

Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences

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EXECUTIVE SUMMARY

To provide more integrated, coordinated care for its residents who are dually eligible for Medicare and Medicaid, Washington State is operating a demonstration under the Financial Alignment Initiative offered by the Centers for Medicare & Medicaid Services. This case study describes: (1) the demonstration's structure; (2) results achieved to date; and (3) insights on the demonstration's implementation from the state and other stakeholders.

- **Demonstration Structure:** The demonstration, which was launched in July 2013, uses a managed fee-for-service model based on Medicaid Health Homes. It does not change how enrollees' medical and behavioral health care or long-term services and supports are delivered, but instead uses health homes to better integrate care across these settings. Washington State contracts with Health Home Lead Entities that, in turn, contract with networks of Care Coordination Organizations (CCO), and together they provide the six required core health home services, including comprehensive care management and care coordination. The demonstration targets dually eligible beneficiaries having at least one chronic health condition and who are at risk for developing another condition and incurring significant medical costs.
- **Results to Date:** An external evaluation is documenting the demonstration's implementation and determining its impacts on outcomes. A recent report covering the time period July 1, 2013 through December 31, 2015 found that enrollees are satisfied with their health homes and care coordinators and feel they are achieving their goals.¹ In addition, the demonstration significantly reduced expensive institutional care (e.g., hospital inpatient and skilled nursing facility admissions and the probability of any long-stay nursing facility use); however, it increased rates of hospital readmission. Separate from the programmatic evaluation, CMS determined that Washington was eligible for retrospective performance payments based on Medicare savings and quality benchmarks. The Washington demonstration achieved an estimated \$34.9 million in Medicare savings its first 18 months, \$30.2 million in the next 12 months, and \$42.0 million in the 12-month period after that;² however, due to lags in Medicaid data availability, these figures do not include Medicaid savings or costs and will be updated when these data are available. As of November 2018, CMS has made three interim performance payments of \$11.6 million, \$10.7 million, and \$14.2 million to Washington State.³
- **Insights on Demonstration Design and Implementation:** Staff from Washington's Department of Social and Health Services and Health Care Authority, as well as Health Home Lead Entities and CCOs, shared insights on the demonstration's design and implementation including:

- **Engaging stakeholders is important to building support for integration activities.** A Health Home Advisory Team -- comprised of representatives from various stakeholder groups -- offered regular input to program design and lobbied for the demonstration when it was in jeopardy.
- **Targeting higher-risk groups offers greater potential to demonstrate results.** Based on the success of its prior chronic care management demonstrations, the state used its advanced data analytics systems to identify and target enrollment to dually eligible beneficiaries with the highest risk and highest costs.
- **Locating and engaging beneficiaries in care management is resource intensive.** Engaging enrollees was more difficult than many had anticipated and required CCOs to adjust their staffing models by hiring staff with expanded skill sets and creating dedicated outreach specialist positions.
- **Encouraging enrollee engagement may improve outcomes.** Health Action Plans (HAPs) promote person-centered planning and improve self-management skills by focusing on an enrollee's goals for his or her own health as well as the action steps needed to achieve those goals.
- **Structuring the health home payment can incent enrollee engagement and in-person care coordination.** Washington's one-time payment for initial enrollee outreach provides an incentive for CCOs to locate enrollees and engage them in their care, while tiered per member per month payments encourage intensive, in-person care coordination.
- **Securing financial support for long-term sustainability is a continuing effort.** Initial financial support for the demonstration came from the 90 percent enhanced federal Medicaid match rate for health home services, but that match ended after eight quarters, and the state has since earned federal Medicare performance payments under the demonstration that provide ongoing financial support.

The health home-based, managed fee-for-service Financial Alignment Initiative demonstration in Washington State carefully targets dually eligible beneficiaries with multiple chronic conditions and high costs. By engaging individuals in their care and focusing on the goals that matter most to them, health home care coordinators help enrollees to make meaningful behavior changes that improve health outcomes and reduce costs. While early evaluation results point to the effectiveness of this model, its long-term sustainability depends on the state's ability to continue to access Medicare performance payments.

Introduction

The nearly 12 million people dually eligible for Medicare and Medicaid are among the highest need enrollees in either program.^{4,5} However, a lack of coordination between Medicare and Medicaid makes it difficult for dually eligible beneficiaries to receive the care they need and increases program costs. In 2011, the Centers for Medicare & Medicaid Services (CMS) announced the Financial Alignment Initiative, which provided states with the opportunity to test new payment and service delivery approaches that fully integrate care for dually eligible individuals.^{6,7} Through this Initiative, CMS and Washington State are testing a managed fee-for-service (MFFS) model based on the Medicaid health home state plan option that overlays strategies to improve care management, improve quality and access, increase accountability, and contain costs on top of the existing fee-for-service delivery system.⁸ The state sees this model as a pathway to achieving its vision of better outcomes for beneficiaries, system efficiencies, and cost containment.

Various approaches have been tried to foster Medicare-Medicaid integration—the blending of the programs’ disparate care management and administrative processes and policies into unified program elements. However, without blended financing, if a state made an investment (e.g., Medicaid-funded care coordination) that reduced expenditures for its dually eligible beneficiaries (e.g., Medicare covered in-patient days), it did not receive any financial benefit from resulting Medicare savings. As such, it has been difficult to align incentives to improve care coordination and reduce unnecessary service use. Under the MFFS model, CMS will make a retrospective performance payment to the state based on reductions in Medicare spending among dually eligible beneficiaries, contingent on achieving required quality thresholds and taking into account any increases in Medicaid spending. While this approach does not blend financing at the payment level, from the state’s standpoint it does support the long-term sustainability of the Medicare-Medicaid integration effort in a way that would not otherwise be possible.

This case study provides an overview of the MFFS demonstration in Washington State. It summarizes the demonstration’s results to date, and provides stakeholder insights on lessons and promising practices from the demonstration’s design and implementation. State Medicaid agencies, particularly those looking to integrate care for dually eligible beneficiaries in non-capitated delivery systems, may find this information useful.

Medicaid Health Home Basics⁹

The Medicaid health home state plan option became available to states in 2011 as a way to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. Health homes integrate physical and behavioral health (both mental health and substance abuse) and long-term services and supports for high-need, high-cost Medicaid populations. By better coordinating whole-person care (e.g., physical and behavioral health services, long-term services and supports) and linking people to needed services, health homes are designed to improve health care quality and reduce costs. Health homes are specifically designed for Medicaid beneficiaries with chronic conditions—to be eligible, an individual must be a Medicaid beneficiary diagnosed with two chronic conditions, one chronic condition and at risk for a second, or a serious mental illness. As a Medicaid state plan population, dually eligible beneficiaries cannot be excluded from Medicaid health homes.

Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services. The team providing health home services may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or any professionals that the state deems appropriate for its model. These professionals may be based in primary care or behavioral health providers’ offices, coordinated virtually, or located in other settings that suit beneficiaries’ needs. States must report specific health home quality measures.

As of January 2019, 22 states and the District of Columbia have a total of 37 approved Medicaid health home models, which have enrolled over 1 million beneficiaries.¹⁰

Background and Overview of the Demonstration

Demonstrations developed under the Financial Alignment Initiative were required to fully integrate all Medicare Parts A and B and Medicaid-covered services, but states had the flexibility to choose a capitated or MFFS model of care. Washington's demonstration design was based on several prior state efforts to coordinate care for complex populations, including the successful Chronic Care Management pilot program, which operated from 2007 to 2013.¹¹ The Chronic Care Management program used Washington's Predictive Risk Intelligence System (PRISM), a data-driven clinical support tool, to identify high-risk Medicaid beneficiaries and provide them with care management, education, and support. The current Medicaid health home-based MFFS demonstration also uses PRISM to target high-risk, high-cost full benefit dually eligible individuals. In addition, the demonstration fosters patient activation and engagement, which the state found to be a key component of the Chronic Care Management program.

Early in the demonstration's planning phase, the state held a series of stakeholder listening sessions.¹² Stakeholders had positive experiences with the Chronic Care Management program and were supportive of the state's plan for a demonstration. There was less consensus on whether the demonstration should use a MFFS or capitated model. Initially, the state proposed a capitated model demonstration in the two largest counties—King and Snohomish—and a MFFS demonstration for all the other counties. While the capitated demonstration never came to fruition due in large part to Medicare rate setting issues, the MFFS demonstration launched on July 1, 2013.¹³ On April 1, 2017, King and Snohomish counties were added to the MFFS demonstration, making it statewide.¹⁴

The demonstration is part of a larger state effort to improve care coordination for Medicaid beneficiaries with complex needs and is jointly overseen by Washington State's Health Care Authority and Department of Social and Health Services. Washington State received CMS approval for two Medicaid State Plan Amendments (SPAs) to create health homes for Medicaid beneficiaries with chronic conditions.¹⁵ The state's Medicaid health home program launched the same day as the demonstration (July 1, 2013), and it has a similar structure (i.e., targeting criteria, enrollment process, benefits, care coordination model, payment rates, use of Lead Entities and Care Coordination Organizations (CCOs)) to the demonstration for dually eligible beneficiaries, except that Medicaid-only beneficiaries are more often served by Health Homes Lead Entities based within managed care organizations.¹⁶

Demonstration Structure

This section describes the overall structure of the demonstration in Washington State, including targeting and eligibility criteria, as well as enrollment processes. It also describes the health home infrastructure that Washington created, benefits covered by the demonstration, and the demonstration's approach to care coordination.¹⁷ The section concludes with a discussion of how health homes are paid.

Target Population and Eligibility

To be eligible for the demonstration, an individual must be enrolled in Medicare Parts A and B and be eligible for Medicare Part D and Medicaid. There are no age restrictions, but individuals cannot have other comprehensive health insurance, be enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly (PACE), or be receiving hospice services.

Individuals eligible for the demonstration must have at least one chronic health condition and be at risk for developing another. Washington targets people who are at the highest risk—those who have a minimum predictive risk score of 1.5 as calculated by PRISM. The state chose the 1.5 score because it identifies the top 20 percent most costly Medicaid beneficiaries, which includes about 40 percent of the dually eligible population.¹⁸ The algorithm uses actuarial methods and an individual's age, gender, and Medicare and Medicaid claims diagnosis and prescription medication data to predict future medical expenditures. As of September 2018, Washington State estimates that of the 34,070 dually eligible individuals who are part of the demonstration population, 20,213 (59 percent) were enrolled in a health home, 7,756 (23 percent) were not yet enrolled, and 6,101 (18 percent) chose not to participate.¹⁹

Health Home Lead Entities and Care Coordination Organizations

Washington State contracts with Health Home Lead Entities that are responsible for developing a service delivery model and administering the health home. Lead Entities have experience developing networks of CCOs. Lead Entities must have the capacity to serve 1,000 to 2,000 enrollees and are responsible for: (1) collecting and submitting claims and encounter data to the state; (2) disbursing payments to CCOs based on services rendered; (3) monitoring quality; and (4) collecting, analyzing and reporting financial, health status and performance and outcome measures. As of September 2018, there were nine Health Home Lead Entities taking part in the Washington demonstration across seven geographic regions.²⁰

CCOs can be managed care organizations, hospitals, Federally Qualified Health Centers (FQHCs), behavioral health organizations, Area Agencies on Aging, community mental health agencies, substance use disorder treatment providers, home health agencies, primary or specialty providers such as AIDS or ESRD clinics, or other community based service providers. CCOs hire care coordinators and are responsible for direct delivery of health home services. CCOs may be affiliated with multiple Lead Entities. In addition, Lead Entities may also be CCOs. Approximately 82 CCOs have been part of health home affiliated networks since the start of the demonstration.²¹

Health Home Lead Entities and CCOs serve both dually eligible beneficiaries in the demonstration and Medicaid-only health home enrollees who are not in the demonstration.

Enrollment Process

After identifying individuals eligible for the demonstration, the state enrolls them in a Health Home Lead Entity based on the individual's zip code and the entity's capacity.²² The state sends individuals a letter 30 days before their effective enrollment date to notify them of their enrollment and describe their options. Participation in the health home program is voluntary and individuals can disenroll completely or disenroll from their assigned health home and enroll in a different health home at any time. For individuals who remain enrolled, the Health Home Lead Entity then assigns them to one of its network of affiliated CCOs with which the individual may have an existing relationship. This is done using a "smart" assignment process based on information from PRISM, including the individual's providers and service use history. If no prior enrollee-CCO relationship exists, the Health Home Lead Entity matches the enrollee with the CCO that is most experienced in addressing his or her individual needs as identified by PRISM.

Benefits Provided

The demonstration does not change the way in which enrollees' primary and acute care, behavioral health care, or long-term services and supports (LTSS) are delivered. Instead, the demonstration uses health homes as a bridge to better integrate care across these settings. Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services.

These six services are provided by the CCO-employed care coordinators who can be clinical or non-clinical professionals (e.g., registered nurses, nurse practitioners or psychiatric nurse practitioners, social workers, mental health social workers, chemical dependency professionals, or counselors). Health home care coordinators do not replace or duplicate the work of case managers for Medicaid home- and community-based services or behavioral health services. CCOs may employ allied health care staff, such as community health workers, peer counselors, or other non-clinical staff to support the care coordinators. To date, CCOs have employed over 700 care coordinators.²³

Care Coordination

After individuals are enrolled, care coordinators reach out to offer an in-home visit during which they assess the enrollee's functional status and screen for depression and other conditions as indicated by the data stored in the PRISM system. They also use the Patient Activation Measure® (PAM®) to assess enrollees' knowledge, skill, and confidence in managing their health conditions and services.

Care coordinators help beneficiaries to articulate their health goals,²⁴ and work with them to develop a person-centered Health Action Plan (HAP). The HAP is one of the foundational tools in Washington's health home model and serves to engage individuals in setting their own goals and increase the skills they need to achieve those goals. The HAP documents items including: gaps in the enrollee's care; the PAM® score; opportunities to prevent emergency department visits, hospitalizations, or nursing facility stays; and the enrollee's goals for improved health, strategies to achieve those goals, and ways in which the care coordinator can help the enrollee to achieve those goals. The state reports statistically significant increases in PAM® scores for individuals who were initially the least activated.²⁵

With the permission of the enrollee, the care coordinator shares the HAP with the enrollee's providers. The HAP is updated every four months to document the enrollee's progress in reaching his or her goals, as well as any changes in health, functional status, or in the PAM®, which is also performed every four months. CCOs cannot begin billing for health home services until an enrollee's HAP has been finalized and submitted to the state.

Once the initial HAPs are completed, health home services can begin. Care coordination is the most frequently used health home service, but it is not needed on a regular basis by all enrollees; some enrollees manage their care themselves or with the help of family and instead may benefit from other health home core services. Data from PRISM, including weekly updates of Medicare and Medicaid claims data, help care coordinators flag current or potential health concerns. Care coordinators work together with enrollees' providers to give them updated HAPs, communicate changes in enrollees' health status, and

offer more intensive support for highly complex beneficiaries by convening monthly case conferences. (See call out box ***Independence Realized*** for one health home enrollee’s story.)

If an enrollee does not currently receive LTSS or behavioral health care, but accessing that service would help to fulfill HAP goals, the care coordinators will work with service-specific case managers (i.e., care managers employed by the state for home- and community-based services waiver programs or by behavioral health providers) to fill in those gaps. As described previously, these service-specific case managers focus narrowly on one service and do not address fragmentation of care across all of an enrollee’s providers—meaning that there should be no duplication of effort with the health home care coordinators.

Care coordinators also work with enrollees to create transition plans that support an enrollee’s move from one care setting to another (e.g., hospital to home). If enrollees are admitted to a hospital or nursing facility, care coordinators are required to make timely visits to the facility and ensure follow-up care is scheduled. In addition, hospitals submit data to an information system that provides real-time notifications to Health Home Lead Entities when their enrollees are seen in an emergency department or admitted as an inpatient.

Payment for Health Home Services

Washington pays Health Home Lead Entities using a tiered approach. Health Homes Lead Entities receive a one-time payment for each enrollee (\$281.28 as of August 2018) for activities related to: initial enrollee engagement; screening and assessment; and development of the HAP.²⁶ After the HAP has been submitted, the Health Home Lead Entity can begin to bill the state for health home services. In the Washington health home model, the state pays Lead Entities on a per member, per month (PMPM) basis only for months in which the Lead Entity submits data indicating that a CCO has provided at least one of the six health home services.

Health Home Lead Entities may bill the state for rendering either intensive care coordination (\$208.36 PMPM) or low-level care coordination (\$83.34 PMPM). The Health Home Lead Entities have the flexibility to define “intensive level” and “low level” care coordination based on documented services provided during the month within broader definitions set by the Health Care Authority.

To incent health homes to engage enrollees, in January 2017, the state started making a 20 percent monthly performance payment to Health Home Lead Entities – on top of the amount they were paid for enrollee engagement and intensive/low-level coordination in that month – if they maintained an engagement rate of 20 percent or higher in that month. The Health Home Lead Entities shared this performance payment with their CCOs, but it did not seem to help engagement rates. With the support of the health homes, the state approved a 20 percent rate increase in July 2018, reflected in the rates stated above, and reduced the performance payment to 5 percent for Health Home Lead Entities maintaining an engagement rate of 25 percent or higher. The State Plan Amendment effectuating this change was approved by CMS as of December 2018 (with an effective date of August 1, 2018).²⁷ State staff report they are beginning to see higher rates of enrollee engagement after the payment increase.

Health Home Enrollee Story: Independence Realized

Mrs. M. had struggled to manage her diabetes and chronic pain. Fluctuating blood sugar levels and other complications of her condition resulted in a skilled nursing facility admission. After she enrolled in a health home, Mrs. M. worked with her care coordinator to set health goals—the most ambitious of which was to transition from the nursing facility to living independently in her own home.

Although her family was supportive and the PAM[®] showed her to be eager to work toward her goal, Mrs. M. needed to learn more about her diabetes and improve her blood sugar management. Mrs. M.'s care coordinator began by: (1) reviewing basic diabetes education materials with her; (2) providing information about how she could apply for Social Security Disability Income; and (3) sharing information about local housing resources. With the assistance of her care coordinator, Mrs. M. began seeing her primary care provider more regularly and was prescribed a new, more effective medication for her chronic pain.

After five months of working with her care coordinator, Mrs. M. attends a community-based diabetes education class, reports a lower pain score, and, most importantly, now lives independently.

Results to Date

CMS contracted with an external evaluator, RTI International, to evaluate the impacts of the demonstrations under the Financial Alignment Initiative.²⁸ The evaluations include information about the demonstrations' implementation and both qualitative and quantitative analyses to determine demonstration impacts on: (1) beneficiary experience of and access to care; (2) quality of care; (3) use of primary and acute care, behavioral health services, and LTSS; and (4) cost of care. Sources informing the evaluation include: demonstration-related documents; focus group interviews with beneficiaries; in-person and virtual site visits to the states including interviews with state staff, Health Home Lead Entities, and CCOs (for the Washington demonstration), and other stakeholders; interviews with CMS staff; beneficiary surveys (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)); appeals and complaints data; other state-reported information; Medicare and Medicaid data on service use and costs; and data from the Minimum Data Set for individuals with a nursing facility stay.

Preliminary Demonstration Impacts

RTI has published two evaluation reports with qualitative and quantitative analyses of the Washington demonstration from its initiation on July 1, 2013 through December 31, 2015.²⁹ Key findings include:³⁰

- **Beneficiary Experience and Access to Care.** Focus groups conducted by RTI and the CMS-sponsored CAHPS survey both provide insight into beneficiaries' satisfaction with the health home program. Most focus group participants reported satisfaction with their health home and improvement in quality of life, access to services, and overall health. Focus group participants had some difficulty differentiating between their health home care coordinators and case managers in the home- and community-based services and behavioral health systems, but reported very positive relationships with their care coordinators overall. In addition, they said that care coordinators helped them to better manage their chronic conditions and become more engaged in their communities, which, in turn, helped them to achieve other goals. Interestingly, they felt that

they achieved their goals by changing behaviors (with the support of care coordinators) rather than by accessing more services. Some focus group participants reported that care coordinators did connect them to new services, including medical equipment, assistive technology, home modifications, and health education.

- **Service Use.** RTI's quantitative analysis found evidence of demonstration effects on service use during in the period from July 2013 to December 2015.^{31,32} The demonstration group had fewer hospital inpatient hospital stays (5.36 percent), emergency department visits (-4.11 percent), and skilled nursing facility admissions (-18.63 percent) and a lower probability of long-stay nursing facility (-24.21 percent) than the comparison group. The 30-day all-cause, risk-adjusted hospital readmission rate was higher for the demonstration group.

Performance Payment

In addition to the regression-based cost calculations conducted as part of the demonstration evaluation, CMS has used an actuarial calculation to determine whether the MFFS model demonstration in Washington is eligible for retrospective performance payments based on cost savings and quality benchmarks.^{33,34} To date, the Washington demonstration has achieved gross Medicare savings of \$34.9 million in its first 18 months, \$30.2 million in the next 12 months, and an estimated \$40.2 million in the 12-month period after that.³⁵ Due to lags in Medicaid data availability, these figures do not include estimated Medicaid expenditures and will be updated when data are available. As of November 2018, CMS has made three interim performance payments of \$11.6 million, \$10.7 million, and \$14.2 million to Washington State.

Insights on Demonstration Design and Implementation

The health home-based MFFS model demonstration in Washington State holds promise as a way to integrate care for dually eligible beneficiaries. To gain further insight into the demonstration, ICRC interviewed staff from: (1) Washington's Department of Social and Health Services and the Health Care Authority; (2) a CCO – the Area Agency on Aging and Disabilities of Southwest Washington (AAADWS); and (3) an organization that is both a Health Home Lead Entity and a CCO – Full Life Care. Following are insights from those conversations:

Engaging stakeholders is important to building support for integration activities.

Stakeholders were familiar with Washington's earlier Chronic Care Management program and supported the state's plan for the demonstration; nevertheless, state staff still saw value in conducting both broad-based stakeholder engagement activities and tailored outreach to specific interest groups.³⁶

The state created a Health Home Advisory Team (HAT) – comprised of representatives from consumer advocacy organizations, provider associations, state and county agencies, beneficiaries, and the union representing most home care workers – to offer regular input to program design. The HAT continued to meet through the demonstration's implementation phase. State staff felt that the HAT's input was particularly helpful in late 2015, a point where the preliminary savings analysis was not yet available and the state legislature planned to end the demonstration. The HAT developed a plan to communicate to enrollees about what would happen when the demonstration ended. This activity prompted stakeholders

to lobby the legislature in support of the program which, along with new information about the Medicare performance payment, resulted in the legislature reversing its decision and the demonstration continuing.

The state continues to value stakeholder engagement, and in 2017 it formed a Service Experience Team (SET) that replaced the HAT. SET membership includes nine beneficiaries, six of whom are health home eligible, as well as community advocates. The SET meets three times a year to provide input on ways to promote choice, quality of life, health, independence, safety, and active engagement in program operations. States designing integrated care programs, including Medicaid health homes, can find value in investing in stakeholder engagement activities.

Targeting higher-risk groups offers greater potential to demonstrate results.

Previous state and federal care coordination and disease management demonstrations for Medicare beneficiaries were not effective in reducing hospital admissions or reducing Medicare costs³⁷ unless they limited enrollment to individuals with high-cost, chronic conditions who were at high risk of hospitalization.³⁸ Washington's Chronic Care Management program (2007-2013) enrolled Medicaid beneficiaries with functional limitations who received in-home personal care and whose Medicaid costs were in the top 20 percent of all Washington State's Medicaid beneficiaries. An analysis of the Chronic Care Management program found that it reduced in-patient admission costs by \$318 per member per month, although when the cost of the intervention was factored in, the overall reduction of \$248 per member per month in total medical costs was not statistically significant.³⁹

The state's experiences with the Chronic Care Management program informed the design of the current MFFS demonstration. Washington uses an algorithm called the PRISM risk score to identify high-risk, high-cost full benefit dually eligible beneficiaries (i.e., individuals with a minimum predictive risk score of 1.5, meaning that their predicted medical costs are 50 percent higher than those of Washington State residents receiving Supplemental Security Income benefits). States considering development of an integrated care program may want to consider how they could use data analytics to target program enrollment. Investment in information technology may be needed to access the data for program design and monitoring.

Locating and engaging beneficiaries in care management is resource intensive.

Although the Health Home Lead Entities attempt to assign enrollees to CCOs based on pre-existing service relationships, the two organizations interviewed said that actually only about 10 percent of their enrollees are individuals already known to them. For the other individuals, the process of engagement in health homes begins with an outreach call from the CCO. The CCOs explain what a health home is, who they are, and what the program offers. Although all dually eligible beneficiaries assigned to a health home are sent a letter by the state with health home contact information, they may not receive these letters or understand them, and the CCOs often must make a considerable effort to engage enrollees in health home services. Health Home Lead Entities cannot bill for beneficiary engagement until: (1) the individual has been located and agrees to meet with the care coordinator; and (2) the HAP has been completed and accepted. Health Home Lead Entities reported that they had lost money as a result of difficulty locating certain enrollees that had been assigned to them. Washington convened a work group of state and health home staff to outline the process for care coordinators to use in locating enrollees, including a policy describing what constituted due diligence in attempting to reach an enrollee. Now CCOs must attempt to contact each new

enrollee at least once a month for three consecutive months. Further, Washington submitted a new State Plan Amendment adjusting its payment methodology to give health homes a performance payment for attaining specific engagement rate targets that has resulted in increased engagement.

Both AAADSW and Full Life Care have adjusted their staffing models to increase their rate of enrollee engagement. For its CCO, Full Life Care began with care coordinators both doing enrollee outreach and engagement and carrying a care coordination caseload. It found that by the time its first care coordinator's caseload was half full, she no longer had the time to do outreach. The organization then restructured, hiring bachelor's-prepared, entry-level social workers exclusively dedicated to outreach. Similarly, AAADSW hired an engagement specialist who is trained as a care coordinator, but is very good at engagement. The engagement specialist makes initial contact with the enrollee then transitions care management responsibilities to a care coordinator.

AAADSW staff described how their care coordinators are trained to use PRISM data to engage enrollees. Knowing that enrollees may be motivated to avoid repeating recent negative events (e.g., a hospitalization or emergency department visit), care coordinators try to identify these events in PRISM and use that information to begin a dialogue. For example, they might first ask a person about a recent hospitalization and then about how that experience went or how the person is feeling now. This often is the entree that care coordinators need to get enrollees to talk about circumstances or behaviors that they might be open to changing.

Encouraging enrollee engagement may improve outcomes.

Washington's MFFS demonstration focuses on developing and implementing HAPs to promote person-centered planning and improve self-management skills. A HAP includes the priorities that an enrollee identifies for improving his or her own health as well as the action steps the enrollee will take and other interventions and supports that will help an enrollee achieve his or her goals. A HAP has information about chronic conditions, gaps in care, ways to prevent hospital and institutional care, and the enrollee's ability to manage his or her health. All care coordination is based on the information and action steps outlined in the HAPs.

To develop the HAP, the care coordinator conducts a home visit, during which they explain the HAP, get enrollee agreement to move forward with developing the HAP, and screen for functional limitations and health conditions. The care coordinators also use the PAM[®] to assess enrollees' knowledge, skill, and confidence in managing their health and establish an enrollee activation level. Care coordinators use this information to start a discussion with the enrollee, who sets priorities about health action goals, and then work with the enrollee to develop a HAP.

Washington provided Health Home Lead Entities with motivational interviewing training to improve care coordinator-enrollee relationships and strengthen skills of care coordinators to promote enrollee self-action. Health home enrollees have reached various health goals through the use of HAPs, including improved blood sugar levels, weight loss, more social connections, better relationships with providers, and fewer emergency department and hospital visits.

While further data analyses are necessary to determine the effect of the Washington demonstration on enrollee outcomes, the use of person-centered planning and enrollee-driven action plans may help enrollees to make behavior changes that lead to improved health. States developing integrated care programs may consider models that emphasize this type of enrollee engagement.

Structuring the health home payment can incent enrollee engagement and in-person care coordination.

Washington uses a tiered system to pay health homes. There is a one-time payment for initial enrollee engagement, screening and assessment, and development of the HAP. As described previously, CCOs often have to put a lot of effort into locating enrollees and convincing them to meet with a care coordinator. By structuring payments such that a CCO can only receive payment after the HAP has been completed, it creates a strong incentive for the CCOs to engage enrollees.

Similarly, tiered payments for care coordination (\$208.36 PMPM for intensive care coordination and \$83.34 PMPM for low-level care coordination) create an incentive for health homes to provide more intensive care coordination. Both AAADWS and Full Life Care indicated that their care coordination is done almost entirely in-person (rather than telephonically) and that their care coordinator-to-enrollee ratios are approximately 1:50, which they consider appropriate given the risk profile of their enrollees.

States developing health home programs for dually eligible or Medicaid-only beneficiaries could consider how they can structure rates to promote program goals such as prompt beneficiary engagement and in-person care coordination.

Securing support for long-term sustainability is a continuing effort.

A 2012 bill passed by Washington's legislature approving the demonstration did not permit any new state funds to be used for its design or implementation.⁴⁰ The 90 percent enhanced federal Medicaid match rate for health home services (see call out box **Health Home Basics** for a description of this authority) for the first eight quarters of health home program operation provided a source of funding and led the state to pursue the Medicaid health home state plan option as a vehicle for the demonstration.^{41,42} At the end of eight quarters, the state would again receive its regular Federal Medical Assistance Percentage, but it would need to identify another source of funding. The assumption was that the demonstration program would either: (1) realize Medicare savings and become self-sustaining; or (2) not achieve savings and be shut down by the legislature.

In spring 2015, when the federal match for health home services was expiring and Medicare savings calculations had not yet been completed, Washington's legislature moved to end the demonstration. As the Health Care Authority and the Department of Social and Health Services began to make plans to wind-down operations, the state received word that the demonstration had achieved \$21.6 million in Medicare savings during the first 18 months of operation.⁴³ As a result, the legislature allowed the health home program – and the demonstration – to continue.

Now the demonstration will operate at least through its scheduled end date of December 31, 2020, but state staff are looking ahead to plan for the longer term. They believe that the demonstration program, with its focus on high-risk beneficiaries, is helping them to learn which beneficiaries could most benefit

from care coordination and what kinds of services are the most helpful to beneficiaries with different needs. The state plans to develop an 1115 Delivery System Reform Incentive Payment (DSRIP) waiver that will allow it to provide care coordination to a broader population.

Care Coordination Organization Profile: Area Agency on Aging and Disabilities of Southwest Washington

The Area Agency on Aging and Disabilities of Southwest Washington (AAADSW) is a public agency providing assistance to older adults and people with disabilities in five counties—Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum. In 2013, AAADSW became a Care Coordination Organization (CCO) in Washington State’s health home program.

Like other CCOs, AAADSW contracts with multiple Health Home Lead Entities, specifically Community Health Plan of Washington, Molina, and OptumHealth.⁴⁴ It has developed HAPs for approximately 1,125 demonstration enrollees and has 40 care coordinators dedicated to the health home program.⁴⁵ In addition, AAADSW employs four managers who train and supervise the care coordinators, but who do not provide care coordination directly to health home enrollees.

AAADSW reports that its enrollee engagement rate is higher than most CCOs in the health home program, which it attributes to the skills of its care coordination staff who all have a social work background, but also have sales or other life experiences that demonstrate they can make “cold calls” to potential enrollees, begin conversations, and develop a trusting relationship with people who are hard-to-reach.

The organization’s leadership also credits its overall success to a combination of the health home program’s emphasis on developing person-centered health action plans and AAADSW’s care management model. As one staff member described it, “People who enroll in the health home and agree to meet with the care coordinator have a desire to make some change in their lives. Even if it’s only a teensy bit – a scrap of a desire – we can take that and grow it and work with them over time to improve how they receive care, change their health behaviors, and improve the way they use the health care system.” They believe that monthly in-person visits by the care coordinator to the enrollees’ homes – or other locations where enrollees feel comfortable – are their “secret sauce.” AAADSW reports that the vast majority of its health home services are for the “intensive care coordination” level of service (described in the **Payment** section on page 7).

A 2017 Oregon Health Sciences University study identified AAADSW as having 11 organizational best practices.⁴⁶ AAADSW’s leadership said that one of the most challenging aspects of their experiences to date was the difficulty of launching the CCO without access to start-up funding. They began with just a few care coordinators, maximizing their caseloads until they generated enough revenue to hire more. Even so, they incurred significant debt. Washington’s recent adjustments to the health home payment rates may improve the financial situation for CCOs.

Health Home Lead Entity Profile: Full Life Care⁴⁷

Full Life Care is a community-based, non-profit organization serving low-income older adults and people with disabilities in King and Snohomish counties.⁴⁸ Established in the 1970s, it provides in-home care, adult day programs, outpatient mental health care, housing supports, and other services to help people remain as independent as possible. In April 2017, Full Life Care became a Health Home Lead Entity, and as of July 2018, it had a demonstration enrollment of 1,491.

Organization leaders said that they greatly benefitted from the experience of another Health Home Lead Entity, the Northwest Regional Council (NWRC) – northwest Washington's Area Agency on Aging – in planning for the launch of their program.⁴⁹ Important lessons imparted include how to:

- **Implement a “smart assignment” process** to identify which CCO would be the best fit for an enrollee's needs while simultaneously being responsive to CCOs' referral requests based on staffing capacity. NWRC helped Full Life Care to use the PRISM system to identify enrollees' diagnoses and providers and assign them to the most appropriate CCO.
- **Choose metrics** to monitor the performance of care coordinators, contracted CCOs, and the health home's own internal management. This has helped Full Life Care to better understand when it should ask the state for more enrollees and when it should hire more staff. Establishing measurable operational metrics has been a critical feedback tool for Full Life Care to support contracted CCOs in developing their own health home-related infrastructure, especially given the lack of available start-up funding.
- **Leverage available information technology** to improve performance. NWRC, Full Life Care, and Southeast Washington Aging and Long-Term Care (another Area Agency on Aging) have formed a consortium and share the same care management information system. They work together in an ongoing collaborative to improve the functionality of this system for care coordinators and for administrative operation of their health home programs.

Full Life Care and the other Health Home Lead Entities are responsible for training the CCOs' care coordinators. Health Home Lead Entities take turns to lead two-day training programs that use a curriculum developed by the state.⁵⁰ Topics covered include: health home fundamentals; outreach and engagement; PRISM; use of the Patient Activation Measures; motivation and coaching for activation; development of the HAP; care transitions; and documentation and quality assurance. Health Home Lead Entities also provide training to CCO care coordinators on their own care management information systems and ad hoc training on special topics.

Summary

The Washington State MFFS Financial Alignment Initiative demonstration is structured around Medicaid health homes and incorporates many of the elements of earlier care coordination efforts in the state, particularly the Chronic Care Management program. A key element of the demonstration is its use of the state-developed PRISM algorithm and the PRISM secure, web-based information system, to identify and manage individuals at high risk of having future high-cost events. As of September 2018, approximately 34,000 dually eligible individuals were part of the demonstration.

The state assigns enrollees to one of nine Health Home Lead Entities, which, in turn, use a smart assignment process to match enrollees to CCOs based on their diagnoses and providers. CCOs are responsible for engaging the enrollee, developing a person-centered HAP, and providing on-going health home services. The process by which enrollees receive their primary and acute care, behavioral health care, and LTSS remains unchanged: health home services help to integrate and coordinate this care. The

state pays health homes using a tiered approach, including a one-time payment for enrollee engagement and completion of the HAP and per-member per-month payment for either intensive or low-level care coordination if at least one health home service was provided in the month.

A national evaluation of the demonstration has shown good enrollee-reported satisfaction with the program and improvements in quality of life, health, and access to services. Analyses of service use and cost of care have found limited impacts that may be due to enrollees' limited exposure to interventions early in the demonstration. That said, a separate actuarial analysis of Medicare savings found the demonstration saved Medicare a gross total of \$107 million over its first three and a half years of operation while maintaining the quality of care provided to enrollees as assessed by CMS' quality measures.⁵¹

State staff and leadership of a Health Home Lead Entity and CCO provided insights on the demonstration's design and implementation, including:

- Engaging stakeholders is important to build support for integration activities.
- Targeting higher-risk groups offers greater potential to demonstrate results.
- Locating and engaging beneficiaries in care coordination is resource intensive.
- Encouraging enrollee engagement may improve outcomes.
- Structuring the health home payment can incent enrollee engagement and in-person care coordination.
- Securing support for long-term sustainability is a continuing effort.

The information in this case study may be helpful to state Medicaid agencies, particularly those looking to integrate care for dually eligible beneficiaries in non-capitated delivery systems. Twenty-two states currently operate health home programs, which cannot exclude dually eligible beneficiaries. Washington State's health home-based Financial Alignment Initiative demonstration provides an example of how health homes can provide needed care coordination for dually eligible populations with chronic conditions. This model holds promise, especially if states can overcome challenges related to accessing Medicare savings.

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by [Mathematica Policy Research](#) and the [Center for Health Care Strategies](#). For more information, visit www.integratedcareresourcecenter.com.

ENDNOTES

- ¹ D. Justice, et al. “Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report.” RTI International. November 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf>
- ² Sandler, M., Zhao, L., Trapnell, T., et al. “Report for Washington Health Home Managed Fee-for-Service (MFFS) Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative.” CMS, November 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-wa-finalyr2preyr3.pdf>
- ³ Ibid.
- ⁴ Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. “Medicare-Medicaid Coordination Office Fiscal Year 2022 Report to the Congress.” 2023 Available at: <https://www.cms.gov/files/document/mmco-report-congress.pdf-0>
- ⁵ MedPAC and MACPAC. “Beneficiaries Dually Eligible for Medicare and Medicaid: Data Book.” January 2018. Available at: <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>
- ⁶ Ten states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Texas, Rhode Island, South Carolina, and Virginia) used the capitated model in which the state and CMS enter into three-way contracts with health plans to cover all Medicare and Medicaid services in return for a blended prospective payment. New York State has two capitated demonstrations: Fully Integrated Duals Advantage (FIDA); and FIDA I/DD, which enrolls dually eligible beneficiaries with intellectual and developmental disabilities. Virginia ended its demonstration as of December 31, 2017. For more information on the demonstrations, see: Centers for Medicare & Medicaid Services. “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.” SMDL 11-008. July 2011. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
- ⁷ A demonstration in Minnesota is testing an alternative integration model that is separate from the capitated or MFFS models being tested in the other Financial Alignment Initiative demonstrations.
- ⁸ Colorado also tested a MFFS model, based on accountable care organizations, and that demonstration ended as of December 31, 2017.
- ⁹ Health Home Information Resource Center. “Medicaid Health Homes: An Overview.” April 2018. Available at: <https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf>
- ¹⁰ Health Home Information Resource Center. “Medicaid Health Homes: An Overview.” September 2018. Available at: <https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf>
- ¹¹ Jingping Xing, J., Goehring, C., and Mancuso, D. “Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs.” *Health Affairs*, 34(4); April 2015. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0655>
- ¹² See http://www.chcs.org/media/Stateholder_Engagement_without_PPT.pdf and http://www.chcs.org/media/DSHS-HCA_Presentation.pdf for examples of meeting slides, an agenda, and other materials.
- ¹³ Washington’s original health home SPA, WA-13-008 (<https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf>), included 13 counties. A second SPA, WA-13-17 (<https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-17-HHSPA.pdf>), added 23 more counties.
- ¹⁴ For more information, see Washington’s SPA WA-16-0026. Available at: <https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-16-0026.pdf>
- ¹⁵ Washington’s initial two health home State Plan Amendments were: WA-13-008 that covered 14 counties (see: <https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-08-Ltr.pdf>); and WA-13-17 that covered 23 additional counties (see: <https://www.medicare.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-13-17-HHSPA.pdf>).

¹⁶ WA-13-008: Creates a chronic medical conditions health home model in 14 counties (Phase I) (approved 6/28/13, effective 7/1/13) WA-13-17: Creates a chronic medical conditions health home model in 23 additional counties (Phase II) (approved 12/11/13, effective 10/1/13)

¹⁷ For additional information on the demonstration's design, implementation, and oversight, see the Memorandum of Understanding available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf> and the final demonstration agreement available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSFDA_Amendment.pdf

¹⁸ Individuals with a PRISM score of 1.5 are predicted to have medical costs that are 50 percent higher than those of a reference group (Washington residents receiving Supplemental Security Income benefits, average risk score 1.0) over the ensuing 12 months.

¹⁹ Washington State Health Care Authority. "Washington State's Fee-For-Service Dual Eligible Demonstration Monthly Report." October 5, 2018. Available at: <https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf>

²⁰ Washington State Health Care Authority. "Washington State's Fee-For-Service Dual Eligible Demonstration Monthly Report." October 5, 2018. Available at: <https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf>

²¹ Interview with Alice Lind, Washington Health Care Authority and Beverly Court, Washington Department of Social and Health Services. July 5, 2018.

²² Health Home Lead Entities must have an individual's consent to enroll them in the Health Home. The consent form must be maintained in the individual's health record.

²³ Interview with Alice Lind, Washington Health Care Authority and Beverly Court, Washington Department of Social and Health Services. July 5, 2018.

²⁴ For more information on PAM, see: Hibbard, J., Stockard, J., Mahoney, E., and Tusler, M. "Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers." *Health Services Research*. 2004 Aug; 39(4 Pt 1): 1005–1026. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/>

²⁵ Beverly Court. Washington Department of Social and Health Services. Personal communication, November 13, 2018.

²⁶ Washington Health Care Authority. "Contract: Qualified Managed Fee-for-Service Health Home." Available at: <https://www.hca.wa.gov/assets/billers-and-providers/FFScontract.pdf>

²⁷ See: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-18-0028.pdf>

²⁸ E. Walsh, et al. "Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan." RTI International. December 2013. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf>

²⁹ D. Justice, et al. "Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration." RTI International. July 13, 2016 (Updated July 18, 2017). Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalReport.pdf> and D. Justice, et al. "Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report." RTI International. November 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf>

³⁰ D. Justice, et al. "Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Annual Evaluation Report." RTI International. November 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf>

³¹ Ibid.

³² The demonstration uses demonstration years (Dys) for the purposes of reporting on quality and savings. For demonstrations not beginning on January 1 of a calendar year, DY 1 was extended until the end of the following calendar year. The Washington

demonstration was implemented on July 1, 2013, making DY1 July 1, 2013 through December 31, 2014 for the purposes of evaluation.

³³ The MFFS demonstrations are eligible for performance payments from CMS if they achieve statistically significant Medicare savings, net of any increased federal Medicaid spending, as determined by annual actuarial calculations. In the capitated model demonstrations, states and CMS establish savings percentages (approximately 1 percent in the Demonstration Year 1, increasing to about 5 percent by year 5) that are deducted up front from the blended Medicaid and Medicare Part A/B payments made to plans. For more information see: Medicaid and CHIP Payment and Access Commission. "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare." January 2018. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>

³⁴ Note that the actuarial analysis used for the cost savings calculation is different from that used in the qualitative analysis of differences in utilization and costs between the demonstration and comparison groups. For more information on the actuarial method see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf>

³⁵ Sandler, M., Zhao, L., Trapnell, T., et al. "Report for Washington Health Home Managed Fee-for-Service (MFFS) Final Demonstration Year 2 and Preliminary Demonstration Year 3 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative." CMS, November 2018. Available at: <https://innovation.cms.gov/Files/reports/fai-wa-finalyr2preyr3.pdf>

³⁶ Washington State Health Care Authority. "Duals Engagement Framework." July 26, 2011.

³⁷ L. Nelson. "Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination." Congressional Budget Office, January 2012. Available at: <https://www.cbo.gov/publication/42924>

³⁸ Peikes, D., Chen, A., Schore, J., and Brown, R. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures among Medicare Beneficiaries: 15 Randomized Trials." *Journal of the American Medical Association*. 2009;301(6): 603–18.

³⁹ Jingping Xing, J., op cit.

⁴⁰ Washington State Department of Health and Social Services and Washington State Health Care Authority. "State Demonstrations to Integrate Care for Dual Eligibles. Demonstration Proposal: Washington." April 2012. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WashingtonProposal.pdf> and "Third Engrossed Substitute House Bill 2127. Chapter 7, Laws of 2012. Effective May, 2, 2012. <http://leap.leg.wa.gov/leap/budget/lbns/2012Omni2127-S.SL.pdf>

⁴¹ The match is only available for health home services, not other Medicaid-covered services that may be provided to demonstration enrollees as a result of the development or implementation of a HAP (e.g., personal care services, non-emergency medical transportation, substance use disorder treatment, etc.). For more information, see: Centers for Medicare & Medicaid Services. "Health Homes for Enrollees with Chronic Conditions." SMDL: 10-024. November 2010. Available at: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>

⁴² The Washington demonstration expanded statewide in waves. The program started in 14 counties (Pierce, Clark, Cowlitz, Klickitat, Skamania, Wahkiakum, Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, and Yakima) on July 1, 2013. The enhanced match period for this wave expired on 6/30/15. On 10/1/13, health homes were expanded to 23 additional counties (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Thurston, Island, San Juan, Skagit, Whatcom, Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman). The enhanced match period for this wave expired on 9/30/15. The final two counties, King and Snohomish, were added effective on 4/1/17, and the enhanced match will end on 3/31/19.

⁴³ This number was subsequently revised upward to \$34.9 million with another preliminary estimate of \$32.1 million in Medicare savings during the next 12 months of operation (Demonstration Period 2). For more information see: Wilkin, J. "Report for Washington Managed Fee-for-Service (MFFS) Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates: Medicare-Medicaid Financial Alignment Initiative." RTI International. July 2017. Available at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalMedicareCostYr1FinalYr2Preliminary072817.pdf>

⁴⁴ AAADSW had a contract with the other Health Home Lead Entity in its service area, but chose not to continue that because of the low rate of enrollee referrals it was receiving.

⁴⁵ D. Kelly. “Working As a CBO to Impact Health Outcomes: The Magic Sauce of At-Home In-Person Community Based Case Management.” Presentation. Aging and Disability Business Institute. July 17, 2018.

⁴⁶ P. Wilkens, R. Pittman, J. Heilman, T. Charleston, and M. Meyers. “Best Practices for Care Coordination: The AAADSW Model.” Available at: <http://www.helpingelders.org/download/7719/>

⁴⁷ Full Life Care also operates a CCO, which provides health home services to its own enrollees as well as contracting to provide care coordination services to other Health Home Lead Entities in King and Snohomish counties that are operated by managed care organizations.

⁴⁸ For more information, see: <https://www.fulllifecare.org/>

⁴⁹ For more information, see: <https://www.nwrcwa.org/>

⁵⁰ Washington State Department of Social and Health Services. Aging and Long-Term Support Administration. “Health Home Care Coordinator Core Training Materials.” Available at: <https://www.dshs.wa.gov/altsa/stakeholders/washington-health-home-program-core-training>

⁵¹ Sandler, M., et al., op cit.