King County

August 19, 2015

Dorothy Teeter
Washington Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Via email: Dorothy.teeter@hca.wa.gov and medicaidtransformation@hca.wa.gov

Dear Ms. Teeter:

King County is pleased to provide feedback on Washington's draft application for a global Medicaid Transformation Waiver. As we stated in our initial feedback in July following the release of the concept paper, we are highly supportive of Washington's intent to pursue 1115 waiver authority to drive health and health care transformation.

We have identified the following gaps in the application as the most critical ones that need to be corrected and have offered suggestions on how to address them.

Issue # 1: Gaps in population health improvement domain

Overall, the application's strategies focus primarily on populations with complex chronic medical and behavioral health conditions, and on older adults. While important, this is insufficient to meet the "80/20" proposition.

The waiver needs a substantial and more clearly spelled out investment in population health and prevention strategies by addressing the leading risk factors to prevent chronic disease, by promoting emotional well-being and substance abuse prevention, and by investing in prevention strategies focused in childhood and adolescence in order to address a wider range of social determinants of health. This balanced portfolio approach is essential, and we support the comments and strategies recommended by the Health Coalition for Children and Youth and the Healthy Washington Coalition.

The following gaps should be addressed to strengthen the prevention and population health strategies in the waiver application.

Gap or Concern	Proposed modification in application or other actions
In the hypotheses to be tested and the evaluation plan, population health is missing.	Modify the evaluation section on page 13 to incorporate an additional hypothesis that speaks to prevention, such as: "After the transformation projects are implemented, the prevention and control of chronic disease (such as diabetes and cardiovascular disease) will be strengthened as a result of community and clinical-community interventions that successfully target common risk factors such as high blood pressure, weight, unhealthy diet, lack of physical activity, and tobacco use." The measurement approach should be broadened to incorporate measures and indicators appropriate for population health strategies (from sources such as BRFSS) to complement the clinical performance measures in MCO and BHO contracts. For example, while for the clinical care domain a measure related to diabetes control may be appropriate, other types of measures are needed for community level efforts that target associated risk factors (e.g., levels of physical activity). Earlier guidance prepared for SIM states included population level measures that were "amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years." http://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf
Population health strategies appear to be aimed at "targeted" populations only and do not reference links to the Plan to Improve Population Health or Prevention Framework	Population health in the context of a global waiver should not be defined as the health of just a targeted subset of Medicaid patients who *already* have multiple, complex health conditions. Eliminate "targeted populations of" in order to be clear that population health and primary prevention strategies in the toolkit could and should apply more broadly to the Medicaid population overall and the geographic areas where they reside. In the August 14 webinar, you stated the focus of the population health domain would include the prevention and management of diabetes, cardiovascular disease, obesity, smoking, and mental health/substance abuse. Please modify this section to reference these areas of focus and the connections to the Prevention Framework. Prevention opportunities should include those focused on children and youth, and those focused on systems and environments. Limiting projects in this domain to the high cost/high risk subgroups that appear to be the chief focus of the care delivery redesign efforts would be a serious flaw and not

	achieve the 80/20 proposition. If the waiver projects do not push into the domains of working on system and environment aspects, there exists a fundamental disconnect with the rationale for having the ACHs serve as coordinating entities. The ACHs are multisector tables, and include many sectors that influence health, outside of the delivery system and that go beyond a focus just on linkage to social services at the individual level. If the different sectors involved in an ACH don't see a role to play in the waiver, it could make it very challenging to sustain the engagement of the non-clinical sectors in the ACH.
Population health improvement domain is missing examples	Incorporate several examples of evidence-based clinical-community partnerships and community prevention strategies. Incorporate examples such as evidence-based strategies for obesity reduction and increased physical activity, hypertension strategies consistent with the Million Hearts campaign, and mental health promotion and substance use prevention strategies. In addition, the population health domain examples and eventual toolkit should include other evidence-based projects that can achieve results in the waiver's five-year time frame and that evidence shows will impact Medicaid costs. They include strategies in: - Community-based asthma interventions - Oral health - HIV/AIDS/STD/Chronic Hepatitis C - Violence and injury prevention (including fall prevention for older adults) - Unintended pregnancy prevention Sources of evidence-based examples include: • The Centers for Disease Control and Prevention's new Community Health Improvement Navigator Database of Interventions, which enables searching on risk factors, populations, settings, outcomes, and more. http://wwwn.cdc.gov/chidatabase • The Guide to Community Preventive Services

Approach to defining transformation projects is too narrow	On page 26, there is a statement that transformation projects will be "prioritized based on evidence and research-based success in Washington State." Transformation projects should not be limited to only those that have already shown success in Washington; we recommend you delete "in Washington State." The Department of Health and local public health jurisdictions should be called out as primary resources to engage in developing the menu of transformation projects under the population health domain.
Concerns about the approach to the coordination of Initiative 1 transformation projects via ACHs and the associated timeframe. As we emphasized in letter of July 8, there are significant oversight, compliance, technical, recordkeeping, data infrastructure, financial, and other roles that are required for a coordinating entity. There is currently a notable mismatch between the current nascent state of ACHs and the extent of infrastructure needed to carry out the proposed expanded roles.	To assure the success of Initiative 1: - The state should provide more clarity about the distinct roles of and interplay among the State, ACHs, BHOs, and MCOs, and play out detailed examples of how funds would flow and how different types of risk would be managed in a few sample transformation projects. - The application should include a realistic plan for how ACHs or other coordinating entities would be supported and resourced to develop infrastructure (potentially including costly new legal structures and extensively revised governance structures) for managing waiver projects in the planned timeframe. The state should address how planning capacity would be resourced *prior* to Year 0. The timeline for coordinating entity infrastructure development is not realistic – year 0 is not even 12 months and should be longer. - There is a significant need for the State to explore and address conflict of interest issues. Organizations involved in ACH governance and backbone roles include those that would potentially play roles in decision-making about what projects to implement in the region, and their design, implementation, contracting, payments, and evaluation. There is a complex web of conflict of interest at play; the application should recognize this dynamic and speak to a plan for addressing it. - The application should provide more details on the criteria by which an ACH, or other coordinating entity, would be evaluated to assess whether it has sufficient capacity to serve as the coordinating entity.

Issue # 2: Gaps in continuum of care for those with substance use disorders

Given the extent of substance abuse issues among the newly Medicaid eligible population, the waiver should include a demonstration project that tests Medicaid coverage of a full substance use disorder treatment service array in the context of an overall SUD service delivery transformation. Initiative 1's focus on bi-directional integration of physical and behavioral health services is an important feature within SUD delivery system transformation, but it is only one element.

On July 27, 2015, Vikki Wachino, Director of the Center for Medicare and Medicaid Services (CMS), issued a letter to State Medicaid Directors (SMD# 15-003), providing guidance to states on the use of the section 1115 Medicaid waiver for inclusion of "new delivery opportunities for individuals with a substance use disorder". King County believes that this opportunity could not be more timely given the current work with CMS on the global Medicaid transformation waiver, and with the 2020 deadline for full physical and behavioral health integration.

Gap or Concern	Proposed modification in application or other actions
Insufficient response to substance use prevention and treatment, given the extent to which it is a driver of costs in the Medicaid program	Act on the opportunity provided under SMD 15-003, a new opportunity for Medicaid demonstration projects authorized under section 1115 to test Medicaid coverage of a full SUD treatment service array in the context of overall SUD service delivery system transformation. Whether this opportunity is applied for as part of the current transformation waiver, or through an amendment, we recommend that it be pursued as soon as possible so that it can be well-integrated into the overall Medicaid Transformation. Among the elements of a comprehensive evidence-based design: • Better use of evidence-based practices in the SUD field including screening and intervention services in a broad range of settings, integration with primary care, withdrawal management, medication assisted treatment, care coordination, long-term recovery supports • Recovery support and preventive services such as peer counselors embedded in communities and recovery coaching • Aftercare supports for long-term recovery such as transportation, employment, housing, and community and peer supports • An IMD waiver for acute stays in ASAM level 3.0 and 4.0 facilities • Strategies to address prescription and illicit opioid addiction, consistent with national efforts to curb this epidemic

	• Enhancing provider, plan, county and state capacity to secure, maintain, and utilize 42 CFR Part 2 compliant consent to disclose and/or re-disclose records on substance abuse treatment for the purposes of care coordination, population health management, research and evaluation We believe that this waiver element holds the ability to be budget neutral and shore up a continuum of services where significant gaps exist in Washington State's current system.

Issue # 3: Housing and Employment-related gaps

We commend the state for prioritizing housing and supported employment services as viable recovery-oriented evidence-based practices that result in integrated and competitive employment and housing options for individuals with behavioral health disabilities. At a local level we have seen the cost effectiveness of providing these programs and are in full support of adding supported housing and employment as part of the Medicaid-funded demonstration.

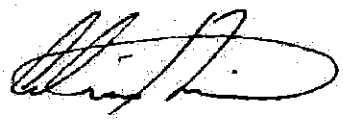
Gap or Concern	Proposed modification in application or other actions
Omission of clinical services in the supportive housing service	The list of services should be modified to make clear that clinical and community health worker/peer support services should be incorporated as part of a supportive housing service. They are an integral part of the model, and often include services such as nursing, wound care, motivational interviewing, health education, self-management support, care coordination, help enrolling and retaining coverage, etc. that are not directly paid for by Medicaid under current supportive housing partnership arrangements. The model and the benefit must be constructed as a partnership among housing programs, physical health services, and behavioral health services in order to succeed – not a stand-alone payment to housing organizations that occurs outside of a partnership arrangement.
Use of PRISM score and HUD definition of homelessness, and process for determining eligibility	We remain concerned about the proposed design for a supportive housing service and the associated access processes. PRISM score alone would be a step backwards in the work in King County to develop criteria designed to prioritize high risk homeless adults for supportive housing. We have effectively been using data from multiple sources (including factors such as justice system involvement and other indicators of vulnerability) to prioritize supportive housing access. PRISM score should be

	one, but not the only, factor. This will be critical to assuring sustainability over the long-term. Additionally, how this type of statewide service flows into and coordinates with existing local/regional supportive housing processes is critical, so as to build upon elements already in place rather than set up potentially conflicting or duplicative structures.
Omission of housing services in other Transformation projects	Where there is evidence to support it, housing-related and housing-based activities and supports for other Medicaid populations should be incorporated into "clinical-community" waiver strategies as part of Initiative 1. Activities such as outreach, assessment services, moving-related assistance, stabilization services and eviction prevention, assessment of and modification to the home environment to reduce asthma triggers and reduce fall risk, and other housing-related services may be key elements within clinical-community partnerships that are working to reduce avoidable institutionalization, prevent hospital readmissions, and improve population health. While the targeted high need and chronically homeless populations are very important elements of the waiver, it is vitally important that other at-risk households have better access to transformation projects that promote housing stability and a holistic approach to the integration of the social determinants of health with physical, behavioral, social and emotional health and well-being strategies. A more comprehensive set of strategies will allow us to turn the curve in our state to significantly reduce the number of people that become chronically homeless and need crisis intervention services.
Process for determining eligibility for supported employment	Within King County we have seen that the functioning level of individuals within our system do not necessarily reflect the level of needs once an individual enrolls in supported employment services in order to achieve job placement and job retention. Therefore we encourage the state to ensure the eligibility criteria for supported employment services allow maximum flexibility and are set as a minimum without inserting additional criteria that may be intended to manage capacity but may also unintentionally limit the flexibility of enrollment for individuals and providers.

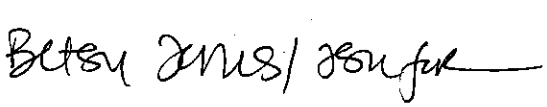
Omission of resources for technical assistance and infrastructure development for supported employment	We encourage the state to make available sufficient resources to adequately support infrastructure development and ongoing technical assistance for supported employment not only at the start-up phase but on an ongoing basis in order to implement and maintain fidelity standards of the Individual Placement and Support (IPS) model.

Sincerely,

Patty Hayes
Director
Public Health-Seattle & King County



Adrienne Quinn
Director
King County Department of Community and Human Services



Betsy Jones
Health and Human Potential Policy Advisor
Office of King County Executive Dow Constantine