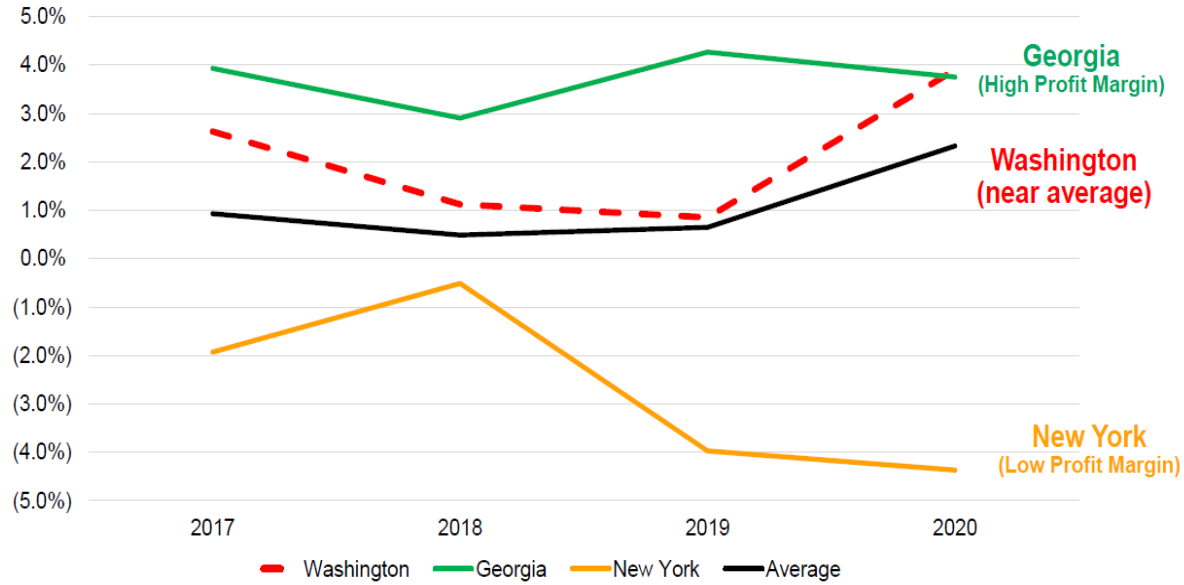
Risk margin

- Managed Care offers a flexible approach
- Covid dynamics create a profit, even windfall, but we can adjust accordingly



Source: *Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting (SOA, 2017)*
*WA Risk Margin changed to 1% in 2021.





Flexible gain share options, ensures premium stability by limiting risks and placing protections on rate payments

Previous Gain Share

- ✓ HCA Risk
- ✓ MCO Risk

Max MCO Gain: 4%

Max MCO Loss: none

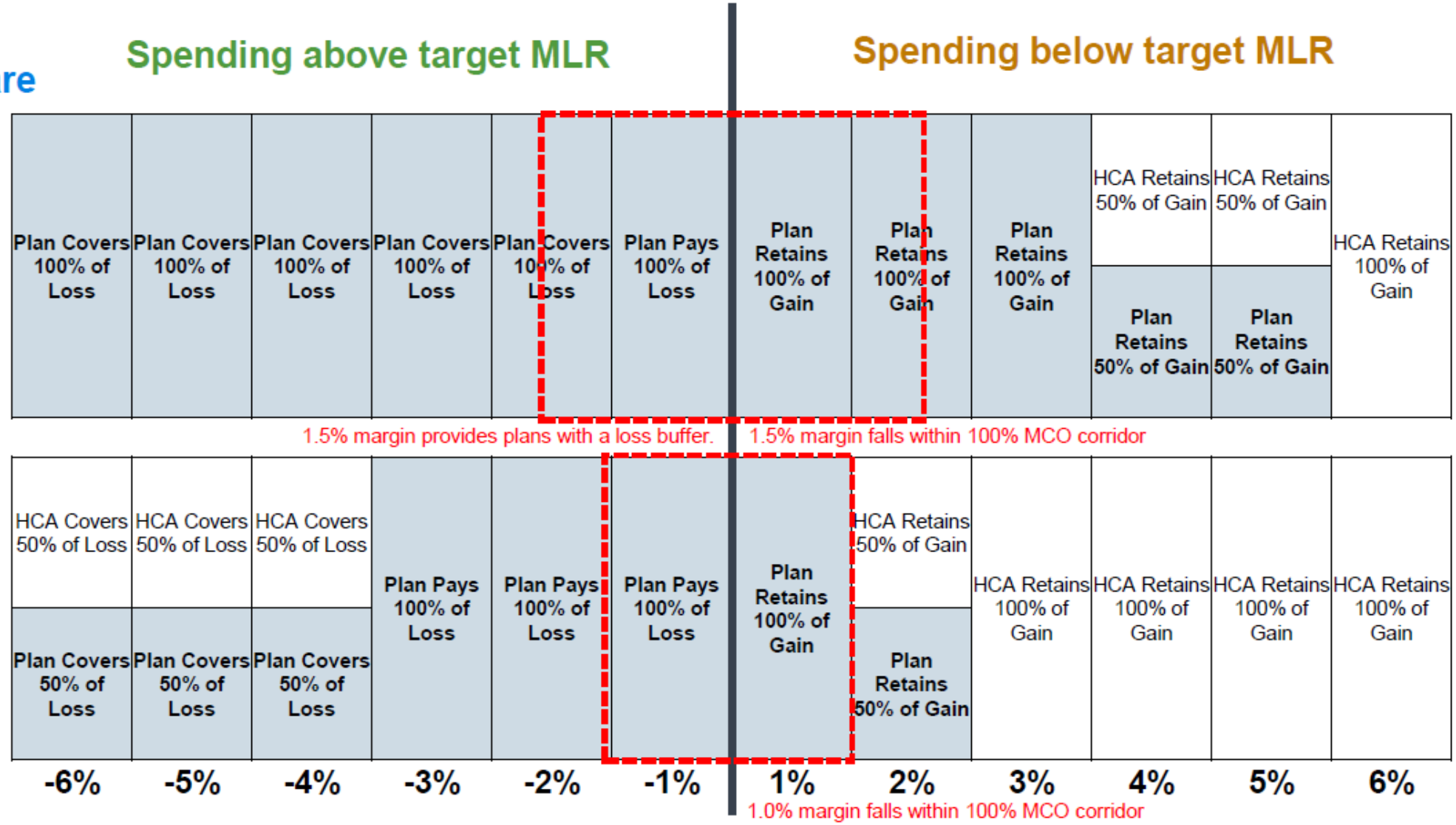
Max HCA Payments = Capitation

Asymmetrical 2-Sided Corridor

Max MCO Gain: 1.5%

Max MCO Loss: 100% of loss up to 3%;50% of all loss after *Introduces additional HCA risk, but is partially offset by immediate savings from margin*

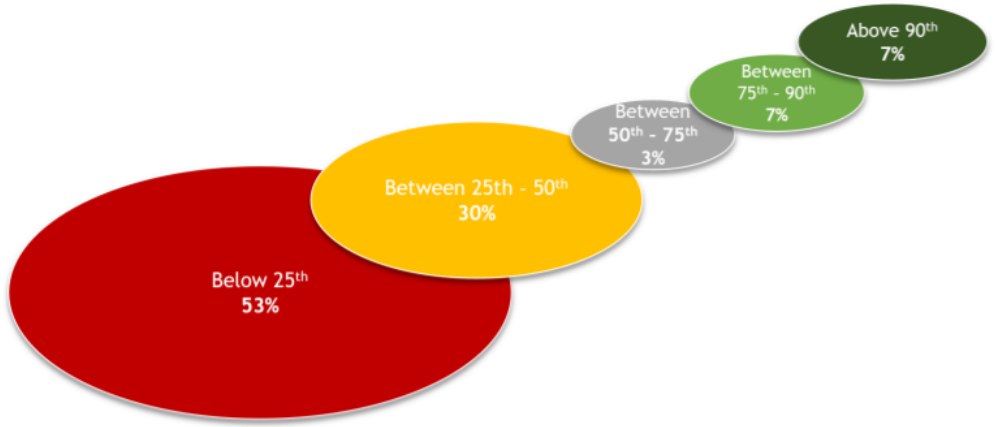
Max HCA Payments = Capitation + 50% MCO Losses over 3%



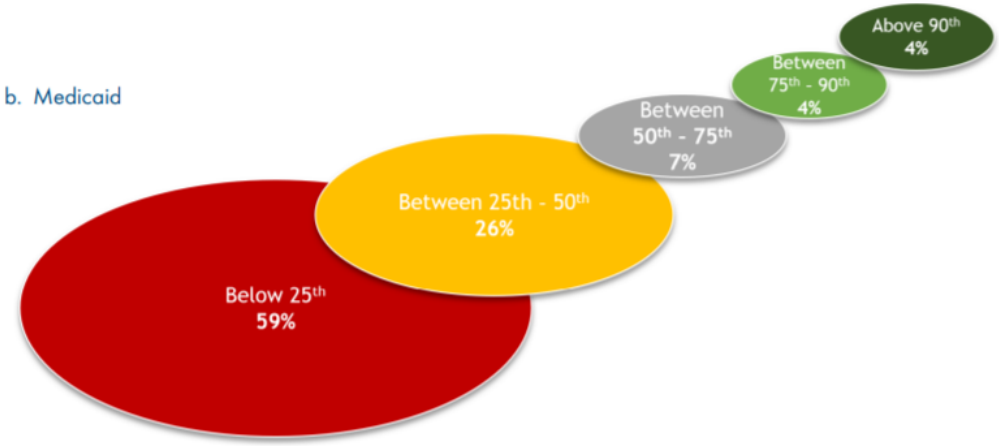
Managed care competes on quality

Figure 1: Summary of Washington State Performance Compared With NCQA HEDIS National Benchmarks

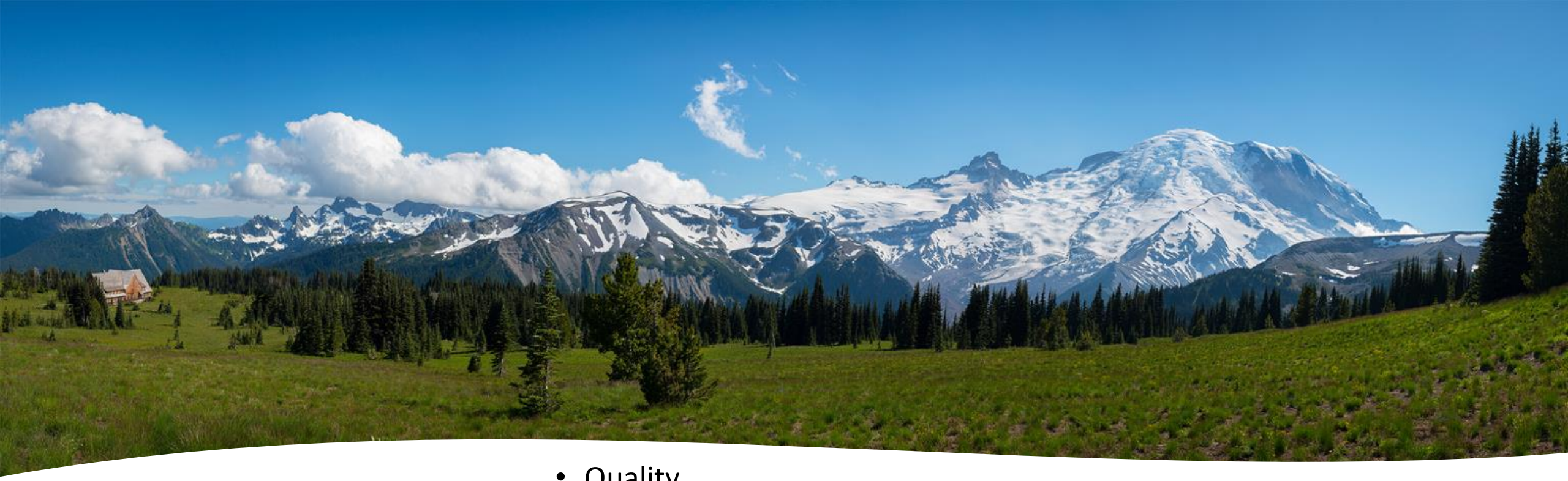
a. Commercial



b. Medicaid



https://www.wacommunitycheckup.org/reports/2021-community-checkup-report/#Comparing Washington State With National Benchmarks



Quality is key – managed care offers much

- Quality
  - Medical Collaboratives (Bree)
  - Health Technology Assessments
  - Pharmacy and Therapeutics committee, DUR, PDL (and note re rebates)
- Plan report cards and star ratings using HEDIS and CHAPS
  - VBP metrics – 2% withhold
    - HEDIS
    - VBP contracts
  - NCQA Accreditation
  - TEAMonitoring
- Note on customer rating
- Health equity and health related social factors

How we ensure plan accountability for quality

- All HCA Medicaid managed care plans must be:
  - Accredited by National Committee for Quality Assurance (NCQA)
    - Accreditation contingent on HEDIS* measure (46) performance that evaluates quality, access, and timeliness of care
  - Independently reviewed annually by contracted External Quality Review Organization – Qualis Health (per Code of Federal Regulations)
  - Evaluated annually by TEAMonitor, which includes HCA clinical and program staff
    - Includes review of managed care plan compliance with federal laws and contract requirements
    - CMS acknowledges is one of best approaches in nation for monitoring managed care plan performance

*The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely-used performance management tool.

NCQA Plan Accreditation Star rating (2021, every three years)

AMERIGROUP Washington, Inc. *Special Project: None* *Special Area: None*	★★★☆☆	Accredited	Medicaid HMO	WA	Multicultural Health Care Electronic Clinical Data
Community Health Plan of Washington *Special Project: None* *Special Area: None*	★★★★☆	Accredited	Medicaid HMO	WA	Multicultural Health Care Electronic Clinical Data
Coordinated Care of Washington, Inc. *Special Project: None* *Special Area: None*	★★★½☆	Accredited	Medicaid HMO	WA	Electronic Clinical Data
Molina Healthcare of Washington, Inc. *Special Project: None* *Special Area: None*	★★★★☆	Accredited	Medicaid HMO	WA	Multicultural Health Care Electronic Clinical Data
UnitedHealthcare of Washington, Inc. dba UnitedHealthcare Community Plan (WA) *Special Project: None*	★★★½☆	Accredited	Medicaid HMO	WA	Electronic Clinical Data

https://reportcards.ncqa.org/health-plans

WA State report card (every year)

2021 Washington Apple Health Plan Report Card

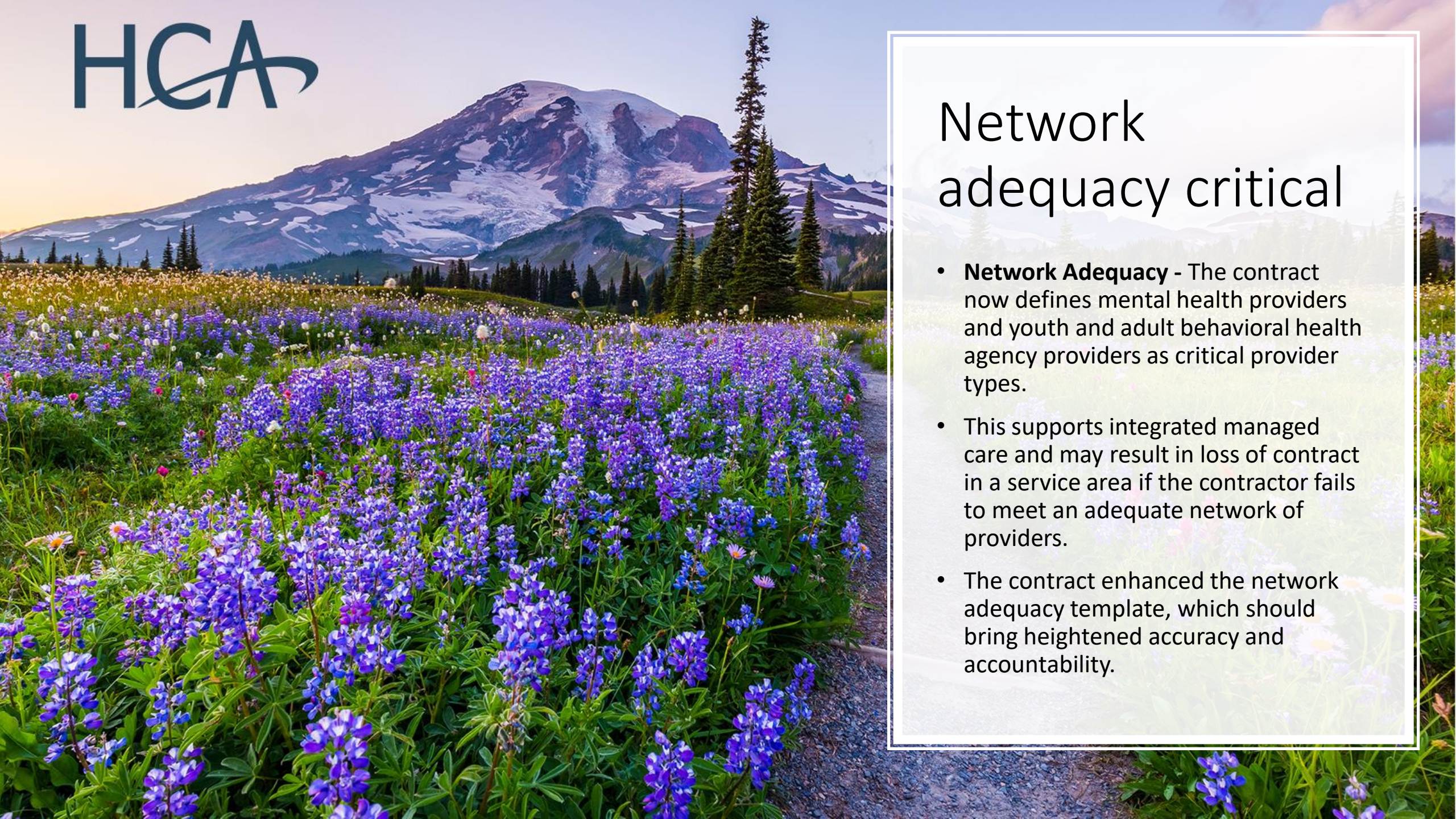
This report card shows how Washington Apple Health plans compare to each other in key performance areas. You can use this report card to help guide your selection of a plan that works best for you.

KEY: Performance compared to all Apple Health plans — ABOVE AVERAGE ★★★ AVERAGE ★★☆ BELOW AVERAGE ★☆☆

Performance Areas	Amerigroup Washington	Coordinated Care of Washington	Community Health Plan of Washington	Molina Healthcare of Washington	UnitedHealthcare Community Plan
Getting Care	★☆☆	★☆☆	★☆☆	★★☆	★★☆
Keeping Kids Healthy	★☆☆	★★★	★★☆	★★☆	★☆☆
Keeping Women and Mothers Healthy	★☆☆	★★☆	★★☆	★★☆	★★☆
Preventing and Managing Illness	★☆☆	★☆☆	★★☆	★★☆	★★☆
Ensuring Appropriate Care	★☆☆	★★★	★★★	★☆☆	★☆☆
Satisfaction with Care Provided to Adults	★★☆	★★☆	★★☆	★★☆	★★☆
Satisfaction with Plan for Adults	★★☆	★★☆	★★☆	★★☆	★★☆

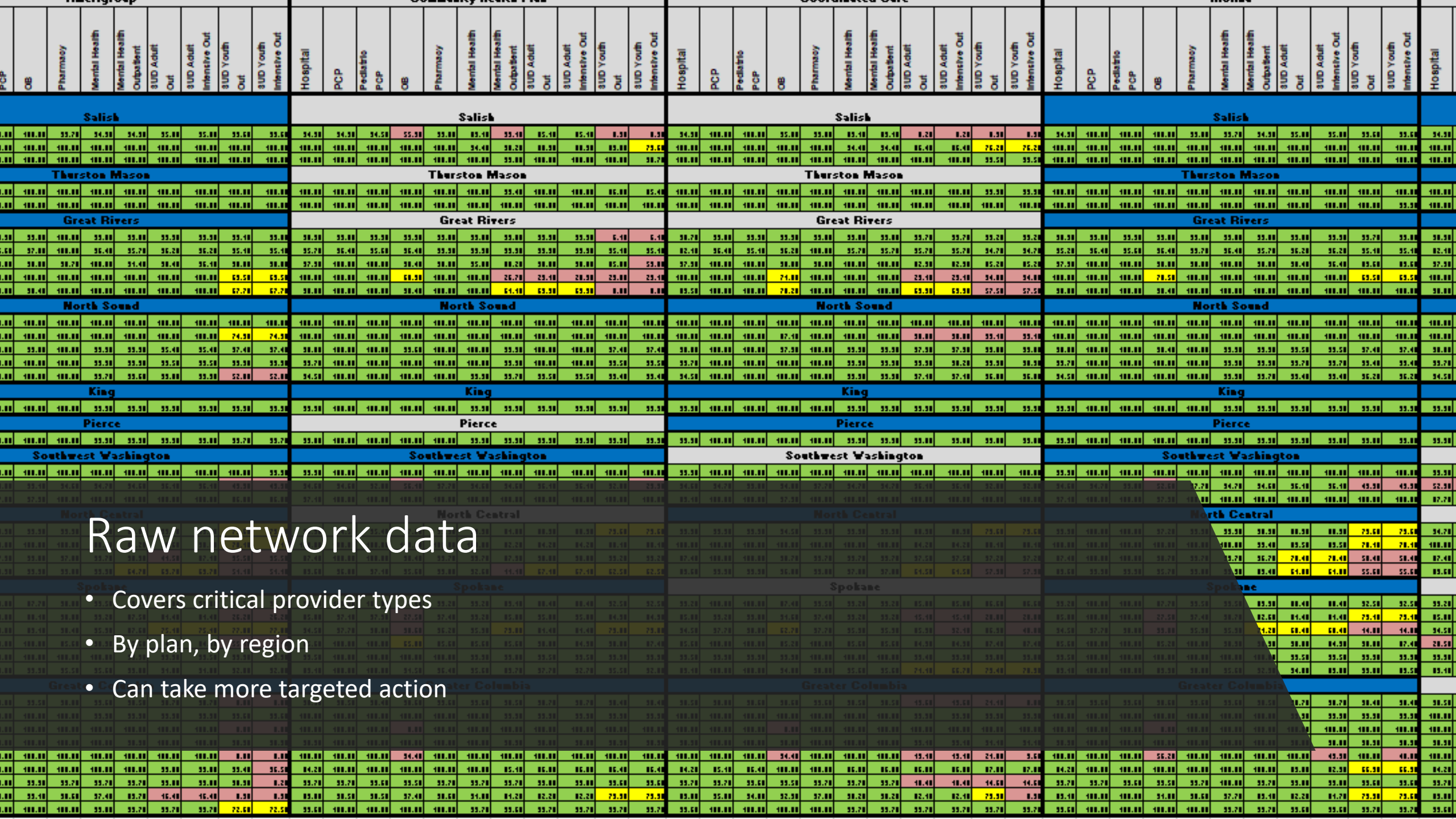
https://www.hca.wa.gov/about-hca/apple-health-medicaid-and-managed-care-reports

- Customer satisfaction is high with managed care



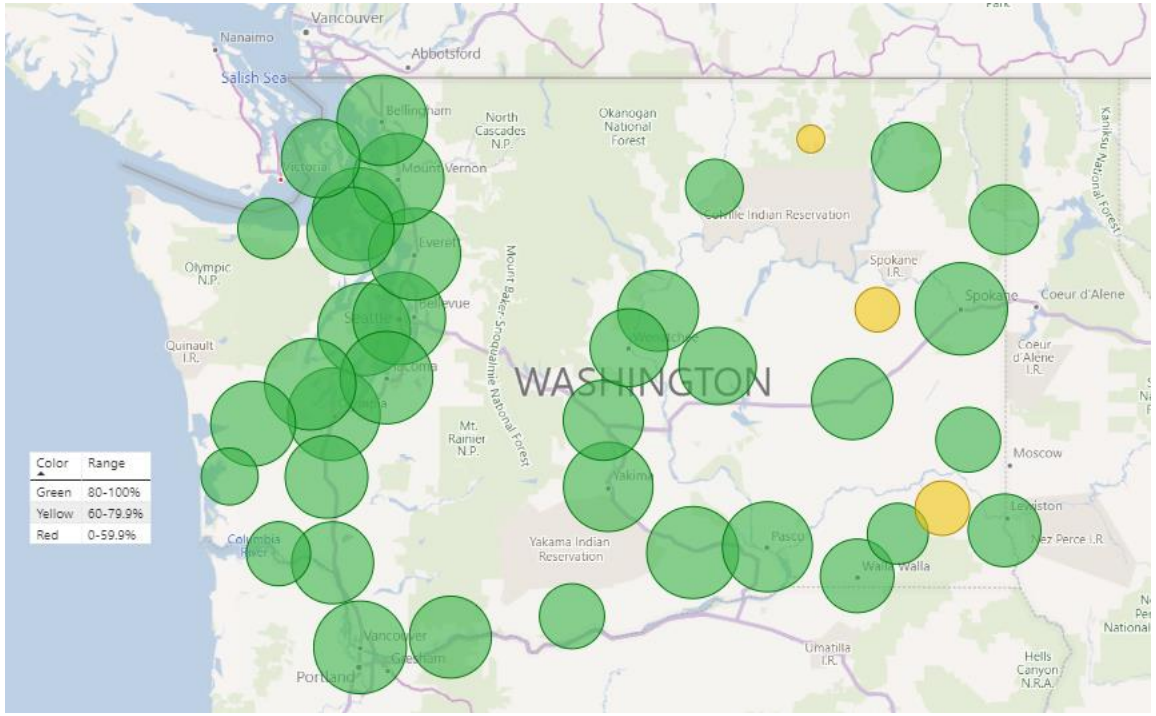
Network adequacy critical

- **Network Adequacy -** The contract now defines mental health providers and youth and adult behavioral health agency providers as critical provider types.
- This supports integrated managed care and may result in loss of contract in a service area if the contractor fails to meet an adequate network of providers.
- The contract enhanced the network adequacy template, which should bring heightened accuracy and accountability.

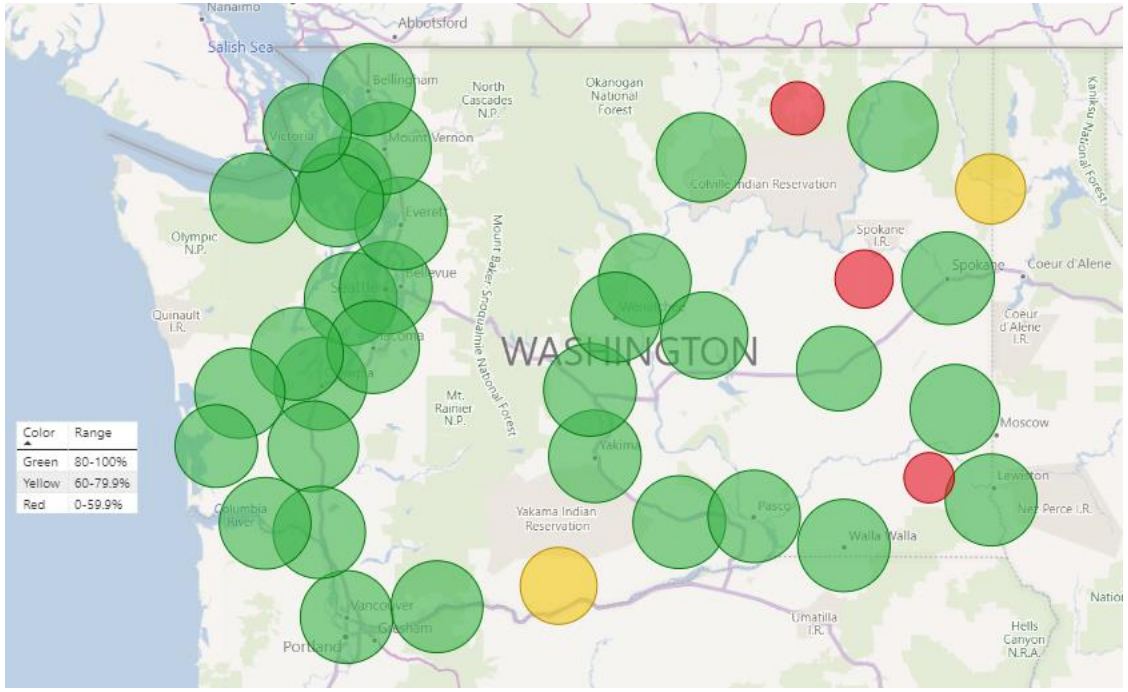

Raw network data
• Covers critical provider types
• By plan, by region
• Can take more targeted action

Network adequacy

All categories:

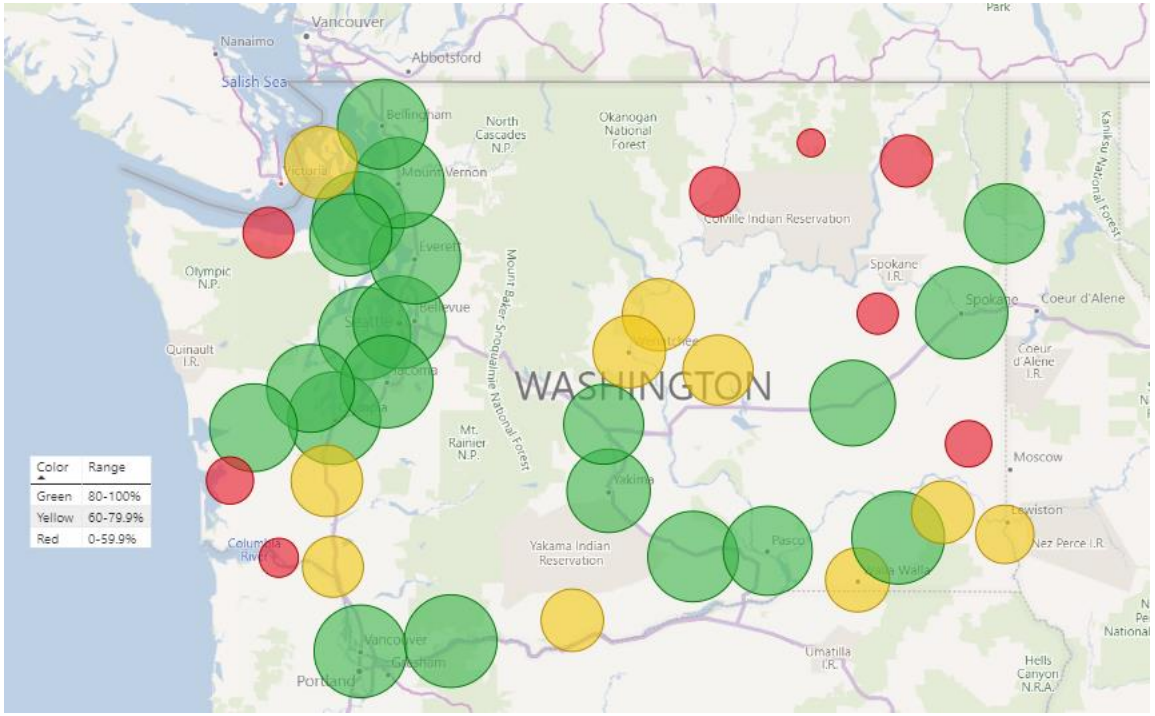


Delivery hospitals:

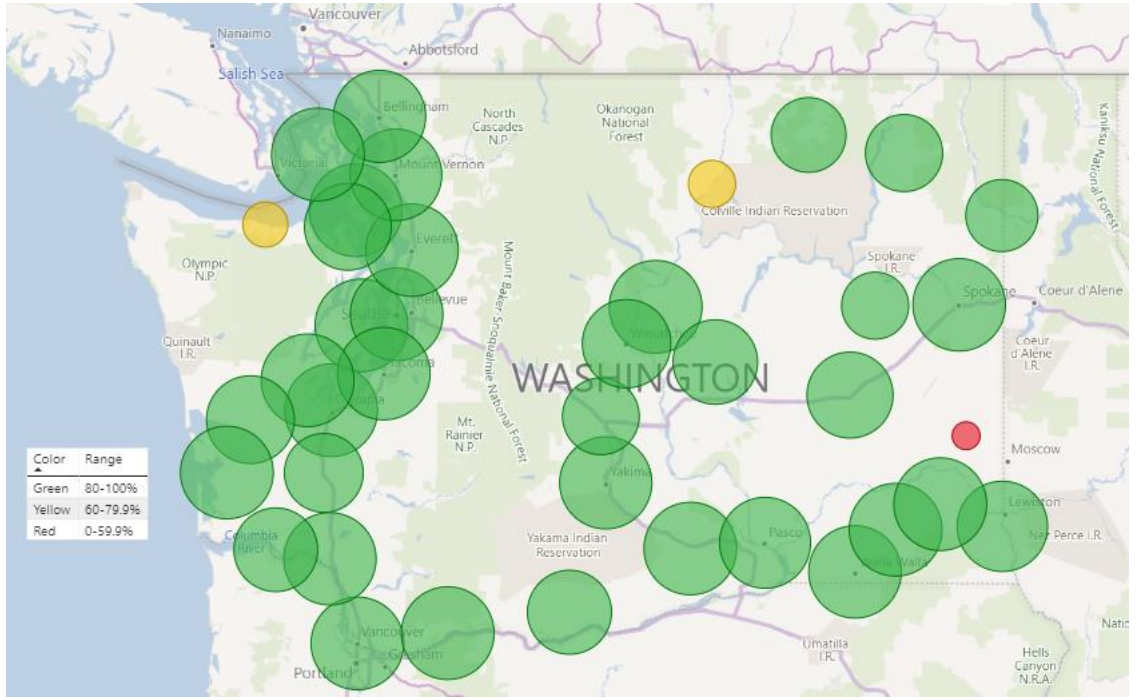


Network adequacy – behavioral health

Youth SUD outpatient:



Mental Health outpatient:



Rural health access and stability critical

- CMS Community Health Access and Rural Transformation (CHART) Model
  - In fall of 2021, Washington State began working on a seven-year, $5 million CHART Model, designed to help transform the health care system in rural communities.
    - It will test whether aligned financial incentives, increased operational flexibility, and robust technical support change rural health care delivery system redesign.
    - Through this model, the Health Care Authority (HCA), North Central Accountable Community of Health, participating hospitals, and other partners will work together to:
    - Increase access to equitable, coordinated, high-quality whole-person care.
    - Increase population health by building healthier communities and connecting local and regional partners.
    - Bend the cost curve across all payers.
  - Rate enhancements – Critical Access Hospitals; Rural Health Clinics; Sole Community Hospitals
  - Workforce challenges

Opportunities to improve health-related social factors for managed care

- Access to technology tools and internet services need to be classified as a social determinant of health.
- Funding of programs to support members and providers like our waiver services.
- The provider workforce needs good educational opportunities that help support.
- Providers need interoperable mechanisms to support the coordination and exchange of data across care settings

Medicaid transformation - 1115 Waiver renewal and future of managed care

- **Many lessons that are replicable.**
- **Waiver elements**: Family Caregiver supports; Supportive employment and Housing; Accountable Community of Health (ACHs) to develop community capacity, with focus on behavioral health integration, opioid use disorder treatment.
- Since 2018, more than 20,000 individuals have been enrolled in the Foundational Community Supports (FCS) program.
- Relative to a matched comparison group, statistically significant findings include:
  - Employment rates increased
  - FCS Supportive Housing participants receiving long-term care services accessed in-home services at a higher rate
  - FCS Supportive Housing participants not engaged with the long-term care system were connected to state and federally funded housing projects at a higher rate.
- Washington's 1115 waiver includes SUD and Mental Health IMD waivers.

Working with community—Health equity and health-related social factors and Accountable Communities of Health (ACHs)—Must work closely with MCOs

- Washington's ACHs are regional, community-oriented organizations focused on equity.
- Our goal is to be more focused on equity as a strategy and outcome, rather than a "philosophy" (as it was framed in the current waiver). We're building on the great examples we have and new opportunities:
  - One ACH released a Health Equity RFP for awardees to build community capacity to address persistent inequities, worsened by the pandemic. Awardees helped to implement strategies to facilitate effective implementation and the showcasing of evidence based best practices and success stories.
  - Another ACH released a report from the Consumer Voice Listening Project, where 34 grassroots and CBOs surveyed 2,860 individuals from over 40 different communities on health conditions, barriers to accessing care, patient experience, and how health care experiences could be improved.
  - During the pandemic, ACHs developed an equitable, accessible vaccination campaigns.

Life Stages Framework for Waiver Renewal Strategies

Confirmed MTP Renewal Strategies Across the Life Stage Framework

Family Formation

- Expanding postpartum coverage

Childhood

- Ensuring continuous enrollment in coverage for children ages 0-6

Adolescence

- Discussion transitional age youth (I/DD/BH/Foster children)

Adulthood

- LTSS rental subsidies
- Coordinated Personal Care
- Guardianship
- Presumptive eligibility

Aging / Older Adulthood

- MAC and TSOA

- Exploring K12 BH service waivers for crisis care

- SUD IMD
- Mental Health IMD
- Criminal Legal System involved individuals / Re-entry

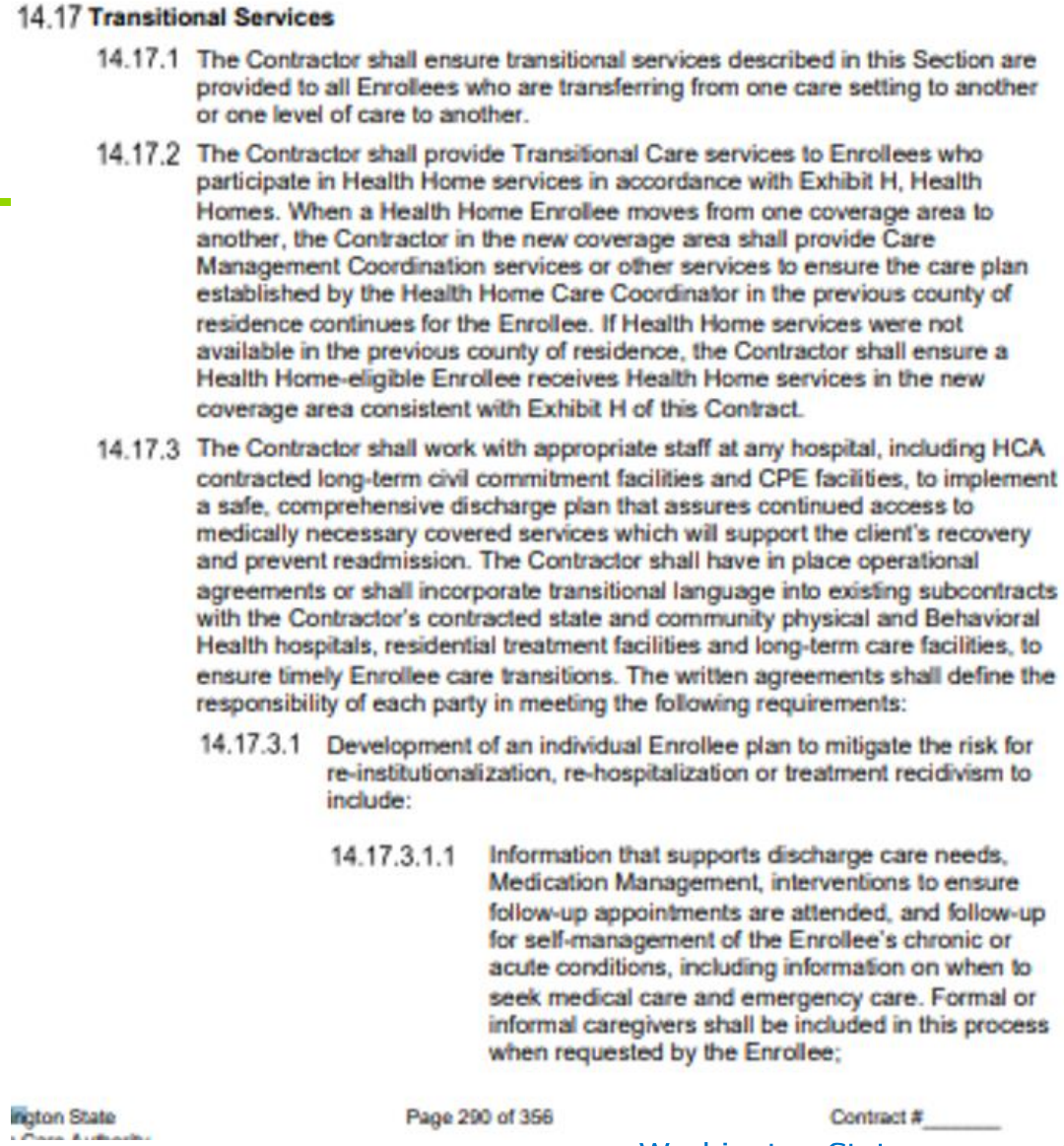
- **Accountable Communities of Health** (ACH) accelerator programs as community convenor with health equity focus
- Tribal (evolution of DSRIP program)
- Self-Attestation of AI/AN clients for 100% federal match
- Payment for community health aides, dental health aide therapists (DHATs), and behavioral health aides (to support AI/AN populations)
- Foundational Community Supports

Sources: World Health Organization, U.S. Health Resources and Services Administration, The Colorado Opportunity Project, 2015

A new viewpoint or framework for the future, highlighting the importance of inter-system connections – managed care key to success, but States must ensure the connection occurs, including considering waiver services

Plans help with care coordination and discharge planning

- Many complex cases – transitional age youth, I/DD, ITA etc.
- MCOs help across the board for Covid hospital discharge
- Can especially help with discharge planning from higher levels of care, and the required role that we make the MCOs play in that process.



14.17 **Transitional Services**

14.17.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another.

14.17.2 The Contractor shall provide Transitional Care services to Enrollees who participate in Health Home services in accordance with Exhibit H, Health Homes. When a Health Home Enrollee moves from one coverage area to another, the Contractor in the new coverage area shall provide Care Management Coordination services or other services to ensure the care plan established by the Health Home Care Coordinator in the previous county of residence continues for the Enrollee. If Health Home services were not available in the previous county of residence, the Contractor shall ensure a Health Home-eligible Enrollee receives Health Home services in the new coverage area consistent with Exhibit H of this Contract.

14.17.3 The Contractor shall work with appropriate staff at any hospital, including HCA contracted long-term civil commitment facilities and CPE facilities, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which will support the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Contractor's contracted state and community physical and Behavioral Health hospitals, residential treatment facilities and long-term care facilities, to ensure timely Enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

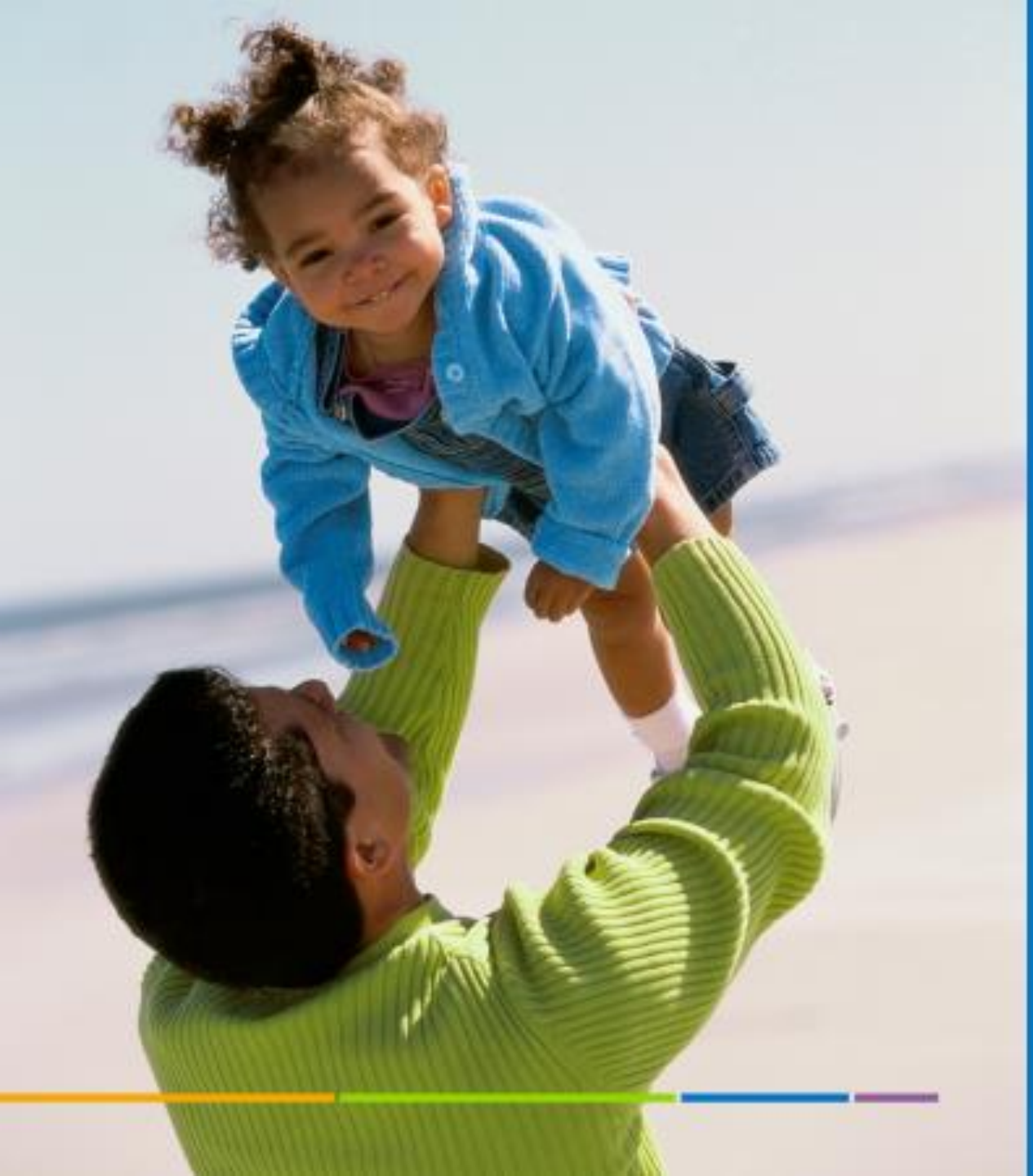
14.17.3.1 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

14.17.3.1.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee;

Washington State Health Care Authority

Framework for the future – Managed care Procurement Factors, a key tool for states

- 10 years since HCA last did a new full procurement. Legislature assumed substantial budget savings/cost avoidance, but savings not likely now because we know costs.
- In 2016, HCA required existing MCOs to re-bid for the physical/behavioral health integrated; HCA issued a bid for foster care; and a mini-bid in 2020 for plans to enter other regions in preparation for potential Covid impacts.
  - The RFP assessed plans by region throughout the state, different than prior procurements. Do regional contracts work?
- Need to define purpose, vision and goals, consider interdependencies



Questions?

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Washington State Health Care Authority