



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
PO Box 45010, Olympia WA 98504-5010

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Washington Medicaid Integration Partnership

Programs that fit people, not bureaucratic tradition

The Washington Medicaid Integration Partnership is an integrated, client-centered approach to care for Medicaid-eligible adults. Medicaid Integration Partnership integrates services throughout the care system, coordinating medical, mental health, substance abuse, and eventually long-term care for 6,000 persons in a pilot project in Snohomish County. Medicaid Integration Partnership provides opportunities for efficiencies and cost savings not available in the current system. Medicaid Integration Partnership will focus on client needs, not bureaucratic priorities. Everyone agrees that integration of health care services is best for people and should be our goal.

Origins of the project:

- In 2002, Department of Social and Health Services (DSHS) Secretary Braddock outlined a goal of integrating health care, and approached the legislature for support.
- The 2003 budget proviso authorized DSHS to “develop an integrated health care program designed to slow the progression of illness and disability and better manage Medicaid expenditures for the aged and disabled population.”
- The budget proviso authorized DSHS to transfer funds within the department to implement the **Washington Medicaid Integration Partnership**.

Benefits to the consumer:

- People with multiple health care conditions will receive coordinated care.
 - Many people experience more than one health care condition.
- People with no “medical home” will get a doctor.
 - Many people with Medicaid can’t find a doctor to serve them. **Medicaid Integration Partnership** guarantees them a doctor.
 - Access to medical care will enhance the health status of consumers.
- Medicaid Integration Partnership establishes links between primary care, mental health care, substance abuse, and eventually long-term care.

Key elements:

- Integrates care through health plans that develop partnerships with providers of medical, mental health, substance abuse, and long-term care.
- Integrates funding streams to facilitate integrated care and reduce administrative overlap.
- Provides key data to guide, monitor, and evaluate the model.
- Provides for better access to services through comprehensive care coordination and management. This results in better outcomes for service recipients and a more efficient use of available tax dollars

Research projects cost reductions:

- Recent studies show that improved access to specialized care reduces subsequent medical costs.
 - A DSHS study demonstrated that mental health treatment offset up to 50% of the cost of providing medical care. Psychotropic medication with mental health treatment offset up to 64% of the costs.
 - A DSHS study demonstrated that chemical dependency treatment for SSI clients saved \$252 per client per month in medical costs above and beyond the cost of providing alcohol/drug treatment. Similarly, improved birth outcomes and medical cost savings of \$1,700 per baby in the first two years of life were demonstrated when chemical dependency treatment was provided to pregnant women.
 - Texas saved approximately \$123 million dollars over two years in a program that coordinated medication and other services.

System concerns:

- Will Medicaid Integration Partnership disrupt overall RSN services?
 - The impact on the Regional Support Network (RSN) is minimal – limited to outpatient mental health services for 6,000 of the total of 143,000 persons on Medicaid in the RSN.
 - Medicaid Integration Partnership draws only about 7 % of current RSN funding to provide its piece of the outpatient mental health services benefit.
 - The RSN will continue to provide consumer services including crisis, residential, and inpatient services in Snohomish County.
 - The RSN will continue to provide the current array of community services including ombudsman services, Quality Review Teams, and tribal liaisons.
- Will Medicaid Integration Partnership disrupt consumer care?
 - Consumers should experience a “seamless” change.
 - Medicaid Integration Partnership will use existing mental health providers in the community to provide outpatient services.
- Does Medicaid Integration Partnership duplicate administrative requirements?
 - New administrative demands will be minimal as Medicaid Integration Partnership will be just a couple more among many current payers for local mental health providers.
- Will Medicaid Integration Partnership cause job losses?
 - DSHS has encouraged bidders to work with Snohomish County, the local RSN, and providers to organize and deliver services instead of hiring new people.
 - Given that only about 7 % of the current RSN funding will go to Medicaid Integration Partnership, even a worst-case scenario impacts a minimal number of jobs.
- Has Medicaid Integration Partnership planning included community leaders?
 - Meetings and dialogue with community leaders has occurred for over a year. DSHS initiated discussions with RSNs in January of 2003, Snohomish County in May, and providers and Tribes in November.

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Comments on the Mauer/Jarvis "White Paper" related to WMIP

General Comments:

The data and conclusions in the Mauer/Jarvis White Paper regarding WMIP appear to have developed from early DSHS concepts and figures but do not accurately reflect the current proposal.

The fiscal impact of shifting RSN funds to the WMIP contractors will be less than the Mauer/Jarvis analysis suggests. Current planning has approximately 7% of current RSN funding shifting to the WMIP contractors.

The concern that WMIP may shift resources to persons with lower mental health need is unfounded given state law requirements to serve the highest need consumers first.

WMIP is a voluntary program and any individual consumer concerned about change in or loss of benefits may stay with existing medical and RSN providers.

Mauer/Jarvis First Recommendation:

Defer implementation of WMIP until the financing can be redesigned to prevent a substantial shift of resources away from persons with the highest mental health need.

DSHS Comments:

- By law (RCW 71.24.035(5)(b)), one of the duties of the secretary is to assure that mental health resources serve the highest need persons first. All RSNs, as well as the WMIP contractors, must comply with that law. DSHS will incorporate specific language in the WMIP contract to ensure clear communication of this mandate to the WMIP contractors.
- A DSHS actuary is currently developing rate models for the specific services to be provided by the RSN and the WMIP contractors. Those models will guide financing decisions.

Mauer/Jarvis Second Recommendation:

Creating a new clinical service model shared by the behavioral health and medical systems should move forward.

DSHS Comments:

- DSHS is preparing to engage the RSN, local providers, the WMIP contractors, and others to help develop a clinical model that addresses primary care and behavioral health issues for the populations to be served.

In response to comments in this “White Paper” and elsewhere, DSHS anticipates additional planning and language in the WMIP contract to discourage cost shifting between WMIP and the RSN.

Given that this is a demonstration project, DSHS is developing plans to evaluate the impact and necessary future changes to the integration model.

Mauer/Jarvis Third Recommendation: (related to the first recommendation above)

Use medical cost savings to finance increased services to Medicaid enrollees with low to moderate behavioral health needs. Retain use of the RSN funds that shift to WMIP for persons with high need.

DSHS Comments:

- By state law, RSN funds – even those shifting to WMIP – must be prioritized for persons with high need.
- WMIP has prioritized the adult disabled population and will not focus resources on persons with low to moderate mental health need.
- DSHS studies demonstrate cost savings in medical services when mental health and substance abuse services are provided. The WMIP pilot will provide us with additional opportunity for analysis of savings potential.