Transforming Lives

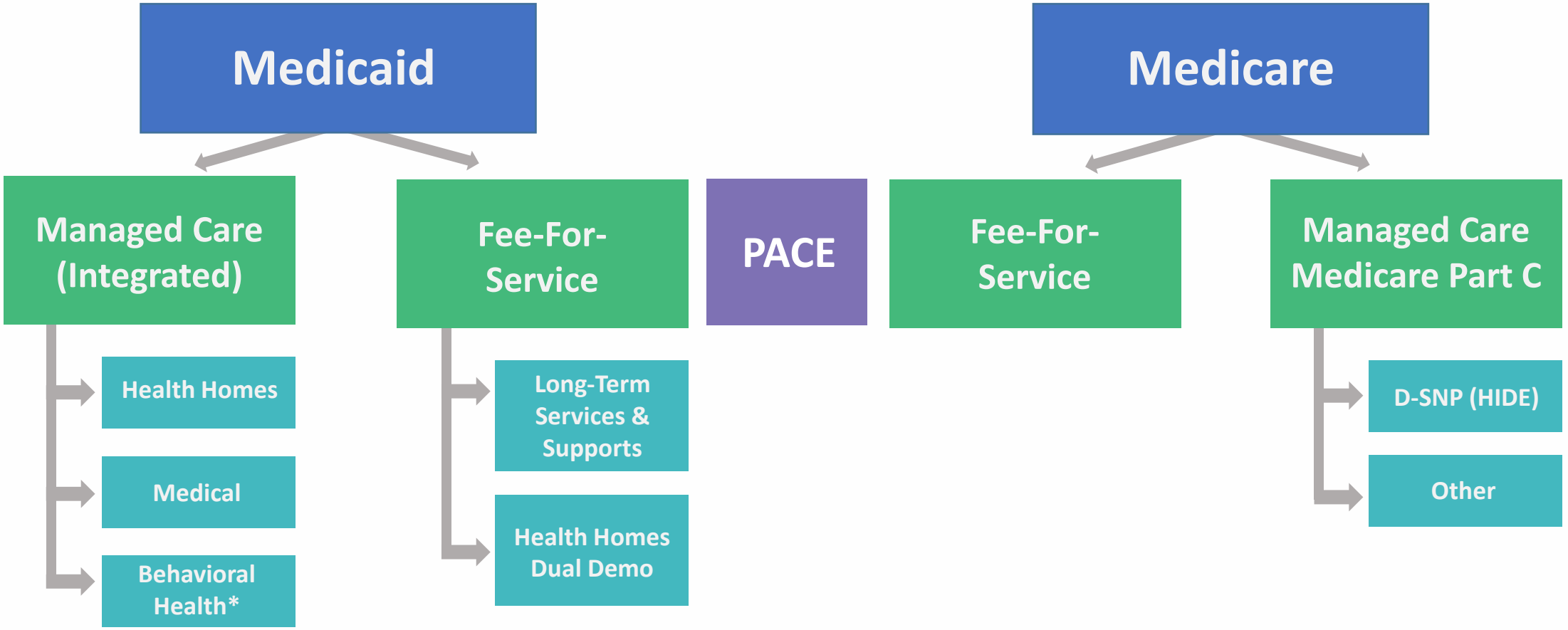
Advancing our Duals Strategy: A WA approach to integrating care

August 2023

Washington State Department of Social & Health Services

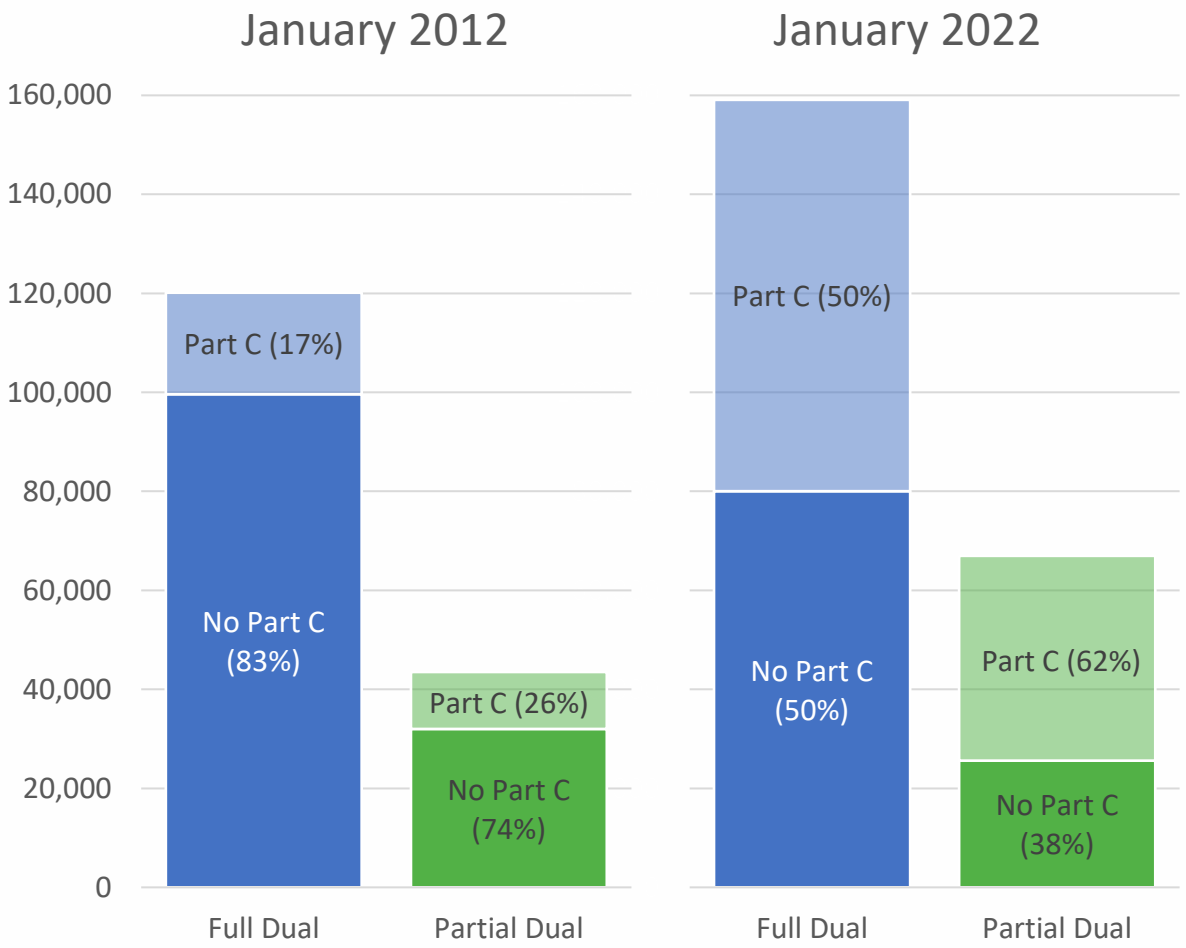
Transforming lives

Washington Delivery System Landscape



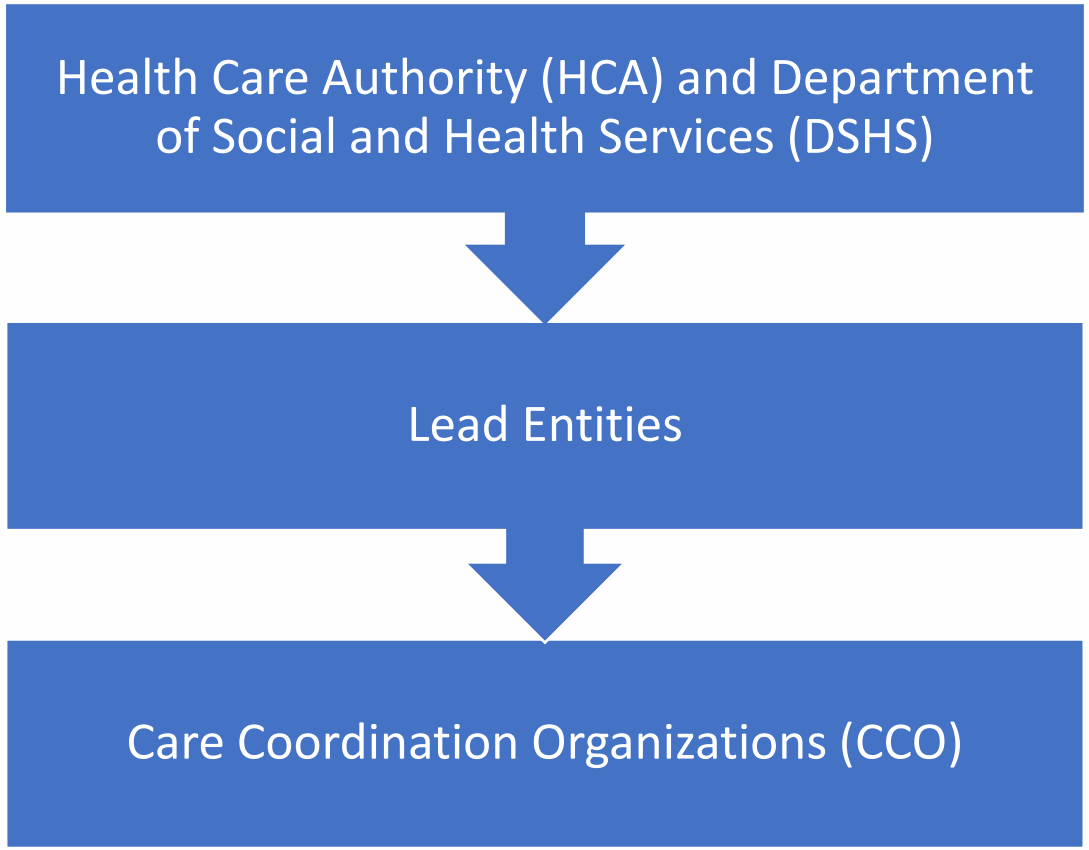
*Behavioral health only enrollment for duals.

Prevalence of duals in WA enrolled in Medicare Part C



- The percent of duals enrolled in Medicare Part C has increased substantially since 2012
- 17% to 50% for Full Duals
- 26% to 62% for Partial Duals

Washington's Health Homes Model



- The Health Homes program is managed by Washington State HCA and DSHS
- Lead entities provide oversight of service delivery and administrative support
- Care coordination is delivered at the **local level**

Objectives

Improving and enhancing D-SNP care coordination by allowing high risk individuals to maintain proven intensive care coordination services through the Health Home program

Utilize and preserve the Health Home Care Coordination Organization (CCO) network and expertise

Provide continuity of care and services for our highest risk populations in FFS and DSNP and as they transition across the continuum.

How it Happened

FAQs (CMS)

2019
- Origins of idea to offer Health Homes to clients enrolled in D-SNP

2020
- Proposal sent to CMS –supp bene?
- Ongoing conversations on how to expand

2021
- CMS guidance released: State can require D-SNP to use community-based providers

June 2021
- First meeting with Health Homes leads and MA plans

December 2021
- First draft SMAC language

April 2022
- AMMI grant awarded
- Ongoing planning meetings to work through challenges

July 2022
- Readiness Review & MOC approval, reports being finalized

December 2022
- Contracts actively being signed!
- Model of Care training for HH Care Coordinators

January 2023
- Implement D-SNP HH program

Ongoing
- Collaboration meetings

How We Did It – policy levers

Mirroring the Existing Program

Require Health Homes be a covered program under Medicare and be included in the bid process

Require Health Homes be included in the Model of Care (MOC)

Require plans to contract with established and proven community based HH network – single statement of work, single rate, single billing structure

Who is Eligible

- If a client was engaged in the Health Home program *before* they enroll in a D-SNP, they retain their Health Home benefit when they enroll with a D-SNP
- MA Plans may offer and provide Health Home to others

As of July, 1460 individuals are engaged in D-SNP Health Homes.

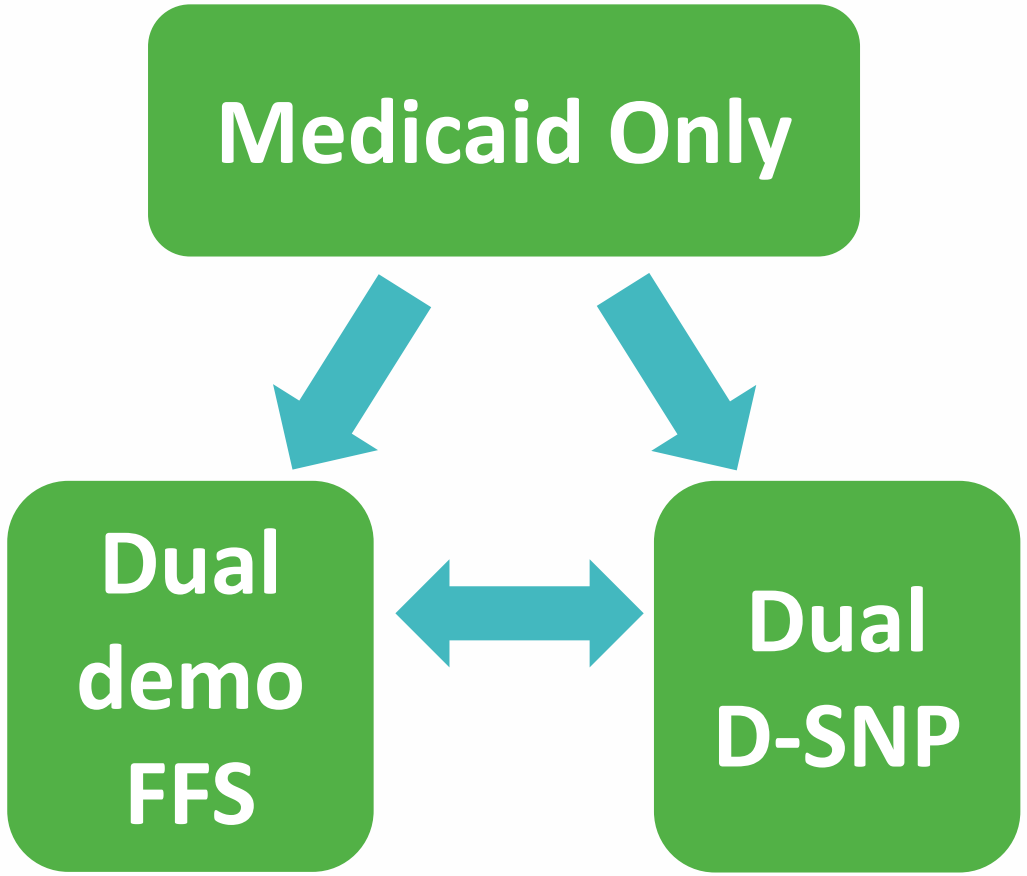
"You can explain what I need to do in a way I can comprehend."
– Health Homes client

Care coordination across the continuum

Expanding Health Homes to D-SNP allows us to offer this high intensity service to the highest risk and most needy clients across delivery systems– meaning that a single care coordinator can assist an individual as they transition from one delivery system to the next.

"The most important part of me advocating for my medical care is having you in my corner. "

– Health Homes client



Lessons Learned

Change takes investment

Shared savings comes in many forms

Need dedicated staff

Leverage what you know, use your data

Seek out help, ask questions

Include providers and MA plans – have the difficult conversations

"I cannot say it strongly enough. Being a cancer patient is a very lonely thing, and having the support of all of you has been a real blessing."

– Health Homes client

Thank you!

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