Below are comments received on the Medicaid Transformation demonstration Initiative 1, Project Toolkit through February 2, 2017.

Contents

American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

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Stephen Kutz
Cowlitz Tribe

Vice-Chair
Cheryl Rasar
Swinomish Tribe

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Puyallup
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Tulalip
Upper Skagit
Yakama

Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

February 2, 2017

Dorothy Teeter, Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Re: Comments re the Transformation Project Toolkit

Dear Ms. Teeter:

On behalf of Washington's twenty-nine Tribes and two urban Indian health programs, the American Indian Health Commission for Washington State (Commission) would like to once again thank you and your staff for your continued efforts to work with the tribes and urban Indian health programs (UIHPs) in the process of finalizing the 1115 Waiver. This letter provides comments regarding the Health Care Authority's (HCA) proposed Transformation Project Toolkit. We have listed our comments and questions below under relevant topics referenced in the toolkit and in prior discussions with the tribes and UIHPs.

1. **Certification Process**

   a. **No Tribal Certification.** HCA requires Accountable Communities of Health (ACHs) to complete a certification process prior to receiving transformation project funding. Please confirm that the tribes and UIHPs are exempt from this certification process.

   b. **ACH Certification.** Please confirm that the HCA will require all regional ACHs to meet the tribal representation and tribal policy requirements referenced in the CMS 1115 Waiver Special Terms and Conditions as part of the certification process referenced in the toolkit. These requirements should be documented in the transformation toolkit. See Section 45(a)(ii), 23(f) and 24.

2. **HCA Tribal Transformation Project Guidance.**

   a. **Exemption from the Transformation Toolkit.** At the HCA Tribal Protocol Workshop held on February 2, 2017, tribes, UIHPs, and HCA staff identified key differences in transformation project requirements for tribes and UIHPs versus ACHs. We request that the Transformation Project Toolkit apply only to regional ACHs and not tribes, UIHPs, or tribal organizations. The models provided in the transformation toolkit should not be required of tribes, UIHPs, or tribal organizations. These models have not been tested with American Indians and Alaska Natives (AI/AN) and their

communities. Tribes and UIHPs have developed their own models and those models should be respected.

b. **Tribal Transformation Project Guidance.** We request HCA provide a streamlined tribal/UIHP specific transformation project guidance that includes (1) a requirements checklist that apply to tribes, UIHPs, and tribal organizations; and (2) a framework for each of the transformation projects. The comments and questions outlined in this letter should be addressed in the HCA Tribal Transformation Project Guidance.

c. Plain Language Requirement. We also request the HCA Tribal Transformation Project Guidance comply with the Governor's Executive Order 05-03 which requires state agencies to adopt plain language principles and produce clear written communication that improves the readers' ability to understand how to comply with requirements.

3. Regional Health Needs Inventories and Regional Health Improvement Plans. Please confirm that tribes, UIHPs, and tribal organizations will not be required to complete a Regional Health Needs Inventory (RHNI) or a Regional Health Improvement Plan (RHIP). ACHs are new entities whereas tribes and UIHPs have a long history of assessing their communities' and service populations' needs and planning and implementing effective, culturally based programs to address those needs. Tribes and UIHPs will apply their existing knowledge and incorporate Medicaid transformation strategies into their current plans. These plans have been developed and vetted through each tribe's representative governmental process. UIHPs have similar processes through their governing boards.

4. Tribal and UIHP Project Participation and Selection

a. **Required Projects with Regional ACHs.** Can tribes/UIHPs fulfill their requirement to complete the two mandatory projects (Opioid and Bi-Directional Care) by partnering with their Regional ACH? For example, if a tribe in the Olympic Community of Health (OCH) partners on both the OCH's Opioid and Bi-Directional Integration of Care projects, could the tribe/UIHP then select one or more of the optional projects to complete independently from the OCH? If yes, please confirm that the tribe/UIHP will receive incentive payments for their independent optional projects. In addition, will the tribes and UIHPs receive a proportionate amount of the incentive payment awarded to the ACH for the tribes/UIHP's participation?

b. **Transformation Projects under a Statewide Tribal/UIHP Effort.** Can tribes, UIHPs, and/or tribal organizations complete transformation projects under a statewide tribal/UIHP effort? Tribes and UIHPs have expressed interest in collaborating and sharing expertise. Under a tribal statewide framework, each of the listed projects would have an organization with tribal expertise in that subject matter serve as the statewide lead. The lead would be comprised of one or more tribes, tribal organizations, or UIHPs. The lead would receive additional incentive payments for their role as the lead organization for that project. The lead will be further defined in the HCA Tribal Transformation Project Guidance. Other

tribes/UIHPs not serving as the lead would be eligible to complete their own projects in that subject matter area and receive individual incentive payments.

c. **Transformation Project Activities that Tribes/UIHPs Already Perform.** If tribes/UIHPs are performing many of the listed project activities, will the tribes/UIHPs receive funding for those current activities as long as (1) the tribes/UIHPs are not currently being reimbursed by Medicaid for those services; and (2) the project improves upon or expands the tribe's/UIHP's current efforts? Please provide further clarification regarding the rules applicable for projects that already exist and incentive payments for those projects. For example, many tribes have implemented efforts to improve access to quality oral health care across their community but may need to develop the data infrastructure to measure the program's progress.

d. **Transformation Projects Not Listed in the Toolkit.** The State requested comments from stakeholders in the development of the transformation project list. Tribes and UIHPs were repeatedly informed at the initial Global Waiver Tribal Workshops in 2015 that the development of a tribal transformation project list would be separate from the statewide process and occur at a different time. We request that the State abide to its commitment to the tribes to support tribal projects not listed within the toolkit as long as the projects fall within the parameters of the 1115 waiver objectives to lower costs, improve patient care, and improve population health.

e. **Domain 1 Requirements.** Please confirm that tribes/UIHPs will be exempt from the focus area regarding financial sustainability through Value-Based Purchasing. Tribes as sovereign nations possess the authority to determine what activities they will pay for including those efforts that improve and enhance population health or bi-directional care. Tribes and UIHPs will determine their own mechanisms for financial sustainability.

5. **Performance Measurement.** Please confirm that consistent with the CMS 1115 Special Terms and Conditions, tribes and UIHPs may use comparable GPRA measures in lieu of the statewide performance measures.

6. **Funding**

a. **Administrative funds.** Please confirm that funding for administrative purposes or for assistance with infrastructure will be available for tribes, UIHPs, and tribal organizations on the same basis as it has been or will be made available for ACHs.

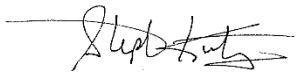
b. **Workgroup funding.** Please confirm that funding for workgroups as referenced in the transformation toolkit will be available for tribes, UIHPs, and tribal organizations on the same basis as it has been or will be made available for ACHs.

c. **Match funding and Intergovernmental Transfers (IGT).** Tribes, UIHPs, and tribal organizations should not be subject to IGTs or to providing match funding. ACHs are not required to put up a non-federal match because the State has found other non-federal

expenditures to use for the match. Those statewide expenditures benefit the entire state population including AI/AN. Tribes and UIHPs serve the AI/AN population, and therefore, should have access to an equitable share of the statewide non-federal expenditures being used for the non-federal match for the ACH programs. Imposing match funding would be inequitable to tribes, UIHPs, and tribal organizations. We request that HCA provide clarification that Section 86 and 87(d) of the CMS 1115 Waiver Special Terms and Conditions will not apply to tribes, UIHPs, and tribal organizations.

We look forward to continuing to develop the tribal transformation project guidance with the tribal representatives, UIHP directors, and our HCA partners. If you have any questions regarding these comments, please contact Vicki Lowe, AIHC Executive Director, at vicki.lowe.aihc@outlook.com or 360-477-4522.

Sincerely,



Stephen Kutz, Chair
American Indian Health Commission of Washington State

cc:

Lane Terwilliger, JD, CMS, CO
Cecile Greenway, CMS Medicaid Region X Program Branch Manager
David Meacham, CMS Associate Regional Administrator for Seattle
Rhonda Martinez-McFarland, CMS Region X Native American Contact
MaryAnne Lindeblad, HCA State Medicaid Director
Tribal Leaders
Tribal Health Directors
Urban Indian Health Program Directors
AIHC Delegates
Indian Policy Advisory Committee Delegates
Vicki Lowe, AIHC Executive Director
Heather Erb, AIHC Legal Consultant
Nathan Johnson, HCA Policy Director
Jessie Dean, HCA Administrator of Tribal Affairs
Elizabeth Watanabe, HCA Healthier Washington Tribal Liaison
Joe Finkbonner, NPAIHB Executive Director
Laura Platero, NPAIHB Policy Analyst

Amerigroup Response to the Project Toolkit

Amerigroup leadership and staff, both at the Washington health plan level and within our corporate team, have engaged in the State's innovation work since the beginning. We have been vocally supportive of many of the components of both the Innovation Plan and the Medicaid Transformation Project demonstration and we appreciate the opportunity to provide comment on the Project Toolkit, which we see as defining the foundation of success for the Demonstration. Below, you will find our comments, suggestions, questions, and desired opportunities to partner further with the state as pieces of the Toolkit coalesce and implementation begins.

Value-Based Payment Transition Taskforce

In general, we are supportive of this Taskforce being formed. We see it as an opportunity to break down some of the barriers to successful transition to a VBP system. However, there are some details about the trajectory of the Value-Based Payment Roadmap that still need to be hammered out and discussed with managed care organizations and HCA, especially given adjustments to the Roadmap formula laid out in the Special Terms and Conditions (STCs). We would prefer these detail-oriented conversations happen privately with our MCO colleagues and HCA before we jump into the broader systemic conversations that will be occurring at the Taskforce level.

Recommendation: Reconvene the group that first met in May 2016 when the Roadmap was initially released to discuss new elements of the Roadmap laid out in the STCs before the Taskforce is launched.

Domain 1: Health and Community Systems Capacity Building

Financial Sustainability through Value Based Payment

We have a number of ***questions*** related to the activities of this particular foundational element:

1. Will the survey/attestation assessment differ from what was released in RFI form by HCA in 2016?
2. How will the Taskforce ensure participation from all affected providers in this particular assessment?
3. Is the 2016 VBP RFI the baseline for assessing VBP attainment and will the results of the Toolkit assessment be compared to the responses to the 2016 RFI to show improvement? Or will the Toolkit assessment stand as the baseline for VBP attainment for the duration of the Demonstration?
4. Will the new adjustments to VBP attainment list in STC 41 be included in the final draft of the Toolkit and will ACHs' potential VBP incentives be tied to the new attainment formula?
5. Will there be additional support given to BH Providers, particularly in non-integrated regions, to more immediately implement VBP models once their region does integrate?

Recommendation: As part of a national entity, we would appreciate alignment in the definitions, benchmarks, models, and assessments that state has around VBP with HCP-LAN recommendations and white papers.

Workforce

First, we appreciate MCOs being included as potential partners on the Workforce Development Taskforce. As our business practices shift to becoming even more quality-focused, we know that our own employment patterns will have to change as well, which could affect the availability of certain professions to be employed by other sectors of the health system. We want to be a part of the developing solution, not a barrier.

Recommendation: To better serve and improve the health and wellbeing of the patients, we believe it is important to have a health workforce that is trained in providing trauma-informed care and service so that some of our most vulnerable members of society feel welcomed into our health system and motivated to improve their own health outcomes. We would like the Taskforce to explore and create recommendations on how administrators, providers, peer counselors, mental and medical health center and hospital staff are trained in providing trauma-informed care and support to patients. Additionally, we think this is a vital course that should be offered at medical schools, nursing schools, and health technical colleges so that the workforce of the future has already received training in creating these welcoming environments.

Systems for Population Health Management

We see this particular foundational element as both the biggest opportunity and risk of this Demonstration. So far in our state, data sharing, transfer, and warehousing have posed challenges, both from entities to the state and back out, within closed healthcare systems themselves, and across clinics and hospitals. And, in order for VBP practices to be truly successful, our data transferring and interpretation have to be seamless and consistent.

We know that another Taskforce may be duplicative and overtax the current sectors of the system that will need to participate in the VBP Transition and Workforce Development Taskforces. However, we see an immediate need to collectively determine the barriers and co-create a plan to overcome those barriers to not only make this Demonstration successful, but to also create a sustainable HIT/IS system that is usable after the Demonstration is complete.

Additionally, we believe this kind of plan needs to be created at the state level with constructive input from the ACH regions. Since regional boundaries are arbitrary for healthcare catchment areas, we need to design and stand-up a data information and sharing system and processes that accommodate entities that cross multiple regions so that multi-region organizations aren't forced to connect with different platforms in their different service areas.

Domain 2: Care Delivery Redesign

Project 2A: Bi-directional Integration of Care and Primary Care Transformation

We are, of course, very supportive of all Demonstration efforts related to clinical integration. We also appreciate that a plan for how each region will get to financial integration is required so that communities can start understanding the impacts integration could have on them and how to develop the right infrastructure to address those impacts.

Related to the models/interventions proposed: We already work with a number of clinics who employ both of these models, we just may not always be able to reimburse the services they provide under each model. The promise of this particular project is in developing the workforce and HIT capacity of both community mental health centers (CMHCs) and primary care providers (PCPs) to fully execute on these models, especially in rural areas.

One area of focus we would like to see more process milestones designed around is how we can support the continued integration of mental health and substance use disorder (SUD) services and the connection of,

especially SUD services, to primary care and hospitalists. Focusing on this specific realm of integration will allow for Project 3A to also be more successful and connected to this project.

Project 2B: Community-Based Care Coordination

We support the idea and implementation of a system to "coordinate the care coordinators". We also see a lot of promise in the recommended model, The Pathways Community Hub. However, we request that the HCA convene conversations immediately with all interested MCOs (we would be one) to work through how this model aligns and doesn't align with our contract requirements, particularly our care coordination and Health Homes requirements. Additional topics of conversation that need to be covered include:

- How much the Demonstration will pay for building the infrastructure of each Hub in each region
- How the Hub infrastructure will be sustained
- How connecting to the Hub and contracting for services through the Hub will be reflected in our rates
- How to incorporate the pre-built RVU and Code sheets the Pathways team has already create into the Medicaid fee schedule
- Certification requirements for people providing services under a Hub structure (i.e., formal CHW Certification)
- Hub Certification vs a Hub-like system (we would prefer Hubs in each region be certified to provide the Pathways)

We also would like the state to provide guidance and leadership around each region choosing the same technology platform when building the Hubs. That will allow us to more easily shift our business practices if we can interact with just one system.

Project 2C: Care Transitions

We have worked extensively with the hospitals and WSHA on transitioning patients from the hospital into the next level of care they need and we consistently run into the issue of different organizations operating different models of care transitions with varying levels of fidelity to their models. While this requires us to be nimble in the work we do with our providers, the system as a whole may not reach the outcomes we need to reach if one consistent model isn't called for.

Additionally, this is an area where we could use some significant alignment between the different licensing/regulatory bodies and quality assurance entities. HCA, CMS, WA DOH, JCAHO, and NCQA all have different ways of defining requirements for facilities and measuring success of care transitions. For this project to be truly successful, state and national policy changes or regulatory waivers may be necessary.

All that being said, we find that this could be a very valuable project, particularly in regions where we consistently have issues placing patients into SNFs after they're ready for discharge.

Question: We see tremendous potential in the jail transitions portion of this project. However, if a region wants to take on both care and jail transitions, are they able to? Or is selection of this project contingent on choosing only one focus area? That kind of distinction will be necessary in the coming months as ACHs choose their projects.

Project 2D: Diversion Interventions

We work with a number of partners on ED Diversion in a number of regions to specifically address ED Diversion. The work and strategies outlined in this particular project support and align well with our work with our partners. Additionally, we support communities exploring how to use their paramedics and EMS system to its full capacity. However, it is not entirely clear whether VBP models would be applicable to community paramedicine services. If regions do choose to implement this model, we would like to discuss sustainability with the state at the beginning of project design so we know exactly how a MCO would be held accountable.

We see great value on focusing on Jail diversion but this is a community issue that requires multiple traditional and non-traditional health sectors to participate. We want to ensure that the accountability and risk aren't placed on only healthcare sectors since we may not have as direct an impact on jail diversion as some of our community partners.

Domain 3: Prevention and Health Promotion

Project 3A: Addressing the Opioid Use Public Health Crisis

To tackle this pervasive issue, ACHs will need to reach deep into the community and bring in sectors that are very tangential to the traditional health system. We support a whole community effort but also would like to know which parts of the system will be held accountable to or bear the risk of the project's outcome improvement. Most of the outcome metrics listed in Appendix I are related to what happens within the healthcare sectors. If many different parts of the community are working together on this effort, it doesn't seem prudent to pin the outcomes and risk on one or two parts of the larger whole.

Project 3B: Maternal and Child Health

Throughout the course of ACH work, we have committed staff to working on maternal and child health initiatives so it's a soft spot for our company. Additionally, we have already begun to work with Nurse Family Partnership in referring our members into their programs. Therefore, we are very supportive of it being included in the Toolkit and firmly believe that if it was a required project across every region, Washington would make substantial gains in population health improvement.

We also believe messaging around this particular section is important and are supportive of language changes that emphasize the importance and effectiveness of preconception care and education for women and men of child-bearing age. Delaying pregnancy until both parents are ready, healthy and well is important in early and lifelong child development.

Question: Overall, we absolutely support the inclusion of home visiting programs and look forward to determining how to sustain these programs past the Demonstration. But, will regions be constrained to these two particular models? Although we support NFP and Early Head Start, there are a number of other evidence-based home visiting models that provide an infrastructure we can build off of in the regions that select this project. Will there be room and funding to add additional models to the Demonstration?

Recommendation: For metrics associated with increasing access to LARC, we recommend also using the newly endorsed NQF metrics that are more clinically-based so that we have metrics at both the system and

project/provider level. These metrics will provide us a much more accurate picture of the number of women planning and spacing their pregnancies. The metrics include:

- NQF# 2904 Contraceptive Care-Access to LARC
- NQF #2903 Contraceptive Care-Most and Moderately Effective Methods
- NQF#2902 Contraceptive Care-Postpartum

Project 3C: Oral Health

We support all providers in doing what they can to expand access to dental services. For the rural regions that decide to take this project on, it will be very important for the state to consider how to include capacity building, for dental providers in particular, into the funding formula. Because of the deficit of Medicaid dental providers in rural areas and the travel time to get to those providers, rural ACHs may have to work more extensively to integrate Oral Health into the health system than their urban counterparts.

Question: How will this kind of project align with the intention to sustain projects and new models of care through VBP? Will MCOs be responsible for helping develop that?

Project 3D: Chronic Disease Prevention and Control

The Chronic Care model is more of a framework and approach to addressing patients with chronic conditions, not a specific intervention. The framework is applied within a PCMH, team-based care model so it's hard to understand how this project is differentiated from the PCMH model called out in Project 2A. We can see that this framework approach provides for more regional adaptability to meet current and future workforce needs. This will be particularly important in rural areas and Tribal Nations.

Recommendation: Because CDSM and DPP are already covered services, having them included as recommended interventions would provide consistency as we transition into a new delivery system and will encourage additional linkages between clinics and the community.

Overarching Questions

- How many metrics will be tied to the Demonstration in total?
- What expectations do you have for MCOs in collecting and reporting on those metrics? Will we be expected to report it to the state, to the regions themselves, or both?
- If a region wanted to take elements of one project and incorporate it into another project, will the ACH be able to earn the incentives of both projects? For example, if an ACH wanted to incorporate elements of oral health into the integration projects, would they be able to earn incentives for both?

Once again, thank you for the opportunity to comment on the Toolkit. We look forward to working in partnership with HCA on the details of implementing this Toolkit and the Demonstration.

For follow up questions and discussion, contact:
Caitlin Safford, Director of External Affairs and Community Development
Caitlin.safford@amerigroup.com
206-492-1666

Via email: MedicaidTransformation@hca.wa.gov

February 2, 2017

Nathan Johnson, Chief Policy Officer
Washington State Healthcare Authority

Re: Beacon Health Options' Comments on Draft Medicaid Transformation Toolkit

Dear Mr. Johnson:

Beacon Health Options (Beacon) applauds the Health Care Authority's (HCA) vision for Washington State, and the commitment this toolkit represents to making an integrated system of care a reality. Beacon is the premier behavioral health organization in the country, serving more than 50 million individuals on behalf of more than 350 client organizations, and employing approximately 5,000 staff across the country and in the UK. We have extensive experience working with public and private stakeholders to transform communities. Overall, the Medicaid Transformation Toolkit reflects the principles of evidence-based practices and data-driven care that are fundamental to our mission.

In 2015, Beacon was honored to be selected as the Behavioral Health-Administrative Services Organization (BH-ASO) for the Southwest Washington Early Adopter region. Over the past year, we have worked closely with regional stakeholders to implement and administer a robust crisis system that is an essential part of the continuum of care in Clark and Skamania counties. Reflecting on the Toolkit, we would like to call out the importance of including the crisis system as an important collaborator for all of those initiatives, especially Projects 2A, 2B, and 2C. Part of creating a successful, integrated system that allows for collaboration is ensuring that crisis plans are in place and that all parts of the continuum are coordinated. The model followed in Southwest Washington presents an example of how crisis can be one of the conveners in an effort to create a more robust diversionary program.

Beacon would also like to suggest the inclusion of additional information on Project ECHO and other telephonic resources for opioid management support for Project 3A. In partnership with our clients, Beacon has been working to address both the causes and impact of opioid use and misuse. We have committed to providing resources for Project ECHO. The resulting clinician-to-clinician support that Project ECHO and similar programs provide can be an important way to extend resources and develop capabilities in the local community.

Beacon is grateful for the opportunity to comment on the Medicaid Transformation Toolkit, and looks forward to working with the HCA and the broader Washington State healthcare community to make the vision of Healthier Washington a reality.

Sincerely,

Julia Bernstein
Vice President, Strategy & Development
Beacon Health Options
Julia.Bernstein@beaconhealthoptions.com
510-771-0754

better
health together

Dorothy Teeter
Health Care Authority
Via email

Dear Director Teeter,

Thank you for your hard work in developing a powerful Medicaid Transformation Project Toolkit. It is exciting to see Accountable Communities of Health around the state readying for action. The following comments were generated from the governing board of the Better Health Together Accountable Community of Health region.

As we have prepared our region for the Transformation Demonstration projects, we are pleased to see a number of evidenced based practices incorporated into the Toolkit. During this demonstration period, we will be most successful if we can leverage existing efforts in the region and take them to scale. Additionally, we are committed to working collaboratively with our ACH colleagues across the state, and with partners to ensure that we align at a statewide level where it makes sense and customize for maximum local impact. At BHT, we appreciate the competitive spirit that is embedded in our health transformation. However, we do not want to see ACHs compete unnecessarily and potentially effect overall population health in our state. This is especially true with the porous borders in our Eastern Washington region as ACH boundaries do not match up with natural medical referral patterns, Community Action Organizations, Workforce Development Council, Aging and Long Term Care, and Behavioral Health Organizations service areas. It would be a disservice to our communities to pit one ACH against the other.

It will be critical that we develop strong synchronized statewide efforts especially as it relates to:

Financial Sustainability through Value-based Payment: One of the challenges facing health transformation is the shift in how we pay for health in our communities. This is a complex relationship between payers, providers and community organizations who will face new pressures to deliver critical services. We are concerned that 9 separate ACH regional plans will create unnecessary complication and not allow for sufficient coordination; we would appreciate additional clarity on how the regional plans will connect to the work of the statewide Value Based Payment Transition Taskforce. We expect leadership from the Health Care Authority to ensure we can move forward with a coordinated system that is appropriately aligned across the state.

Additionally, we continue to have questions around the commitment to a 2% reduction in Medicaid spending. We look forward to specific information about how this will be calculated

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and measured. We see a potential for transformation efforts to concentrate in the highest population centers and leave behind our rural communities. It would be morally wrong for us to ignore the rural areas of our state who often face different challenges. This further emphasizes our desire to improve health across the state, not pit ACHs against each other.

Population Health Management: Over the past two years of our ACH development, we have consistently articulated the need for strong data systems to provide appropriate population level health data. We are delighted to see a more robust strategy for sharing, accessing and analyzing data. This is likely to be slow and clunky work as we develop cross sector systems to track outcomes. We expect this to be a high priority with local investment to match up with the ACH needs.

Community-based Care Coordination: We are pleased to see the Pathways Community Hub included in the Toolkit. Though BHT was an early adopter of the outcome-based Hub model for our ACH Regional Health Improvement project, we support the change of making this project optional. We applaud the requirement that regions who choose community-based care coordination projects must utilize the Pathways Community Hub as the *only* fundable Care Coordination option. We feel strongly that in order to maximize statewide efficiency, the Pathways Community Hub provides the required evidenced based practice infrastructure to ensure that we are creating the most effective system to breakdown silos between health care and social determinants of health efforts. We are especially excited about the potential for Pathways to be linked with other Demonstration projects; for example, one Pathway links an outcome to enrollment in a Patient Centered Medical Home, a preferred model for bi-direction integration.

Additionally, we support and advocate for the ability to develop regionalized efforts that can be scaled fast. The Better Health Together region has a long history of pilot projects, many of which align with the models noted in the Project Toolkit. However, we are interested in the regional flexibility to link projects for funding that may adapt existing models to local efforts already in place. As we contemplate how many simultaneous delivery system reform efforts our region can take to make the biggest impact, we will look for opportunities to leverage existing infrastructure (Pathways Community Hub) with key projects such as Opioid and Diabetes Chronic Disease Self-Management. We hope that the funds flow for Domain 2 and 3 projects will allow for creative linking of existing efforts to align with models referenced in the Toolkit to support the maximum outcome.

Bi-Directional Integration of Care: We are very supportive of efforts to accelerate both the payment and care delivery models that focus on whole person care. We believe great work has occurred in our region through our rural health systems, Federally Qualified Health Centers and payers to begin this work. BHT is ready to support the appropriate efforts to move this work forward.

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Access to Oral Health Services: This continues to be a top priority for our region. The two models put forth do not address the access to care issues facing our region. We would like to see adaptions of the suggested model to address, or at least pilot, new reimbursement rates to build our network of Medicaid accepting dentists. For instance, an increased incentive payment for specific populations we might work with through the Medicaid demonstration efforts (pregnant moms, people with diabetes, etc).

Better Health Together is fully committed to partnering with the state, Tribes in our region and key players that will be necessary to dramatically improve the health of our region. We thank the HCA for their efforts to secure resources for the hard work ahead of us. This is no easy task and we stand ready to act.

Sincerely,

Alison Carl White

Alison Carl White
Executive Director

On Behalf of the BHT Board of Directors:

Tom Martin, Chair	Christine Barada	Kai Nevala
Sharon Fairchild, Vice-Chair	Alison Boyd-Ball	Jessica Pakootas
Greg Knight, Secretary	Antony Chiang	Torney Smith
Dean Larsen, Treasurer	David Crump	Jeff Thomas
Peter Adler	Jay Fathi, MD	Pam Tietz
	Lynn Kimball	Phillip Tyler

CC:
Better Health Together ACH Leadership Council
Nathan Johnson, Health Care Authority
Chase Napier, Health Care Authority
Lena Nachand, Health Care Authority

- We support the state's efforts to transform our healthcare system to a client-centered continuum of care that is more fully integrated and coordinated. These Medicaid Transformation Projects are an important step in that direction

- That said, we were disappointed to see a lack of Toolkit content supporting the use of school-based coordinated health services as a critical element of a comprehensive system of care We believe this is an omission that should be rectified in the revised version

- Here's why:
  - There is a substantial & growing body of research evidence supporting two general themes about the relationship between health and education:
    - Healthy children and youth do better in school, and complete more education
    - People who complete more education are healthier and have lower healthcare costs
  - Consider if you will
    - In nearly every community there are families who are not accessing needed health services for their children & youth
    - In many of our communities the needed services are inadequate or entirely absent
    - In every community there is a school -the one place that a significant portion of the population - nearly every child between the age of 6 and 18 – can be found for six hours a day (more in some cases), five days a week is school
  - There are successful models of school-based coordinated physical and behavioral health services which, however, they are not available in most schools.
  - There is a common perception that the legislative response to the state Supreme Court decision in the McCleary case will provide resources that will ensure these health services in every school. Based on review of both the Governor's and the Senate's budget proposals, this perception appears to be inaccurate.

Our Request:

As you revise the toolkit and develop the planning templates, you should allow – perhaps even incentivize - school-based coordinated health services as an acceptable strategy within each of the three domains

The Rationale statement for Domain 2 in the Toolkit states, *"The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time."*

School-based coordinated health services address all three of these elements. It will increase access to care and decrease disparity in health & school outcome for children and youth, especially for rural and vulnerable youth populations

Mike Hickman, Assistant Superintendent
Capital Region ESD 113

Erin Riffe, Director of Behavioral Health Services
Capital Region ESD 113

CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

January 30, 2017

RE: Comments on Medicaid Transformation Project Toolkit

Washington State Health Care Authority
Attn: Medicaid Transformation
P.O BOX 42710
Olympia, WA 98504

Dear Medicaid Transformation Team,

The Cascade Pacific Action Alliance (CPAA) is pleased to offer the following comments on the current draft of the Medicaid Transformation Project Toolkit. In making these comments, the CPAA is guided by a culture of collaboration across sectors and systems to improve safety and well-being in the Central Western Washington region.

We are generally supportive of the opportunities presented in the Draft Toolkit, and we are pleased to see overall alignment with the Regional Health Improvement Plan that the CPAA has previously developed. Specifically, the Toolkit's projects concerning Community-Based Care Coordination (Domain 2), Chronic Disease Prevention and Control (Domain 3), and Maternal and Child Health (Domain 3) directly align with the CPAA's priority areas of Care Coordination & Health Integration, Chronic Disease Prevention and Management, and Adverse Childhood Experiences (ACEs), respectively. Additionally, the Toolkit's focus on Bi-Directional Integration of Care (Domain 2) and Addressing the Opioid Use Public Health Crisis (Domain 3) may successfully expand on the CPAA's current project work, which is focused on youth behavioral health coordination and youth marijuana prevention and education.

Additionally, we have several questions and comments about the draft document:

Overall Approach

When considering overall project implementation, a key question asked by our regional partners centers on how much flexibility there is for different counties to utilize different projects or strategies within the toolkit. As a multi-county region, do stakeholders from all seven counties have to work on the same project(s) and implement the same strategies or can counties within an ACH select which projects and/or strategies they engage on based on their respective needs and capacities? We recognize and support the value of evidence-based practices and the need for standardized performance measurement. Yet, we also believe that project designs and implementation models that recognize the *differences* in our communities are vital to making the most of the Medicaid Transformation Demonstration opportunity. We are concerned that a one-size-fits-all approach that does not provide flexibility in this regard will overlook the different community needs and capabilities that vary considerably across our diverse region.

Trauma-Informed Care Principles

The CPAA is very focused on prevention and early intervention in order to improve the health of our communities and residents. With this in mind, we would like to recommend that the SAMSA trauma-informed care principles, which were referenced in an earlier version of the toolkit draft but are no longer included in this latest draft, be reintroduced into the toolkit. Moreover, we suggest that the SMASA trauma-informed care principles be applied not only to the maternity and child health section, but rather be used as an *overall lens* throughout the document, including workforce development. To achieve better health this key systemic issue cannot be ignored.

Financial Sustainability through Value-based Payment *(Domain 1)*

The value-based payment section of the toolkit raises a number of questions for CPAA stakeholders and partners. It would be helpful to have more concrete definitions of what Value-based Payment (VBP) is and what having payments tied to value looks like on a practical level for our local providers. There is concern that many provider organizations may not yet be equipped to operate successfully within VBP Payment models, especially small to mid-sized providers in rural areas, and we see a need for a clearer foundational understanding across the state. Some partners are concerned that the timeline on annual VBP benchmarks in the toolkit may be overly ambitious.

CPAA would also like more clarity on how the ACH activities will specifically relate to existing efforts to transition to VBP, and how the state will ensure those efforts are not duplicated (e.g., Practice Transformation Hub, etc.).

Workforce *(Domain 1)*

CPAA is pleased to see that workforce development continues to be a priority in Medicaid Transformation, as it is an essential step towards care delivery equity, especially in our rural communities. As mentioned above, in keeping with our region's focus on prevention and early intervention, including mitigating the effects of Adverse Childhood Experiences (ACEs), our stakeholders and partners believe that there should be an element of trauma-informed care and/or Neuroscience, Epigenetics, ACEs, and Resilience (N.E.A.R.) science training included in the toolkit. Specifically, we would like to see the SAMSA trauma-informed care principles added back into the Project Toolkit in this and other sections.

We believe that more clarity is needed in the Workforce section on how the Demonstration activities will not supplant existing efforts. Will ACH partners be able to build on and/or modify existing regional efforts in addition to the state's plan to build on work done by other health workforce committees?

Addressing the Opioid Use Public Health Crisis *(Domain 3)*

While the CPAA agrees that Opioid Use is a serious public health problem in our region, our partners have expressed concern over the large number of existing opioid response efforts and potentially duplicative work. Given the many different initiatives in response to this crisis, it is unclear how will we be able to measure the specific impact of the work of ACHs.

It is also unclear whether ACHs will receive prescription data from the Health Care Authority (HCA) or the Managed Care Organizations (MCOs). This will be vital information for any meaningful opioid response effort.

Another concern in our region is whether there are enough providers with the capacity to treat the issue. In addition to increasing the number and capacity of health care providers, more case management and recovery supports will be needed to address the opioid crisis in the region effectively.

In closing, CPAA appreciates the opportunity to provide comments on the Medicaid Transformation Demonstration Project. We believe the Demonstration Project aligns well with key elements of our regional health needs improvement efforts, and we look forward to working with the Health Care Authority to improve the health of our region.

On behalf of the CPAA,

Winfried Danke,
Executive Director
CHOICE Regional Health Network
CPAA Backbone Support Organization

January 24, 2017

To: Washington Health Care Authority

Regarding: the toolkit for Medicaid Transformation Projects

I am a nurse coordinator providing support for faith community nurses (parish nurses) and health ministers that offer a health ministry to their congregation and community. Faith community nurses and health ministers fall under the definition of a Community Health Worker as trusted members of the (faith) community in which they serve.

I am writing to request that Coordinated Care, such as a Pathways type model, remain a required element of the Toolkit for Medicaid Transformation Projects.

Since I work with health ministries within communities of faith I thought I would explain why this requirement is important through the telling of a modern day parable*:

A group of volunteers traveled from afar to restore a failing orchard. As they worked, they saw the trees grow in health and they returned to their home with a renewed spirit. They told many stories of their success and looked forward to their return the following year with many more volunteers. Their efforts were expensive both in time and funding but they concluded that it was well worth it.

But they did not see what became of the trees once they were gone. Some of the trees that were watered by hand during their time there and had looked so strong had no source of continued watering after they left so the fruit never grew. Some of the trees had low branches trimmed but the higher branches could not be reached by the local workers because they had no ladders and so the fruit grew but withered and died on the tree. Some of the trees were uprooted and replanted to another part of the field but the local workers knew that this area was vulnerable to strong winds and so the fruit grew but was blown off before it could ripen. But some of the trees remained in the part of the field recommended by the local workers, had an irrigation system built with local materials and were trimmed in a way that the workers could still access all the branches long after the volunteers returned home. These trees bore fruit a hundred fold and the community had more to eat than ever before.

What does the parable mean?

This parable gives the secret of curing the sick and restoring health to a community. The volunteers are well-intentioned health care professionals. The orchard is the community and the trees, its members in which they give medical care and provide supplies. The local workers are community health workers who live, work, play and worship with in that community. They know their neighbors and their needs, needs that may not seem directly related to their health care-like, that they have just received an eviction notice, that there are no grocery stores in the neighborhood that sell fresh fruits and vegetables, that there are no safe places for their children to go outdoors and play, or that they can't concern themselves with getting a mammogram because they don't know how they are going to pay the bills this month and have become quite depressed.

The trees that are watered for awhile but were left to dry out are the community members who are given short term fixes such as medication and brief instruction for long term problems such as chronic health conditions. The trees that had fruit wither and die on the high branches are the community members who had issues and questions arise after the volunteers left but had no resources within their community to work these out. The trees that were replanted in a seemingly promising but ultimately devastating part of the field suffered because the volunteers failed to work closely with the local workers and community who knew vital information about their own neighborhoods. Their good intentions proved literally fruitless.

The trees that remained in place that were irrigated properly and tended by the local workers are the community members whose health improved and remained strong for years to come. The medical professionals used their expertise to do great work, but they also respected the unique knowledge that the local community health workers generously offered and supported them through provision of education, supplies and facilities. They provided individualized and comprehensive coordinated care with the long-term in mind and included outcome measures to assess success defined in individual improved health terms. Finally, they built capacity by ensuring that local community health workers were strengthened and integral to the care coordination continuum. Ultimately, their investments paid off with overall improved health in the community sustained by the ongoing connections made through the local community health workers.

Maintaining and improving one's health does not take place behind the walls of a hospital or clinic. It takes place in one's community-in our homes, our places of work, where we shop, where we recreate and worship and with the people we live and care about and trust. A community based care coordination model provides for this to take place with community health workers at its core working with individuals to identify and address barriers to achieving good health.

A brief definition of transformation is "a dramatic change in form or appearance". If you are committed to true transformational change of our health care delivery system it must include coordinated care activities at the community level to be successful.

Thank you,

Debbi Saint

Debbi Saint RN, BSN
Nurse Coordinator, Congregational Health Ministries
CHI-Franciscan Health

Adapted from "A Modern Day Parable" by Michael Rozier, Church Health Reader. Permission given.

January 30, 2017

Submitted to: medicaidtransformation@hca.wa.gov

MaryAnne Lindeblad
Medicaid Director
Health Care Authority
626 8th Avenue, SE
Olympia, WA 98501

RE: Public Comments Regarding the Medicaid Demonstration Waiver Draft Project Toolkit

Dear Ms. Lindeblad:

The community health center (CHC) members of the *Community Health Network of Washington* and the *Washington Association of Community and Migrant Health Centers* appreciate this opportunity to provide written comments on the Health Care Authority's (HCA's) Medicaid demonstration waiver draft project toolkit. We are excited to see the concepts of the projects described in greater detail in the toolkit and look forward to continuing to work with HCA as the demonstration is implemented.

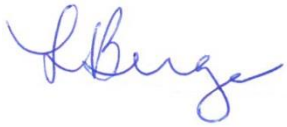
We are committed to being good partners as the state continues its innovative efforts to implement projects that impact the social determinants of health and promote care coordination and community linkages. Washington State CHCs have more than 40 years of experience providing high-quality medical, dental, behavioral health, and pharmacy services to the state's low-income population. This includes providing a number of population health services proven to help improve the health outcomes of our patients. We urge HCA to leverage the experience of the state's CHCs as it moves forward with these efforts.

In the enclosed attachment, we offer comments and recommendations:

- List Community Health Centers separately from other providers;
- Make incentive payments available for projects to bring existing models to scale;
- Require providers serve, or commit to serve, a minimum number of Medicaid clients to receive incentive payments;
- Elevate oral health to a required project and allow for regional flexibility for existing work;
- Ensure appropriate statewide outcome measures across regions and that expected performance measure outcomes account for social risk factors;
- Clarify project management functions;
- Eliminate duplicative state efforts around workforce development;
- Strengthen efforts to address the opioid epidemic by ensuring proper roles for the state and regions and supporting providers in the primary care setting; and
- Promote sustainability by ensuring project support capacity development for providers to track and bill for the service the project is addressing.

If you have any questions about our comments, please do not hesitate to contact us at Leanne.Berge@chpw.org or (206) 515-4710; or at BMarsalli@wacmhc.org or (360) 786-9722 ext. 224.

Sincerely,



Leanne Berge
Chief Executive Officer
Community Health Network of Washington

Bob Marsalli
Chief Executive Officer
Washington Association of Community and Migrant Health Centers

CHNW/WACMHC Comments	CHNW/WACMHC Recommendations
The draft toolkit recognizes the key role that providers generally will fulfill in implementing the projects. However, it fails to specifically reference Washington State's 27 Community Health Centers (CHCs). With more than 40 years of experience providing high-quality medical, dental, behavioral health, and pharmacy services to the state's low-income and underserved populations, CHCs are essential providers of services in an integrated setting. Also, CHCs already provide a wide variety of enhancement (or wrap around) services to more than 30% of the state's Medicaid population. These services are aimed at addressing population health issues. For example, CHCs provide interpreter services so that patients can communicate with their providers and understand their health issues in a linguistically and culturally appropriate manner. The more than 250 sites across the state provide other services as well, including case management, transportation, and nutrition counselling.	**As trusted health care and social service leaders in their communities Community Health Centers should be identified separately so that Accountable Communities of Health (ACH) are encouraged to partner with those providers.** Throughout the draft toolkit, "recommended implementation partners" are explicitly called out by the agency. We recommend that CHCs be highlighted as partners for all the listed projects. As our state's health care safety net, CHCs already provide a systems-based approach to delivering health care and making community connections for their patients. CHCs are uniquely positioned to be partners for each of the projects listed and should be distinguished from other primary care providers or providers generally.
It is unclear in the draft if providers and organizations already engaged in evidence-based efforts to improve health that are similar to or the same as the listed projects will be eligible for incentive payments through the demonstration. CHCs across Washington prioritize providing behavioral health services and a broad array of community services to address whole person care. An important area of focus for the CHC system is the work to integrate mental health into primary care. Over the years, CHCs have seen the need for integrated care and responded by hiring staff to provide patients in need of mental health services with short term interventions. The Bree Collaborative has outlined essential elements for behavioral health integration. Among those elements are services provided at CHCs through the Primary Care Behavioral Health Model	**The toolkit should clarify that projects will have incentives for providers that are beyond the planning stages and are focused on broadening and improving existing efforts to impact outcomes.** For example, project 2A depends on providers committed and willing to engage and eventually bring collaborative care to scale. Collaborative care is a key focus for many providers in the CHC system, but implementation varies due to different resource levels and needs across the system. The toolkit provides an important opportunity for CHCs to take ongoing integration work to the next level to address gaps and include substance use disorder treatment by making services available to patients with mild to moderate mental health needs in the primary care settings.

and the Collaborative Care Model (CoCM). These behavioral health integration models work together, since PCBH provides brief interventions to patients with mild mental health needs, and the CoCM provides longer-term interventions for patients with mild to moderate mental health needs. By incorporating both models we would be addressing behavioral health needs across a broader population.	To address behavioral health integration across the entire continuum of care, the toolkit should incorporate the essential elements of the Bree Collaborative Behavioral Health Integration committee's recommendations. The essential elements were developed to assess and guide provider adoption of integration within primary care across regions: 1. Integrated Care Team 2. Patient access to BH as a routine part of care 3. Accessibility and sharing of patient information 4. Practice access to psychiatry services 5. Operational systems and workflows to support population based care 6. Evidence-based treatment 7. Patient involvement in care 8. Data for quality improvement
The toolkit does not state a threshold or requirement that money expended through these projects benefit the state's Medicaid population. The demonstration will infuse significant Medicaid funding into communities across the state to improve health outcomes. It is critical that these funds be targeted to advance health equity and ensure the state's most vulnerable patients are at the center of advancing innovative approaches to improving health outcomes when providers receiving funds operate toolkit projects.	**We recommend that providers receiving payments through the demonstration serve or commit to serving a minimum threshold (percentage/number) of Medicaid clients.** This requirement should apply across provider sectors, including social service and community-based organizations, in addition to medical and behavioral health care providers. A threshold requirement ensures demonstration funding is targeting the Medicaid population, and helps provide ACHs with a measurement goal. This also ensures ACHs will partner with a variety of partners throughout their region in order to hit the established threshold.
The toolkit recognizes that improving access to oral health is a state-wide priority; however, it does not elevate oral health as a required component of the state-wide transformation process. CHCs have stepped up to the challenge of the current Medicaid oral health services access crisis. In 2015, CHCs provided oral health	**Oral health should be a required project and HCA should allow more regional flexibility in implementing oral health projects or incorporate more of the best practices already employed throughout the state.** Oral health is a fundamental component of overall health and should be elevated as a required project because it fits within the focus on

services to about half of all adults and a third of all children enrolled in Medicaid. From 2014-15, CHCs increased the number of patients seen by 55%. Many community health centers are already actively pursuing one, or both, of the strategies suggested in the Project 3C. CHCs are national leaders, establishing mobile dental clinics to reach their most underserved patients and working alongside their medical colleagues to identify patients who need oral health services and provide services where it is most needed.	integration and to not do so falls short of whole person care. The toolkit prescribes three focus areas for the ACHs' work. These areas may not be what ACHs have identified their own priorities. For example, health IT may not be as important for ACHs as the ability to refer their patients to specialty care services to provide immediate relief. Significant work to develop their own regional priority and focus areas is already underway at various ACHs, such as oral health case management and care coordination. The draft toolkit should accommodate grassroots transformation initiatives already underway across the state.
We are concerned that both the project-level and system-wide performance measures were removed from the draft toolkit and that the toolkit does not address how performance measurement and value-based reimbursement will account for differences in populations served. The new draft indicates that the measures listed in the appendix are for illustrative purposes only. We are concerned that these measures are "potential" only and that different measures could be implemented for the same projects across regions. These measures are critical to the overall success of the demonstration not only because they are tied to providers and partners receiving transformation funds, but also because they could validate whether or not the projects are having a meaningful impact on the health outcomes of Washington patients.	**As the demonstration is implemented, HCA should have a clear and transparent process for how measures will be chosen and tracked across regions, how those metrics will be tied to funding, and publish a clear methodology for how measures and payments control for differences in the populations being served by provider groups.** We recommend HCA work with subject matter experts with experience in evidence-based practices to ensure the appropriate metrics are selected and establish more consistency across regions as different ACHs implement the same projects. These measures should be consistent for the demonstration period as well and not change from year to year. For each project in the toolkit, there needs to be common measures across the state so that there is some comparability. ACHs should retain flexibility to add additional measures they believe are regionally important, but a common set of measures is necessary. HCA's methodology should also account for differences in population served by providers, taking into consideration providers, such as CHCs, that serve individuals with social risk factors when assessing performance measurement achievement which will drive incentive payments through demonstration funding as well as value based payment incentives.

We appreciate that references to "dedicated project managers" and "site-specific implementation teams" are made throughout the toolkit. However, additional information would be helpful to ensure clarity around reporting structure, roles, and funding. The toolkit has extensive reach and impacts many sectors. For this reason, the proposed work will require a significant project management and coordination. While it is understood that this will depend on the work that is undertaken by the regions, more direction is needed to understand which entity will lead these efforts and ultimately be accountable for its success.	**The toolkit should clearly indicate to which organization(s) project managers and teams report, what their various roles will be, and how this workforce will be hired and financed.** ACHs and community partners could experience significant barriers throughout the demonstration period because of the lack of clarity in the draft toolkit. Without adequate resources for this workforce, organizations that are already strained and smaller organizations will be burdened. To ensure a smooth transition after the demonstration ends, the toolkit should require that a transition plan be in place for these managers and coordinators, before the project implementation stage.
Two statewide health workforce taskforces already exist. The existing taskforces are: 1. Health Workforce Council, which is convened by the Workforce Training and Education Coordinating Board, and 2. Washington State Behavioral Health Workforce Assessment and associated committee. The behavioral health workforce assessment contract is held by the UW Center for Health Workforce Studies and is being done in collaboration with the Washington State Workforce Training and Education Coordinating Board.	**Efforts through the demonstration waiver should build upon existing statewide taskforces and the work they have already achieved, rather than create additional entities.** We recommend that the Department of Health's Office of Rural Health be involved in these efforts as they do a great deal of health workforce development all over the state. It is critical that demonstration resources supporting these taskforces should be focused on increasing the health care workforce that serves the Medicaid population.

To ensure successful implementation of the efforts described in Project 3A (Addressing the Opioid Us Public Health Crisis), the toolkit needs to reassess some aspects of the projects, including whether some tasks should be addressed at the state level rather than on a region by region basis and how to support and promote care management. For example, the draft toolkit describes efforts to address workforce capacity at the medical, nursing, or physician assistant school or licensing board level. These types of activities are best approached at a statewide, rather than at the regional, level. Also, the toolkit states that education will be funded but the clinical piece is not referenced except to describe that "referrals" should be in place and that SUD providers should be "connected" with primary care. The toolkit fails to acknowledge those SUD providers who are already working within the clinical setting.	**Within Project 3A, HCA should remove activities from the ACH role that are best addressed at the statewide level and include elements that support and promote referrals to evidence-based clinical treatments and support SUD providers within the primary care setting.** HCA should not include influencing school curricula or licensing board activities at the ACH level, but address this at the state level. HCA should highlight the work that many CHCs are already engaged in within the primary care setting, such as providing Medication Assisted Treatment. MAT, along with the approaches described in the toolkit rely on strong care management to be successful.
There are barriers to billing for many of the services provided through toolkit projects. For example, Project 3A outlines that projects administered by ACHs should increase access to treatment by offering brief interventions and support referrals to treatment. However, currently ICD SUD codes are rejected in a primary care setting preventing providers from billing for services rendered.	**HCA should ensure that projects support capacity development for providers to effectively track and/or bill for the service the project is addressing.** This will lead to increased synergy, effective use of resources, and a streamlined pathway to sustainability. Sustainability of the projects and successful implementation are based in part on ensuring sufficient resources to promote greater access to evidence-based practices. HCA must ensure that providers can bill for services rendered.

COMMUNITY HEALTH PLAN of Washington™

February 1, 2017

Submitted to: medicaidtransformation@hca.wa.gov

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue, SE
Olympia, WA 98501

RE: Public Comments Regarding the Medicaid Demonstration Waiver Draft Project Toolkit

Dear Ms. Lindeblad,

Community Health Plan of Washington (CHPW) is a committed partner in Medicaid Transformation as a key strategy to achieve a Healthier Washington. As the only Washington-based, not-for-profit Medicaid managed care plan, CHPW is focused squarely on the success of Washington's Medicaid program, the health of the Washingtonians it serves, and the communities in which they live. The Medicaid Transformation Demonstration provides the investment and flexibility needed to achieve the goals of the triple aim of better care, healthier people, and smarter spending. CHPW believes the Medicaid Transformation Project Toolkit (toolkit) presents an ambitious approach to regional health system transformation that if carried out with effective project management, role clarity, a focus on building Medicaid provider capacity and integrated delivery systems, and in coordination with the expectations of the Medicaid managed care contract; it has the real possibility of succeeding in achieving its goals.

It is with the spirit of optimism and partnership, CHPW offers the below comments to strengthen the toolkit:

- *Ensure efforts to support the transition from fee for service payment to value-based approaches is integrated throughout the toolkit with a clear role for managed care plans, not just as the end payer, but as full partners in the transition.*
  - While the ambitious goals of achieving value-based payment are apparent, the utilization of the transformation Demonstration toolkit to address the system-wide capacity development to accommodate value-based payment is not. The transition to value-based payment to sustain each project should be addressed earlier rather than often times being included simply as, "implement VBP strategies to support…" within the scale and sustain phase.

- *Activate the Statewide Value-Based Payment (VBP) taskforce to support the evolution of payment and refine the focus of the Accountable Community of Health (ACH) role in VBP.*

- The Taskforce should establish core VBP capacity domains for providers and a common assessment tool. Currently there is not a common vision for VBP across the state, thus making it difficult for providers to assess their capacity, address gaps related to engagement with managed care plans, and ensure they can accommodate VBP arrangements.

- The State should use the VBP Taskforce to discuss common approaches to payment in Medicaid. By utilizing the Taskforce, the state can create common approaches for payers and providers and support one of its Paying for Value goals of sending common signals to providers.

- The Taskforce should be used to track the success of projects shifting toward value-based payment mechanisms as well as be the forum to elevate and address challenges to shifting projects to value-based payment. The Taskforce should also be used to identify opportunities for managed care organizations, behavioral health organizations (BHOs), and ACHs to collaborate on projects that will collectively assist the state in meeting VBP payment benchmarks.

- The Taskforce, in partnership with the state and federal government, should work collectively to address the conundrum of how to move away from the current health care "currency" of encounters to build actuarially sound rates to a different approach that supports the true intent and benefit of value-based payment. Until this conundrum is addressed, achieving advanced alternative payment methodologies will still be superficial and the ability to realize savings that can be invested in the social determinants of health will be difficult.

- Refine the focus of the ACH regional value-based payment efforts to address capacity development at the provider level rather than tracking achievement of value-based payment benchmarks in the region. ACHs should be empowered to support the transition to value-based payment in their region by assessing capacity against value-based payment domains, understanding the gaps that exist across regional providers, and then using resources and incentives available in the projects to drive practice change. It is outside the ACH scope to address levels of percentage of payment which is directly correlated to the value-based payment benchmarks.

- *Integrate Demonstration related statewide health workforce efforts into existing state-level taskforces and redefine the regional level workforce efforts*.
  - Energy and funding should be directed at supporting and participating in the existing health workforce efforts rather than duplicating them. Existing efforts include the Health Workforce Council, which is convened by the Workforce Training and Education Coordinating Board, and the Washington State Behavioral Health Workforce Assessment and its associated committee. The behavioral health workforce assessment contract is held by the UW Center for Health Workforce Studies and is being undertaken in collaboration with the Washington State Workforce Training and Education Coordinating Board.

Further, the Department of Health's Office of Rural Health should be involved in these efforts as they already do a great deal of health workforce development all over the state.

  - Certain activities listed as regional workforce activities would be better undertaken at a statewide level, rather than region by region. For example, influencing residency and medical school curricula and influencing licensing boards are best approached at a statewide level.

- *Utilize the Medicaid Demonstration Integration Project to effectively promote and incentivize a stepped model*[1] *of care and facilitate partnerships across the care continuum to ensure a truly integrated delivery system*.
  - CHPW applauds the Health Care Authority for requiring Project 2A: Bi-directional integration of Care and Primary Care Transformation and recognizing the synergy of financial and clinical integration. It would be helpful to further clarify roles and participants in the planning stages and in addition to those listed as implementation partners include BHOs.

  - CHPW acknowledges the need for a strong primary care practice as a foundation in order to incorporate the integration of behavioral health; however, the option to integrate should not be a choice but a milestone on the continuum a clinic site or a health system progresses along. Additionally, CHPW has received feedback through its Mental Health Integration Program, which is built on the tenets of the Collaborative Care model, on the effectiveness of utilizing a stepped care approach. This approach builds on the Patient Centered Medical Home and includes a brief intervention and treatment and then incorporates collaborative care. The current project description does not utilize a stepped care approach and allows for a choice rather incenting progress toward more advanced models of integration as capacity grows.

  - CHPW would also like to impress upon HCA that bi-directional integration will benefit from the promotion of partnership across primary care and behavioral health settings as well as with social services organizations, jails, and homeless services. At a minimum, the project should ensure that strong partnerships are built across the care continuum between primary care and behavioral health and the demonstration of these partnerships should be incented.

- *Guarantee appropriate statewide outcome measures across regions and that expected performance measure outcomes account for social risk factors.*
  - While ACHs are interested in choosing measures that are regionally meaningful, there must be some minimum evaluation standards for each project across ACHs. Further, required measures should align with existing requirements within managed care contracts, especially those measures tied to value-based payment.

[1]Unutzer, Jurgen. "All Hands on Deck." *Psychiatric News* (published on March 3, 2016) http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.3a28

- HCA should work with subject matter experts at a state and national level to develop an approach to account for differences in social risk factors across populations, when assessing performance measurement achievement. This is a critical step, both for assessment of performance incentive payments tied to the demonstration and as value based payment approaches flourish across the state. A recent report from U.S. Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation stated, "...in order to properly align payments and ensure value-based purchasing programs achieve their intended goals, the relationships between social risk and performance on these programs need to be better understood."[2]

- *Ensure the Medicaid Transformation Toolkit aligns with and supports the Medicaid Managed Care contract.*
  - Medicaid managed care will be critical in sustaining the transformation shaped by Demonstration investments through value-based arrangements with provider systems. Thus, the work carried out through the Demonstration should complement and support the direction envisioned for managed care contracts over the course of the Demonstration not duplicate. Additionally, HCA should ensure that the efforts and expectations for managed care in relation to the Demonstration are reflected within the Medicaid managed care contract.

  - Within each project, a critical planning step should be to partner with managed care plans to assess the related expectations within the Medicaid Managed Care contract and current services and infrastructure already in place as well as strategic pilot projects initiated by MCOs. Over time, projects should also support capacity development for providers to effectively track, code and/or bill for the service the project is addressing. This will lead to increased synergy, effective use of resources, and a streamlined pathway to sustainability. While this should apply across the board, specific attention should be paid to: systems for population health management, practice transformation, bi-directional integration of care, community based care coordination, and transitional care.
    - CHPW recommends that HCA make incentive payment available for projects to bring existing models to scale. CHPW encourages incentives payment meet providers where they are, so Washington is incentivizing models that are more advanced.
    - Specifically in bi-directional integration of care, there are efforts nationally to support billable codes for collaborative care in Medicare and Medicaid. Currently, there is not capacity at a provider level to do this type of

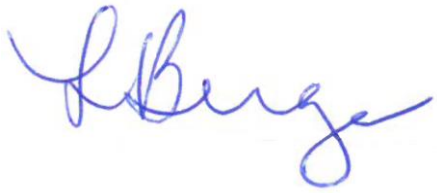
[2] Office of the Assistant Secretary of Planning and Evaluation, U.S. Health and Human Services, "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs A Report Required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014." December 2016
https://aspe.hhs.gov/sites/default/files/pdf/253971/ASPESESRTCfull.pdf

coding/billing and the Demonstration could support that capacity development.[3]

- The Demonstration will support capacity development for the Medicaid safety net delivery system to successfully participate in health system transformation and engage in evolving Medicaid managed care contracts. To ensure the Medicaid delivery system is being prioritized in transformation projects, the Demonstration should require providers serve, or at least commit to serve, a minimum number of Medicaid clients to receive incentive dollars. Evidence of this increase in access should be demonstrated each year.

Again, thank you for the opportunity to comment on the Medicaid Transformation Demonstration. We are looking forward to partnering in this transformation. If implemented effectively, the Demonstration will facilitate, motivate, and sustain positive change in Washington's health system. As always, please contact us with any questions or comments at Leanne.Berge@chpw.org or (206) 515-4710.

Sincerely,



[3] Press, Matthew, M.D., Ryan Howe, Ph.D., Michael Schoenbaum, Ph.D., Sean Cavanaugh, M.P.H., Ann Marshall, M.S.P.H., Lindsey Baldwin, M.S., and Patrick H. Conway, M.D. "Medicare Payment for Behavioral Health Integration (December 14, 2016) DOI: 10.1056/NEJMp1614134

January 31, 2017

Dorothy Teeter
Washington State Health Care Authority
Olympia, WA 98504

Dear Dorothy:

On behalf of Coordinated Care of Washington (CCW), this letter is in response to the draft Medicaid Transformation Demonstration Project (MTDP) Toolkit that was released for public comment on January 3, 2017. We recognize the ongoing development of the MTDP Initiatives, and appreciate the opportunity to express our comments and questions.

Moving forward, we would like to submit the following request for your consideration: encourage linkages between Projects and Taskforces (regional, statewide), particularly focused on systems for population health management, performance measurement, and connections between the three MTDP Initiatives.

• *Value Based Payment Transition and Workforce Development Taskforces*: How will the survey/ attestation assessment be validated from both providers and MCOs? How will the identified and recommended strategies "for education, training, and technical assistance" be aligned with the planning aspect of each implemented Project? Will there be a statewide taskforces established for Project 2A and 3A beyond the connection through the aforementioned Taskforces?

• *Practice Transformation Support Hub*: Will regions participating in FIMC ahead of 2020 be prioritized beyond other regions participating in Project 2A? What is the role of Managed Care Organizations in coordinating with, or facilitating the development and provision of "training and tools that strengthen practices' use of data to drive decision-making, contract negotiations, demonstrate health improvement/outcomes, and connect care delivery transformation success with cost reduction?"

• *Systems for Population Health Management*: Please specify what data state agencies will provide and the timeline for dissemination as it relates to the Regional Health Needs Inventory. What role will Managed Care Organizations play in supporting reporting and monitoring of data regionally and statewide? What role will Managed Care Organizations play in assisting with Project 3B, "[c]onduct consumer-focused research…and to develop messages for promoting preconception health and reproductive awareness?"

• *Performance Measurement*: Please specify the required Project-level and system-wide outcomes (if they will be consistent statewide) versus the process-specific metrics (if they will be determined regionally), and the associated baselines. Are process metrics also referred to as 'performance indicators' noted in the Special Terms and Conditions? Will Project applications (whether required or optional), include additional metrics not listed in the Toolkit? What metrics will ensure linkage between Projects 2D, 3A and 3C? What mechanisms of accountability will be used to ensure each ACH solicits and incorporates continued community input?

• *Initiative 1 connecting to Initiatives 2 and 3*: How will Project 2B be linked to Initiative 3, particularly if a region implements the Pathways Community HUB Model; will that region be required to undergo HUB

certification? How will Project 2C be connected to Initiatives 2 and 3; can the lead entity for this Project also be a delegate (direct service provider) for the associated benefits package(s)?

The following are a few suggested points of clarification related to the Special Terms and Conditions finalized on January 9, 2017:

• *STC 25* (Tribal Coordinating Entity) / *STC 26* (Tribal Specific Projects): What is the role of Managed Care Organizations in the Entity, and Projects, particularly around reporting and monitoring of data? What is the timeline for the release of these Projects and the cross-walk of the statewide common performance measures to the GPRA?

• *STC 28* (Attribution Based On Residence): How do Klickitat and Okanogan Counties count in attribution? How will changes to regional boundaries, and the re-procurement of Managed Care Organizations, be coordinated with development of Project 2A?

• *STC 29* (ACH Provider Agreements under DSRIP): What are the expectations and role of Managed Care Organizations in the following, "ACHs must establish a partnership agreement between the providers participating in Projects," particularly since MCOs sit on the governance/leadership boards of ACHs.

• *STC 30* (Project Objectives), section d (Community-based Whole-person Care): How, if Project 2B is optional without the requirement of one single, will the following by achieved, "In addition, develop linkages between providers of care coordination by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination protocols across providers, and to promote accountable tracking of those beneficiaries being served?"

We look forward to working with the HCA on this next phase of the Medicaid Transformation Demonstration Project implementation.

In Partnership,

Jay Fathi, MD
President and CEO
Coordinated Care

Greater Columbia
Accountable
Community of
Health

February 2, 2017

RE: Comments on Medicaid Transformation Project Toolkit

Washington State Health Care Authority
Attn: Medicaid Transformation
P.O. BOX 42710
Olympia, WA 98504

Dear Medicaid Transformation Team,

Greater Columbia Accountable Community of Health (GCACH) is pleased to offer the following comments on the current draft of the Medicaid Transformation Project Toolkit. We submit these comments with the intention of consistently aiming for a culture of productivity, collaboration and transparency with our partners, other ACHs and the Health Care Authority (HCA). The mission of the Greater Columbia ACH (GCACH) is to advance the health of our population by decreasing health disparities, improving efficiency of health care delivery, and empowering individuals and communities through collaboration, innovation, and engagement.

We are generally supportive of the opportunities presented in the Draft Toolkit, and we are pleased to see overall alignment with the GCACH's Priority Work Groups (PWGs) that GCACH has previously developed. Specifically, the Toolkit's projects concerning Bi-Directional Integration of Care and Primary Care Transformation (Project 2A), Community-Based Care Coordination (Project 2B), Maternal and Child Health (Project 3B), Access to Oral Health Services (Project 3C), and Chronic Disease Prevention and Control (Project 3D) directly align with the GCACH's priority areas of Behavioral Health, Care Coordination, Healthy Youth and Equitable Communities, Oral Health, and Obesity/Diabetes, respectively. We see alignment between the Toolkit and the Strategic Issues in our Regional Health Improvement Plan (RHIP) to 1. Foster cross-sector collaboration, 2. Build healthier, more equitable communities, and 3. Strengthen the integration of health systems and services. Additionally, the Transitional Care (Project 2C) may successfully expand on GCACH's current State Innovation Models (SIM) work, which is titled, "Readmissions Avoidance Pilot."

Additionally, we have several questions and comments about the draft document that are a compilation of thoughts from multiple partners and members:

Overall Approach

Flexibility

When considering overall project implementation, a key question asked by our regional partners centers on how much flexibility there is for different counties to utilize different projects or strategies within the toolkit. As a multi-county region, do stakeholders from all of our counties have to work on the same project(s) and implement the same strategies or can counties within an ACH select which projects and/or strategies they engage on based on their respective needs and capacities?

Along the same lines, how much flexibility is there for our region to choose among evidence-based protocols (specified in the Toolkit or not) to maximize the options for ACHs to reach consensus and find

solutions that work within their regions? We acknowledge that there will be some GCACH-wide strategies that can address needs in multiple counties, and thread those needs together and that performances measures will have to be met. At the same time, we are concerned that a one-size-fits-all approach that does not provide flexibility in this regard will overlook the different community needs and capabilities that vary considerably across our diverse region.

Reinvestment

While we understand the need to focus on improvement in clinical strategies in order to achieve short term savings we believe that true population health improvement will only be achieved through focus on long- term population health strategies addressing the social determinants of health. We request HCA to encourage the reinvesting of savings achieved as a result of this waiver into projects and programs that address the upstream/root causes of disease.

Incentive Payments

As HCA develops the plan for how incentive payments are calculated and earned (Toolkit pg. 1), we urge HCA to consider a payment methodology that provides quality bonuses to providers and ACHs that includes provisions to incentivize the treatment of typically high-cost patients. Any payment methodology considered should not create unintended incentives to avoid treating individuals who are less likely to show savings in their care. The intent of the funding should also be articulated in addition to the structure and details.

ACH Certification Process and Transformation Project Plans

As ACH certification criteria (Toolkit pg. 2) are finalized over the next several weeks, we recommend HCA flesh out the requirements of STC 22 which ACHs are required to comply with in the ACH Project Plan. Specifically, HCA should provide detailed guidance to ACHs on approaches to elevate health equity and recommendations for approaches to achieve authentic consumer engagement. For example, an easy to implement option for HCA to recommend could include the use of a Health Equity Tool in ACH decision making.

Introduction to the Transformation Project Toolkit

Project Planning Activities and Resources

In general, the toolkit places unreasonably high expectations on the ACH for ramping up to and implementing the work in all 3 domains without addressing how planning dollars and administrative dollars will be apportioned to the ACH and the regional partners involved in the planning and project implementation. The public is a necessary partner on the multiple state and regional task forces yet we do not have the resources in many of our regions for consumers to play an active role. Clarity on the resources to support the effort is needed. It will be important to provide guidance on resource allocation as soon as possible and to provide funding for planning and staffing up during a "ramp up period" and options for phasing in work over time.

Regional Health Needs Inventory

Public Health can and should play a leadership role in the development of the RHNI as well as play a role in project evaluation. Assessment, chronic disease prevention, care coordination, injury prevention (opioid abuse), etc. are regular responsibilities of many Public Health agencies. One suggestion is for the Toolkit to call out Public Health as a key partner for the completion of the RHNI's and for project

evaluation activities in the Local Health Jurisdictions (LHJs) that have capacity. All sectors will have a role in this work.

In the interest of expediency, RHNI's should be structured and supported so that they can be completed rapidly using available data. Part II of the RHNI involves intricate mapping of the ever-changing health care system. This section should be either completed at the state level or streamlined so that ACH's can complete a higher-level system inventory that contains enough information to proceed with project selection. Confusion exists on the current boundary lines for Greater Columbia ACH. It is necessary to clarify and confirm those boundary lines before we can contemplate completion of the RHNI.

Statewide Value-Based Payment Transition Taskforce and Workforce Development Taskforce

It would be helpful to have more concrete definitions of what Value-Based Payment (VBP) is and what having payments tied to value looks like on a practical level for our local providers. The statewide Value-Based Payment Transition Taskforce composition does not include consumers or consumer advocates (Toolkit pgs. 6, 8). The Workforce Taskforce includes "consumer advocates and community representatives" but fails to include consumers (Toolkit pgs. 6, 11). Is there consideration for having consumer advocates as part of the process?

Domain 1

Systems for Population Health Management

One observation is that the Focus Area has Stage 1 - Governance, Stage 2 - Planning, but does not include Stage 3 -Implementation. We believe this was likely an unintentional oversight and recommend HCA provide implementation details prior to finalizing the Toolkit.

Domain 2

Project 2A: Bi-Directional Integration of Care and Primary Care Transformation (Required)

The growing body of NEAR (Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resiliency) research speaks to the profound impact childhood trauma has on increased risk for behavioral and physical health issues across the life course. This research, as well as theoretical frameworks around trauma-informed practices, provides a critical lens by which Medicaid project should be viewed. We propose that the NEAR sciences and trauma-informed care principles be included as foundational for any Medicaid Transformation Project. There has been a lot of discussion at our Leadership Council meetings regarding the value of ACEs training as part of two of our Priority Work Groups: Behavioral Health and Healthy Youth and Equitable Communities. I think that our ACH would encourage including ACES (or similar research that comes out) as part of the Waiver projects, particularly within Project 2A.

Within the implementation stage of the PCMH Model for integrating behavioral health into primary care settings, preventive care screenings including the PHQ-9 are to be implemented for all patients to identify unmet needs (Toolkit pg. 19). The PHQ-9 is a depression screening and is not a screen for other behavioral health conditions. Although depression is one of the more prevalent behavioral health conditions in Washington state, the narrow focus of the PHQ-9 will not serve to identify patients who suffer from behavioral health conditions other than depression. Further, while the PHQ-9 is still used in some practice settings to screen for depression, it is based on outdated DSM-IV diagnostic criteria; current diagnostic criteria are contained in the DSM-V. We should be using the best diagnostic criteria available in order to get the best outcomes.

Greater Columbia Accountable Community of Health

Domain 3

Project 3A: Addressing the Opioid Use Public Health Crisis (Required)

While the GCACH agrees that Opioid use is a serious public health problem in our region, our partners have expressed concern over the large number of existing opioid response efforts and potentially duplicative work. Given the many different initiatives in response to this crisis, it is unclear how we will be able to measure the specific impact of the work of ACHs. It is also unclear whether ACHs will receive prescription data from the HCA or the MCOs. This will be vital information for any meaningful opioid response effort. Another concern in our region is whether there are enough providers with the capacity to treat the issue. In addition to increasing the number and capacity of health care providers, more case management and recovery supports will be needed to address the opioid crisis in the region effectively.

Project 3B: Maternal and Child Health (Optional)

We are happy to see the draft Toolkit includes family planning within the Maternal and Child Health project. We recommend the name of the project be changed to "Reproductive Health" to more accurately reflect the focus areas within the project. We also recommend the target population be changed from "women of preconception age" to "women of reproductive age" so as not to limit the value of women's health to an intent to become pregnant nor presume an intent to become pregnant.

Conclusion

We are elated that the Washington State Medicaid Transformation Demonstration has been successfully approved and negotiated through the hard work of the HCA team and we feel privileged to do this work with the HCA. We do have some sincere questions and recommendations about flexibility, the timing of funding, to what degree critical concepts like equity, trauma-informed practices, social determinants of health and consumer engagement can guide this work, and the timely availability of statewide data. On behalf of the community members of Greater Columbia ACH, our regional partners, our Board of Directors and our Leadership Council members, we thank you for your consideration of our comments. Please feel free to contact us with any questions. We appreciate ongoing opportunities to engage with the Health Care Authority as it develops waiver protocols and policies.

Sincerely,
GCACH Backbone Staff

Carol Moser

Executive Director
cmoser@greatercolumbiaach.org
509-460-4584

Aisling Fernandez

Communications Coordinator
afernandez@greatercolumbiaach.org
509-460-4548

HEALTH WORKFORCE COUNCIL

January 31, 2017
Submitted via email to: medicaidtransformation@hca.wa.gov

To Whom It May Concern:

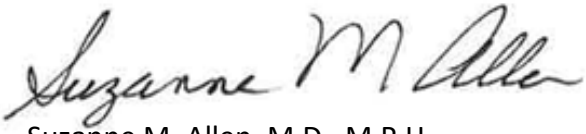
We are writing to provide public comment on the proposed Medicaid Transformation Project Toolkit; specifically, the recommendation to create a Statewide Workforce Development Taskforce.

As the leadership of the state's Health Workforce Council (Council), we are concerned that this taskforce will duplicate existing health workforce development efforts. The Legislature created the Council in 2003 to facilitate ongoing collaboration to address critical healthcare personnel shortages. The Council provides targeted policy development, data-driven recommendations, and advocacy on health workforce issues. The vast majority of the suggested taskforce members are already represented on the Council. We are open to considering additional members to capture the full spectrum of stakeholder needs.

The Council's work over its nearly 15 years of existence highlights the value to the healthcare community, policymakers, and the entire state of a group of disparate voices speaking with a unified voice on policies and improvements to the healthcare system. The diversity of members on the Council ensures a collective voice for high-priority issues of value to the entire healthcare industry, rather than a siloed focus on individual organizational priorities. For more information about the Council and its work, see http://www.wtb.wa.gov/HealthWorkforceCouncil.asp.

We applaud the interest of the Project Toolkit team in focusing on health workforce development, but would strongly suggest the team considers leveraging the existing Council infrastructure for this work rather than creating another group that mirrors many of the Council's current responsibilities. We would welcome a conversation about partnering with the Healthier Washington Team to co-invest in a shared staffing model that allows us to work together to address ideas raised in your toolkit proposal that go beyond the Council's existing portfolio. With further investment, together we could address an even wider range of shared health workforce issues.

Respectfully,



Suzanne M. Allen, M.D., M.P.H.
Health Workforce Council Chair
Vice Dean for Academic, Rural and Regional Affairs
University of Washington School of Medicine

Kevin McCarthy, Ph.D.
Health Workforce Council Vice-Chair
President
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King County

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February 2, 2017

Dorothy Teeter
Washington Health Care Authority
626 8th Ave SE
Olympia, WA 98501
Via email: Dorothy.teeter@hca.wa.go

Dear Ms. Teeter:

As committed partners in the work to transform health and health care in Washington, King County is pleased to provide this feedback on Washington's Medicaid Transformation Demonstration Project Toolkit. King County is deeply engaged in leading health and human services transformation — from our role as a purchaser of health services to our roles in public health, behavioral health, housing, and human services. Working together across county agencies and with community partners, we share a commitment to a health and human services transformation that will improve health, well-being, and equity for all county residents.

We look forward to working closely with you to successfully implement the demonstration project. At this time, we would like to offer suggestions for the Health Care Authority (HCA) to consider before finalizing the Toolkit. Our comments cover three key areas:

- Overarching, cross cutting themes;
- Recommendations regarding project planning and resource activities;
- Comments related to the specific projects within each domain.

Thank you for your consideration. If you have any questions regarding these comments please contact Ingrid McDonald, Policy Director, Public — Seattle & King County, ingrid.mcdonald@kingcounty.gov.

Cross-Cutting Themes

1. Funding – The toolkit outlines an enormous scope of work for the ACHs but is silent on what funding will be available to carry out this work. It is our understanding that further information related to capacity funding will be shared in separate guidance. It is critical that funding levels are commensurate

with the scope of work outlined in the toolkit and that funding levels take into account the greater scope, complexity, cost of living and competitive job market in King County versus other regions of the state. In addition, the role of King County health systems as regional trauma and specialty care providers in service to residents throughout our state and region should be considered. People often come to King County for this specialized care and then end up staying and requiring further service. If there is a mis-match between expectations outlined in the toolkit and funding available to carry out the work, the ACH will not be successful in achieving the desired goals or in supporting providers to achieve the identified outcomes.

2. Flexibility – Clarify that ACHs have the option to choose alternative evidence-based approaches or modify/adapt proposed approaches described in the Toolkit as long as they are in alignment with the projects as proposed and drive toward the standard goals and outcomes envisioned. Also allow for HCA and ACH flexibility to work collaboratively to identify alternative outcome measures and modify milestones as projects progress.

3. Cross-cutting projects – To encourage a system vs. siloed single issue approach, assure the option to propose projects that address the needs of a specific population group across project areas with an integrated approach to project monitoring. For example, enable King County to propose an integrated project to address the needs of frequent users of the jail with interventions related to transitional care, care coordination, diversion projects, or opioid use. Ensure that monitoring of this project is streamlined and not fragmented or duplicative based on which project area bucket each of the interventions lands in.

4. Health Inequities – The proposed performance measures for many of the projects described in the Toolkit do not address many factors that perpetuate health inequities that many counties, including King County, are experiencing. King County wants to include metrics related to criminal justice involvement, poverty, housing and more robust behavioral health indicators that truly reflect the full needs of King County residents. We propose to allow ACHs, in partnership with the HCA, to expand upon and develop new metrics where appropriate for the proposed Toolkit projects that will help address the health inequities that each ACH is currently experiencing. We also propose that in order to allow these new metrics, each ACH will need to sufficiently demonstrate to the HCA an ability to monitor and track the outcomes and metrics addressing the health inequities being targeted.

5. Community Engagement – Community engagement is critical to the development and monitoring of demonstration projects. Without resources to support critical services that many community partners seek in order to participate in these forums (such as child care, transportation, translation), we

risk developing and implementing projects that will not sufficiently reflect the needs of our community. In the toolkit or through other communications, the HCA should commit to allocating resources to each ACH in order to properly conduct engagement with community-based partners.

6. Linkages – We propose that the HCA more clearly define how it envisions neighboring ACHs working collaboratively to ensure that projects across connecting ACH regions are working in tandem and not creating unintended health inequities or disparities, and that standardization of projects occurs where feasible and appropriate. This is especially critical within the I-5 corridor where the Pierce, King and North Sound ACH will all experience multiple projects, yet have residents that access services across ACH boundaries more frequently than in other regions of the state.

Project Planning Activities and Resources

1. Regional Health Needs Inventory (RHNI) – King County appreciates that the HCA will organize and provide as much relevant data as feasible to the King County Accountable Community of Health (ACH) to help meet the RHNI requirement. Please consider the following observations about this requirement:
    a. The system description as outlined on page 76, Section II of Appendix II would require a very comprehensive analysis in King County and would take significant time and resources to complete and keep reasonably up to date. The health care and community-based services system in King County is very robust, changes frequently and is not well documented. To address this concern we recommend a more limited and targeted mapping exercise, connected to specific proposed projects, with an initial snapshot based on existing resources, complemented by new information gathering for those sectors with known weaknesses related to availability and accessibility.

2. Data - While there are statewide taskforces for both Value-Based Payment and Workforce Development, we note that there is not a similarly aligned statewide taskforce for Systems for Population Health Management. As this focus area will require ACHs to align and develop linkages for health systems and data, we feel it is imperative to align these developments not only inside an individual ACH region, but across the state as well. We recommend that HCA add a third Taskforce to the Domain 1 efforts, with a new Statewide Taskforce focused on Systems Integration and specifically data collection and dissemination and linking to larger Health Information Exchanges (HIE). A Statewide Taskforce may also be the ideal table to explore cross-ACH or multi-ACH comparisons to assess the comparative effectiveness of a series of interventions aimed at similar and different populations, using the same underlying data and metrics.

    a. Data Capacity – We appreciate that the HCA has provided greater clarity on the intended role of the ACH with regards to data capacity and monitoring

responsibilities. We also recognize that the HCA and other state departments are limited in the resources that can support ACH data needs and demands in a strategic and timely manner. We are appreciative and encourage efforts to partner, leverage and strengthen regional ACH data capacity to meet the needs of the ACHs, as we believe that both statewide and regional data capacity will be critical to the success of the ACHs.

b. Local Data Sources – Given the availability of unique data sources (e.g. BRFSS oversample and King County Child Health Survey) that are available in King County and not statewide (and this is true of other ACH regions as well), we recommend clarifying the option for ACHs to propose population-based performance measures based upon locally available data.

c. Common Performance Measures – Many of the Performance Measures that are aligned with the States Common Measure Set are metrics that seem to support outcomes for individuals that are more readily able to access traditional health and human service delivery systems (i.e. office-based care). Additional performance measures are necessary to support projects that will address hard to reach/engage populations outside of the traditional health and human services delivery systems, and the unique outreach, engagement and service delivery that will be required. We recommend HCA work with King County and other interested parties to develop these additional measures, particularly in the areas of behavioral health, criminal justice, housing, and employment.

Domain 1 — Health and Community Systems Capacity Building

1. Financial Sustainability through Value Based Payment – The role of the ACHs in accelerating VBP is not clearly defined. King County recommends that the toolkit focus on encouraging and illustrating how ACHs can select projects that will support the move to VBP and disseminating information and creating ownership in the community regarding local progress towards meeting VBP targets. The proposed VBP Regional Planning Activities described on pages 8-9 are more suitable for the state task force. It is inefficient for each of the nine ACHs to source the technical expertise necessary to coach providers, connect providers to training, support attestations assessments of VBP levels and develop regional VBP transition plans. These functions and requirements should be the responsibility of the Statewide Taskforces, the HCA, or possibly the Practice Transformation Hubs.

2. Workforce – In alignment with the comment above, it is inefficient to assume that each ACH will carry out the Workforce Regional Planning Activities outlined on page 11 (training of existing workers, development and deployment efforts and recruitment and retention incentives). The toolkit should encourage each ACH to design/select projects that address workforce needs, but not expect region-wide workforce planning activities that are above or beyond the projects.

As we measure workforce capacity and needs, we recommend looking not only at the quantity of providers but also at the numbers of providers who take Medicaid and what availability they have to take on more Medicaid clients. This is a big issue for network adequacy as many providers might be contracted to serve Medicaid clients (or waivered to prescribe) but have limited capacity for Medicaid patients.

3. Systems for Population Health Management – We notice on Page 14 of the Draft Toolkit that there is no longer a Stage 3 listed for Implementation under this section as was originally outlined in prior versions of the Toolkit. Why was this removed and what is the intended guidance for Implementation in this area?

Domain 2 – Care Delivery Redesign

1. Project 2A: Bi-directional Integration of Care and Primary Care transformation – King County appreciates the inclusion of bi-directional integration that allows a person to establish integrated care in the setting he/she finds most suitable. Please clarify requirements and availability of additional resources available for those regions that move to fully integrated managed care on an accelerated timeline. What qualifies as an accelerated timeline and how will those additional resources be provided (i.e., larger incentive payments, additional capacity building, etc.)?

2. Project 2B: Community-Based Care Coordination - In King County, there are many care coordination efforts as well as several initiatives aimed at creating more efficient centralized approaches. ACHs should have the flexibility to build upon or extend regional efforts to "coordinate the care coordinators" (e.g. Help Me Grow and Purple Binder). Importantly, ACHs should have the latitude to determine what model is most appropriate for the region, and not be limited to the Pathways Community HUB model.

3. Project 2C: Transitional Care – There are not sufficient performance measures aligned with this project. In addition, the measures that are proposed are not relevant for jail transitions (e.g., reduction in ED, hospital use etc.). There is a disconnect between the intent of the interventions (reduce jail use) and the proposed performance measures.

   Project 2D: Diversion Interventions – King County recommends adding a bullet to the Emergency Department Diversion section that includes establishing linkages to community behavioral health provider(s) in order to connect beneficiaries without a behavioral health treatment provider to one (similar to Primary Care Provider requirements). Also, we recommend adding crisis respite providers to required partners. Finally, it is our opinion that the performance measures are not reflective of the intent of the interventions (diversion from incarceration). Please confirm that there will be the opportunity to apply other metrics that are in alignment with the common measures set.

Domain 3 – Prevention and Health Promotion

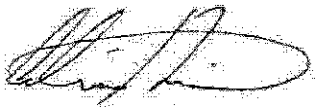
1. Project 3A: Addressing the Opioid Use Public Health Crisis – King County appreciates the attention that the State and the HCA are giving to this growing statewide epidemic. We are concerned however with how the data gathering component of this project will be executed and specifically who will be asked to do this on behalf of the ACH. Many of the activities – including partnering with professional workforce development, training and education; promoting best practices for prescribing; tele-medicine; large scale awareness raising campaigns for professionals and public; education of law enforcement on PDMP; are activities that should be coordinated statewide. We also request the flexibility to develop a project focus that meets the needs and desires of King County versus the more prescriptive focus as outlined in the draft Toolkit. Finally, we propose Behavioral Health Organizations be included in the list of recommended implementation partners for this project.

2. Project 3B: Maternal and Child Health – We propose that Durham Connects (https://www.durhamconnects.org/) be included in the list of recommended approaches for this project.

3. Project 3D: Chronic Disease Prevention and Control - King County appreciates the consideration of both the State and the HCA in light of the impact that this ongoing epidemic has on our community, especially among vulnerable populations. We would appreciate clarification with regards to two points. In selecting the specific target population(s) during the project planning stage, we would welcome guidance with regards to specificity of the term "disease burden" and how projects should define this. Should projects define it with relation to the leading cause of hospitalization or with regards to overall prevalence? In addition, guidance would be appreciated as to whether the disease/population-specific chronic care implementation plan could include multiple chronic diseases or must it be developed for only one disease. We propose that, depending on the selected strategy that the HCA allow for the inclusion of more than one chronic condition.
   We also recommend that you include explicit wording regarding the integration of the socio-ecological model and social determinants of health within chronic care management.

Thank you again for sharing the draft Medicaid Transformation Project Toolkit and for the opportunity to provide feedback. Sincerely,

Patty Hayes Director
Public Health -Seattle & King County



Adrienne Quinn Director
King County Department of Community and Human Services

Betsy Jones
King County Health and Human Potential Policy Advisor

Kitsap STRONG

Memorandum

To:	Healthier Washington Medicaid Transformation Review Committee
From:	Kitsap Strong Leadership Committee
Date:	January 31, 2017
Subject:	Request to include trauma-informed care (TIC) training in Domain 1: Health and Community Systems Capacity Building under Workforce

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On behalf of the Kitsap Strong Leadership Committee, I am writing to provide public comment to the Medicaid Waiver Toolkit, and request that trauma-informed care (TIC) training be included in Domain 1: Health and Community Systems Capacity Building under Workforce.

Trauma-informed Care (TIC) is not a specific evidence-based practice, it is a "culture of care" or theoretical approach to client/patient care.[1] Our current health care system was built upon the central assumption that the mind and body are separate.[2] The ACEs Study and innumerable subsequent studies have shown that the mind and body are actually inseparable, which has inspired the necessary work of integrating behavioral health with primary care.[2,3] This is a more challenging process than merely co-locating mental health and substance use counselors with primary care services, true integration of behavioral health will require a shift in the "cultures of care" of both systems.[1,4]

Requiring trauma-informed care (TIC) training as a part of the *Health and Community Systems Capacity Building* offers the perfect solution to this challenge, as TIC is a "culture of care" that is built upon a new scientific understanding of trauma and the pervasive neurological, biological, epigenetic, psychological, immune system and social sequelae associated with ACEs and trauma exposure.[5,6] There is a growing body of research showing that patients or clients served in trauma-informed systems have greater symptom reduction, reduced time in treatment prior to discharge, improved rates of discharge to a lower level of care, and improved mental health and substance abuse outcomes.[7,8,9,10] A TIC approach has been shown to improve outcomes in behavioral health, chronic disease management, pediatrics & primary care, criminal/juvenile justice, and education.[5,11,12,13]

In addition to recognizing and addressing the impact of trauma and stress on clients, a TIC approach acknowledges that our health care organizations and the helping professionals working in these agencies are under immense "organizational stress".[4]

We know from the ACEs Study and subsequent research from the BRFSS (Behavioral Risk Factor Surveillance Study, 2009 & 2011) how prevalent trauma exposure is in our community; 62% of WA residents have experienced at least one ACE, 26% have experienced three of more. We must recognize that our health care system is comprised of individuals who have experienced high levels of trauma, just like the clients/patients they serve.[4] According to the National Association of Psychiatric Health Systems, “the overall infrastructure is under stress, and access to all levels of behavioral health care is affected”.[14] Expanding the evidence-based practices available to clients is critical, but the potential impact these services could have on the health and wellbeing of our community will not be fully realized until our care system is trauma-informed and using this approach with both clients/patients and staff.

A trauma-informed “culture of care” has massive benefits for staff, in addition to the client outcomes reported above, including improved job satisfaction, employee retention, and higher productivity, in addition to less “burn out” and employee turnover.[5,15]

Kitsap Strong believes that a trauma-informed “culture of care” will enable our health care system to achieve the triple aim of reducing costs, improving patient health, and improving quality of care. As Dr. Jeffrey Brenner, recipient of the MacArthur Foundation "Genius” Award explains, trauma-informed care provides the scientific framework and theory for health care providers to “actually take a holistic view” of patient care, and Dr. Brenner argues that “there's no way you can deliver better care at lower cost without coming to grips with patients' life history."[16]

A trauma-informed perspective opens up new possibilities and pathways to healing because it offers helping professionals a new understanding of the challenges that they are working to address. We noted that the trauma-informed language was removed from the toolkit in the recent revision, and ask that you reconsider this decision.

Please consider this request and make the expansion of trauma-informed care in our community a requirement of “Domain 1: Health and Community Systems Capacity Building.” Thank you for your time and consideration.

The request in this memo is being made by the entire Kitsap Strong Leadership Committee, which is listed on the next page.

Kitsap Strong is a network of community agencies working collaboratively to prevent the myriad of social and health problems associated with Adverse Childhood Experiences (ACEs), including chronic health conditions (diabetes, asthma, heart disease, obesity), mental health challenges (depression, anxiety, PTSD, ADHD) and social conditions (unemployment or underemployment, homelessness, intergenerational poverty, poor academic performance, criminal activity, incarceration). Our mission is to “improve the well-being and educational attainment of Kitsap residents, through a focus on empowerment and equity, the prevention of ACEs, and the building of resilience”.

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References:

1. U.S. Department of Health & Human Services, Public Health Service, Office of the Surgeon General. (2001). *Report of a Surgeon General's working meeting on the integration of mental health services and primary health care*; 2000 Nov 30 - Dec 1; Atlanta, Georgia. Rockville, MD: Author.

2. Levant, Ronald, F., House, Tanner A., May, Stephanie, & Smith, Rachaud. (2006). Cost offset: Past, present, future. *Psychological Services*, 3(3), 195-207. doi: 10.1037/1541-1559.3.195

3. Kiecolt-Glaser J.K., Robles T.F., & Glaser R. (2002). Psychoneuroimmunology: psychological influences on immune function and health. *Journal of Consulting and Clinical Psychology, 70,* 537-547.

4. Bloom, S. L. (2010). Organizational Stress as a Barrier to Trauma-Informed Service Delivery. Becker, M. and Levin, B. *A Public Health Perspective of Women's Mental Health*, New York: Springer (p.295-311).

5. Baker, Courtney N., Brown, Steven M., Wilcox, Patricia D., Overstreet, Stacy, & Arora, Prerna. (2015). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) scale. *School Mental Health.* doi: 10.1007/s12310-015-9161-0.

6. Menschner, C., & Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. *Center for Health Care Strategies, Inc.* Retrieved from: http://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

7. Davis, Rachel & Maul, Alexandra. (2015). Trauma-infomred care: Opportunities for high-need, high-cost Medicaid populations. *Center for Health Care Strategies, Inc.* Retrieved from: http://www.chcs.org/resource/trauma-informed-care-opportunities-high-need-high-cost-medicaid-populations/

8. Greenwald, R., Siradas, L., Schmitt, T. A., Reslan, S., Fierle, J., & Sande, B. (2012). Implementing trauma-informed treatment for youth in a residential facility: First-year outcomes. *Residential Treatment for Children & Youth, 29*(2), 141–153. doi:10.1080/0886571X.2012.676525.

9. Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence, 28*(7), 679–692. doi:10.1007/s10896-013-9531-z.

10. Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services, 56*(10), 1213–1222.

11. Blodgett, Christopher, and Dorado, Joyce (2016). CLEAR trauma-informed schools white paper: A selected review of trauma-informed school practice and alignment with educational practice. Retrieved from: http://ext100.wsu.edu/cafru/research/

12. Machtinger, Edward L., Cuca, Yvette P., Khanna, Naina, Rose, Carol D., & Kimberg, Leigh S. (2015). From treatment to healing: The promise of trauma-informed primary care. *Women's Health Issues*, 25(3), 193-197.

13. Garner, Andrew S., Shonkoff, Jack P., Siegel, Benjamin S., Dobbins, Mary I., Earls, Marian F., McGuinn, Laura, Pascoe, John, & Wood, David L. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. *Pediatrics.* (224-231). doi: 10.1542/peds.2011-2662.

14. National Association of Psychiatric Health Systems. (2003). Challenges Facing Behavioral Health Care: The Pressures on Essential Behavioral Healthcare Services. Washington, D.C.: *National Association of Psychiatric Health Systems*.

15. Fletcher, Natasha O., & King, Asia N. (2016). The efficacy of a trauma informed methodology for Hopeworks 'N Camden. *Rutgers Center for Urban Research and Education*. Retrieved from: http://hopeworks.org/wp-content/uploads/2016/11/HW-Report-FINAL.pdf

16. Levins, Hoag (2015). An Interview with Dr. Jeffrey Brenner: The cost-saving potential of trauma-informed primary care. *University of Pennsylvania.* Retrieved from: http://ldi.upenn.edu/news/cost-saving-potential-trauma-informed-primary-care

17. Larkin, Heather, Felitti, Vincent J., & Anda, Robert F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. *Social Work in Public Health, 29,* 1-16. doi: 10.1080/19371918.2011.619433

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February 2, 2017

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

Dorothy Teeter & Medicaid Transformation Team
Washington State Health Care Authority
626 8th Avenue SE
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Re: Comments on Medicaid Transformation Toolkit draft

Dear Ms. Teeter and Medicaid Transformation Team members:

As a nonprofit committed to advocating for reproductive health care and rights for women and girls in the Pacific Northwest, Legal Voice is pleased to provide these comments on the draft Medicaid Transformation Project Toolkit.

We are pleased to see that the optional section on Maternal and Child Health includes reproductive health. However, we have several suggestions to improve this section.

First, this section should be required, not optional. There are tremendous benefits to public health and health care spending when women have access to reproductive health and family planning services. Pregnancies are the number one driver of Medicaid costs, and an estimated $7 is saved for every $1 invested in family planning services. Making this section required, rather than optional, will contribute to substantial savings in costs due to reductions in unintended pregnancies, as well as reductions to the long-term costs associated with poor birth outcomes.

Further, because reproductive health is such a critical part of women's health, we suggest that the target population for the current "Maternal and Child Health" section be expanded to include all adult women of reproductive age, which is typically defined as including ages 18-44.

Finally, we strongly urge the section named "Maternal and Child Health" be renamed as "Reproductive Health." While this may appear to be a semantic change, in fact, it is an important one. The current draft language suggests that women's health is valued only with respect to their capacity to become pregnant. While it is important that the State recognizes the importance of healthy pregnancies and healthy birth outcomes, the Toolkit should also recognize the importance of women's reproductive health more broadly. This would better reflect the values expressed in our state laws and policies, which protect women's ability to decide when and whether to become

pregnant. Women have reproductive health needs regardless of whether they are actively intending to become pregnant – including those who have already had children. The terms “Family Planning” or “Reproductive Health” would more accurately capture the breadth of the State’s interest in this range of important health care services.

We are committed to ensuring all women and girls in Washington have access to high-quality, compassionate, evidence-based care. The Medicaid population is among the most vulnerable health populations. Thus, we strongly urge the Health Care Authority to consider these suggestions to improve the lives of women and reduce costs to the state.

Thank you for your consideration of these comments.

Sincerely,

Janet S. Chung
Legal & Legislative Counsel

Dear Dorothy,

Thank you for the opportunity to comment on the current draft of the Medicaid Transformation Project Toolkit for Washington State's 1115 Waiver. For the past two years Mercy Housing Northwest has been leading the housing-health partnership work for King County's Accountable Community of Health and we participate in the statewide Health Innovation Leadership Network. Through these forums we have promoted the concept of housing as healthcare and shown our healthcare partners the advantages of including housing in a truly integrated, cross-sector approach to health inequity in low-income communities. We are thrilled that housing plays such a key role in the waiver through the supportive housing benefit in Initiative 3, but there are more opportunities for including housing as a key player in additional projects under Initiative 1.

Housing is a key social determinant of health and reaching people in the communities where they live is an effective platform for health promotion. Mercy Housing Northwest has been making the business case for this approach since 2014 with "Bringing Health Home," our signature housing-health initiative that brings culturally competent Community Health Workers into affordable and public housing communities to provide health education, navigation, wellness programming, and chronic disease management. This initiative has been highly successful and we have been able to expand its reach through strategic partnerships with Public Health- Seattle & King County, Neighborcare Health, HealthPoint, Global to Local, King County Housing Authority, and Seattle Housing Authority. Mercy Housing Northwest and our six partners were chosen as the regional health improvement project for the King County ACH, "Prevention and Management of Chronic Disease in Low-Income and Immigrant Populations through Housing-based Community Health Worker Interventions in King County." Another component to our work is health-housing data integration. In a few months we will have an integrated database in King County (Public Housing Authority data and Medicaid ProviderOne) that will allow us to know the full story of how housing affects health and test the impact of using housing communities as a platform for chronic disease management programs.

As our team reviewed the draft toolkit we were struck by the fact that housing organizations were only included as a recommended implementation partner in 3 of the 8 projects under Initiative 1. We urge you to add housing organizations as a recommend partner in two additional projects- 3B: Maternal and Child Health and 3D: Chronic Disease Prevention and Control. There are many compelling reasons to use housing as a vehicle to better integrate low-income residents with the healthcare system. Affordable housing is where a large share of Medicaid covered people live, as well as people dually enrolled in Medicaid and Medicare, and the health system could reach virtually all of this population if there is a functional way to interact with the affordable and public housing communities. There are promising practices underway that make the case that housing is a natural place for prevention and targeted chronic disease management—it is where the people are.

Sincerely,

Bill Rumpf, President
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Mercy Housing is sponsored by communities of Catholic Sisters

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February 2, 2017

Nathan Johnson
Chief Policy Office
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Nathan.Johnson@hca.wa.gov

Regarding: Draft Medicaid Transformation Project Toolkit

Dear Mr. Johnson:

Thank you for the opportunity to review the Draft Medicaid Transformation Demonstration Project Toolkit. We were pleased to see that several of the issues we had raised in our earlier comment letter on the Special Terms and Conditions have been addressed in this iteration of the Project Toolkit.

Molina remains fully committed to the goals of Healthier Washington and successful implementation of the Medicaid Transformation Demonstration. What follows is Molina's input on remaining areas of concern.

Financial Sustainability through Value-based Payment (VBP)
Molina continues to have significant concerns that the only explicit ACH sustainability mechanism cited in the Toolkit and STCs is the move to Value Based Payments (VBP). VBP models directly reward providers engaged in the VBP. The rewards for providers are generated from the "Shared Savings". Therefore, "Shared Savings" have already been committed to participating providers for attainment of desired performance measures. There is no surplus for ACHs or any other entity that gets generated from VBC shared savings. We do not understand how VBP can be the "sustainability" for ACH projects/programs when ACH's are not party to VBP contracts and there are no savings to share. We consider this a material flaw.

Also of concern is the VBP Incentive requirement to transition Providers to contracts with "downside risk" beginning in year two. Private provider organizations can't be forced to participate in contract terms, including accepting downside risk, if they are not prepared to, or choose not to participate.

Systems for Population Health Management
As currently written the Toolkit continues to delegate certain Health Information Technology (HIT) and Health Information Exchange (HIE) activities to ACHs that they are not designed to or capable of providing or affording, which in turn will take away from their broader role in addressing social determinants of health. Specifically, functions such as HIT and HIE development, software purchasing and global interoperability decisions should be coordinated and potentially administered and paid for at a state-wide level. The cost and resource implication for each ACH to pursue its own HIPPA-compliant, IT systems and care coordination platforms is redundant and unsustainable, and likely sources of serious breaches of sensitive member PHI. Additionally, we are concerned about cost and resource implications

to the MCOs if required to interface operating systems with one or more unique, non-interoperable, and non-standardized HIT system in each of the nine regions. Managing and maintaining HIPPA-compliant IT and data environments filled with PHI requires sophisticated technology and skilled employees or consultants, and is exceedingly expensive in perpetuity. The ACHs are not staffed or resourced to establish and manage complex, expensive IT and data environments.

Value Based Payment and Quality Incentives to ACHs (Reinvestment Pools – STC 42.b)
The design of the Value Based Payment & Quality Incentive funds available to ACHs needs to be revisited. It is our understanding that the current Toolkit links the ACH Incentive Opportunity related to Value Based Payment to meeting the defined statewide calendar year benchmark (30% for CY2017) at a regional level. This design does not take into account the likely differences (disparities) across regions in terms of their baseline level of VBP attainment. We believe the design should be adjusted to reflect an improvement from current the regional VBP baseline in order to make attainment of the VBP opportunity a realistic and unique goal for each ACH. Similarly, the ACH opportunity to capture unearned incentives appears to be tied to performance against a core set of measures (our assumption, which we would like to confirm, is that this core set of measures will match the quality measures that are included in the MCO premium withhold). It will be equally important to account for likely regional differences in "baseline" quality performance in the final design of the DSRIP Planning Protocol and Roadmap. It is possible that we have mis-read this part of the Toolkit, but if not, the correction of these concerns is critical for every ACH to have a fair opportunity to achieve their incentive funds.

We look forward to our continued partnership with the Health Care Authority and success of the Medicaid Transformation Demonstration. Please let us know if you have any questions or desire additional information. We're happy to meet in person or on the phone over the next few weeks about each of the items in this letter.

Sincerely,

Peter Adler
President
Molina Healthcare Washington, Inc.

CC:
Randy Barker, Chief Operating Officer
Gretchen Gillis, Manager of Government Contracts
Laurel Lee, Vice President Member & Community Engagement
Claudia St. Clair, Vice President of Government Contracts

February 2, 2017

Dorothy Teeter and Medicaid Transformation Team
Washington Health Care Authority
626 8th Ave SE
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Submitted electronically to Dorothy.teeter@hca.wa.gov and medicaidtransformation@hca.wa.gov

Dear Director Teeter and the Medicaid Demonstration Team:

Thank you for this opportunity to provide feedback on the Medicaid Transformation Project (MTP) draft Project Toolkit (Toolkit). We are pleased to see the Toolkit's evolution and the addition of critical information ACHs need to move forward with project selection, and implementation. We write with comments regarding the draft Project Toolkit that we believe should be addressed prior to finalizing the Toolkit. We appreciate ongoing opportunities to engage with the Health Care Authority as it develops waiver protocols and policies.

Health Equity

We strongly endorse the changes that HCA has made in the current draft of the toolkit to call out addressing health disparities and improving health equity as an area of emphasis within the RHNIs (Toolkit at 1), a key feature of Transformation Project Plans (Toolkit at 3), a general aim of the MTP projects ("Efforts will focus on improving populations health and reducing disparities to achieve health equity across populations," (Toolkit at 4)), as an aim of workforce transformation (Toolkit at 11), and as the general focus of Domain 3 activities (Toolkit at 41). At the same time, while a number of the proposed project types readily lend themselves to addressing health disparities and improving health equity, providing more concrete expectations for ACHs to choose and explain how their projects address health disparities and consider health equity as a lens through which their policy choices are made will help to ensure that the Demonstration's aspirations to serve as a tool to combat persistent and pernicious inequities in health outcomes, access to care, and the Social Determinants of Health are actually achieved by each ACH and consequently throughout the Demonstrations' reach.

Further, as ACH certification criteria (Toolkit at 2) are finalized over the next several weeks, we recommend HCA flesh out the requirements of STC 22 which ACHs are required to comply with in the ACH Project Plan. Specifically, HCA should provide detailed guidance to ACHs on approaches to elevate

health equity and recommendations for approaches to achieve authentic consumer engagement. At a minimum, HCA should require that ACHs include the use of a health equity tool[1] in ACH decision making.

Incentive Payments

As HCA develops the plan for how incentive payments are calculated and earned (Toolkit at 1), we urge HCA to consider a payment methodology that provides quality bonuses to providers and ACHs that includes provisions to incentivize the treatment of typically high-cost patients. Any payment methodology considered should not create unintended incentives to avoid treating individuals who are less likely to show savings in their care.

Explicit Inclusion of Consumers

We recommend the statewide taskforces include opportunities for both consumers and consumer advocates to participate, and that both are included throughout the demonstration. We appreciate that HCA proposes that the Workforce Development Taskforce will include consumer advocates, but it fails to include consumers. (Toolkit at 6, 11). The statewide Value Based Payment Transition Taskforce composition does not include consumers or consumer advocates (Toolkit at 6, 8). However, HCA has not suggested that consumer advocates be among the sectors represented on the VBP Taskforce. Particularly as VBP systems have the potential for unintended negative impacts on vulnerable and more expensive to treat patient populations, it is critical that the group charged with assessing existing VBP payment methodologies and recommending strategies to address stakeholder needs for assistance in shifting to VBP methods, include individuals who can provide the experience and perspective of the impact of these practices on patients. Additionally, implementation for the opioid use (required) and chronic disease prevention (optional) projects include "consumer representatives" but does not include grassroots consumers. (Toolkit at 47, 63). HCA should clarify its expectations so that ACHs will know when to include consumer advocates, grassroots consumers, or both. We recommend specifying these expectations in the Context for Understanding this Document or Introduction.

Promising Practices

We strongly urge HCA to review and revise the toolkit to make clearer the acceptability of ACHs pursuing projects to test and increase the scale and spread of promising practices for which there is not already a large body of well-developed research addressing its merits. We recognize HCA's acknowledgement of the importance of supporting promising practices (see, e.g., Toolkit at 4 – "The Transformation Project Toolkit reflects the evidence-based strategies and promising practices the ACHS will used to develop …project plans…."), particularly in areas where treatments or approaches to care have not been extensively studied in populations that have historically been subject to health disparities. And, in recent discussions with HCA staff, they indicated a general support for ACHs to pursue such projects under the Demonstration. However, the only project type in which the Toolkit explicitly indicates that ACHs can test a "promising practice" is category 3b, maternal and child health. (Toolkit at 49-51). And, while it is an admittedly course measure of the comparative importance and role that evidence-based and promising practices play in the toolkit, "promising practices" are mentioned

[1] Examples include the City of Seattle Racial Equity Toolkit, *available at* http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf ; and the King County Equity Impact Review Tool, *available at* http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/documents/KingCountyEIRTool2010.ashx?la=en.

four times in the draft, while the term "evidence-based" is repeated seventy-two times. We certainly don't wish to indicate a disapproval of the use of evidence-based practices. However, to make sure that ACHs understand that they will receive support for pursuing projects based in promising, but slightly less already well-trod avenues of research, we urge HCA to make specific mention of promising practices associated with each project type to which they are applicable.

Regional Health Needs Inventory

We endorse the State's requirement that each ACH develop a Regional Health Needs Inventory (RHNI) and particularly that "[e]fforts should be explicitly targeted to address identified disparities in health service access, health service quality, and health outcomes across populations." (Toolkit at 6). It will be helpful to ACHs to clarify this. The statement that "efforts should be explicitly targeted to address identified disparities" is a little unclear placed in the middle of a section on what information will need to be gathered to create the RHNI, rather than what will be done with the RHNI. This should be clarified to state that the RHNI shall include sufficient information needed to determine the existence of disparities in specified metrics between racial and ethnic groups, by age, LGBTQ status, citizenship, LEP status, and having a disability. It will also be helpful to include a minimum list of metrics that will be viewed with an eye to determining if disparities exist across these demographic groups.

Statewide Value Based Payment Transition Taskforce and Workforce Development Taskforce

The Toolkit says that "[t]o the extent that regional and local-level needs are not fulfilled through the statewide taskforce structures, ACHs should convene regional or local-level sub-taskforces to provide input to and guide efforts around regional value based payment transition and workforce development efforts needed for successful implementation." (Toolkit at 6). It would be helpful to state more clearly how ACHs should determine (or by what standard the State will hold them accountable for determining) if statewide task force structures are sufficient to fulfill regional and local needs in these areas. In the alternative, ACHs should simply be required to form such regional/local bodies. The second option is preferable, as the existing VBP methods already in use, the provider community's adaptability to implementing new VBP methods, and need for exceptions to this for specific populations and provider types will vary substantially between regions. Consequently, local/regional stakeholders will need to collaborate with ACHs to determine their VBP-implementation plan.

Domain 1: Health and Community Systems Capacity Building

Financial Sustainability through Value Based Payment

In the prior draft, the VBP taskforce had been assigned the responsibility of developing a VBP payment provisions template, which should, among other things "Define service population exceptions for specific methodologies." (Pre-Draft Toolkit (PDT) at 6). The current draft does not assign the taskforce the responsibility of creating this template. If HCA still intends to create such a template (which we endorse), and this will not be the VBP taskforce's responsibility, the Toolkit should state clearly who is responsible for this and state explicitly the expectations that the toolkit will define exceptions for applicable populations and methodologies.

Per our prior comment above, consumers and consumer advocates are necessary partners in the VBP taskforce's work and should be a listed sector from whom representatives shall be chosen to serve on the VBP taskforce. (Toolkit at 8-9).

The Toolkit (at 9) says that ACHs will "[d]evelop a regional VBP Transition Plan that: Identifies strategies to be implemented in the region to support attainment of statewide VBP targets." It seems overly optimistic and may be counterproductive to charge ACHs with developing a plan to meet HCA's VBP targets. Pre-existing penetration of VBP arrangements into provider communities, possible obstacles to the adoption of new VBP methods, and the size and spread of populations and conditions that will need exceptions to the VBP targets will vary considerably from region to region. While HCA may have sufficient data on which to base its assessment that its targets are reasonable for the State over all, it is incredibly unlikely that they will prove feasible in each ACH as well.

ACHs are charged with "[i]mplement[ing] strategies to support VBP transitions in alignment with Medicaid transformation activities" with the specific numerical VBP penetration targets set by HCA for the state applied to each ACH's region. (Toolkit at 10). At the same time, the toolkit appears to acknowledge that this may not be possible, as it also directs ACHs to "[a]chieve progress toward VBP adoption that is reflective of current state of readiness…" In this context, it is likely best to state explicitly that the State's VBP penetration targets are guidelines from which ACHs may vary based on their individual regional circumstances.

In multiple Stage 3 sections, the toolkit expects ACHs to "[i]mplement VBP strategies to support" the category type described in this section (see, e.g., p.23 – "new integrated system of care," p.28 – "the HUB care coordination pathways," p. 35 – "transitional care," p. 40 – "diversion activities," p. 54 – "maternal and child health project"). It is unclear, however, how VBP strategies may (or may not) support each of these project types which differ significantly between each other, and several of which leave significant room for variation within the project categories. VBP arrangements may be well-suited to some project categories, poorly suited to others, and potentially well-suited to still others with significant gaps to fill before significant VBP arrangement can be successfully implemented. Moreover, using VBP arrangements to push better quality care (instead of aiming to improve care quality and then instituting the means to secure and reap savings from those improvements) seems like the tail wagging the dog. For example, integrated care systems are hoped to provide more timely care within a single provider facility or group, and thus yield higher value care. But, it is the successes in integration and better addressing the whole patient's needs that will deliver value; whereas, simply imposing VBP structures on these clinical programs does little to create the conditions that will result in higher value care. Consequently, the aim should be to better facilitate efficient and effective integrated care with the hope that savings and better value care will result, rather than the other way around. The same could be said for other project types in which the toolkit calls upon ACHs to implement VBP strategies in their support. To this end, we urge HCA to rethink this, and include a more measured aim here. For example, the toolkit might call upon ACHs to create a VBP assessment and implementation plan that is not directly tied to achieving specific artificial benchmarks widely applicable to all ACH activities. Instead, the assessment would be focused on the individual project's readiness and appropriateness for different forms of VBP, including workforce readiness and whether and to what extent populations and/or provider types that are appropriate for exemptions from VBP are included in the project. The implementation plan would then set out benchmarks for steps that might be taken to remedy identified workforce gaps, any forms of VBP that would presumptively be pursued within the project and at what rates, the nature and scope of exemptions from VBP that apply within the project, incentives to be offered to providers for offering exempt services and/or serving exempt populations in the project, and quality metrics to be used to track ACH and provider performance within this plan. Then, within each "Stage 3 - Scale & Sustain" section, where implementing VBP procedures is currently listed as a required step, instead ACHs would be called upon to implement the VBP, workforce enhancement and exemption procedures called for in the plan.

Similarly, HCA should delete the current mandates that ACHs "Begin pay for performance of select outcome metrics," which are found in multiple "Stage 3 – Scale & Sustain: Progress Measures" throughout the toolkit. In the alternative, HCA could require an assessment of patient and provider performance along selected metrics and, to the extent that performance does not meet planned targets, conduct an associated analysis of the project's actual readiness and appropriateness for VBP, including workforce readiness and the project's success in taking up exempt populations.

Workforce

The toolkit (at 11-12) indicates that a responsibility of the Workforce transformation taskforce will be to "[i]dentify gaps in current workforce initiatives/activities as it pertains to Domain 2 and Domain 3 activities" and to develop an action plan that include objections, actions and target dates "that tie directly to Domain 2 and Domain 3 projects." This would likely benefit from some clarification or change. While some project categories will be shared between ACHs, different ACHs may develop projects with significant differences even within the same category of projects. Consequently, it will likely be difficult for a statewide task force to develop a gap analysis and action plan to address workforce numbers and training on a statewide basis solely within the context of Domain 2 and 3 projects. It is also unclear that these efforts will identify larger gaps that will be need to be addressed to help the State reach its VBP targets on a statewide basis. HCA should consider having the task force identify and develop an action plan to address gaps more generally on a statewide basis to assist the State in meeting its broader goals under the Demonstration project.

The toolkit would benefit from clarification of the Regional Planning Activities anticipated for the Workforce project, as well as whose responsibilities these tasks will be. For example, the term "development and deployment efforts" does not provide clear guidance regarding what will be expected in these areas. (Toolkit at 11). Also, while the toolkit's suggestion that regional planning will include "[r]ecruitment and retention incentives and efforts to address workforce shortages," it is unclear whose responsibility this will be. If it will be the responsibility of ACHs, it would be helpful to indicate how they will fund these activities.

The statewide planning activities action plan may include a strategy "[t]he approach to cultural competency and health literacy trainings (particularly for clinical staff, service providers, and other patient-facing staff." (Toolkit at 12). We endorse that health care workers should receive cultural competency and health literacy training. This should be stated more clearly and should not be an optional strategy that the action plan "may include." We expect that health care staff participating in Demonstration activities will generally require and receive cultural competency and health literacy training.

Systems for Population Health Management

This focus area has Stage 1 - Governance, Stage 2 - Planning, but does not include Stage 3 - Implementation. We believe this was likely an unintentional oversight as all other projects in the Toolkit include implementation details and recommend HCA provide the same for this project prior to finalizing the Toolkit.

Sharing data will be crucial to the MTP's success. However, widely authorizing numerous providers, agencies and other organizations to share private information not only about highly private health-related matters, but about social determinants of health that make up nearly every aspect of a person's life raises significant questions about how this information will be protected and to what purposes its

use will be restricted. (Toolkit at 13). An additional bullet point should be added to Stage 1 – Governance, to indicate that HCA will work with ACHs, consumer advocates, academic experts in information security and privacy, and Medicaid recipients to establish limits on what types of information can be shared, by whom and for what purposes to protect Medicaid beneficiaries' reasonable expectations of privacy.

Domain 2: Care Delivery Redesign

Bi-directional Integration of Care and Primary Care Transformation

We endorse HCA's requirement under Option 1 for integrating behavioral health into primary care settings that PCMH providers make a "[d]emonstration of cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing health disparities." (Toolkit at 19). We recommend that, both to ensure that these aspirations are actually realized and to clarify to providers what is expected of them, more concrete requirements be listed here. For example, all MTP providers should be required to receive cultural competency training approved by HCA or demonstrate that they have taken the equivalent training within the past year; providers will need to take "refresher" courses approved by HCA at least every two years. Also, providers should be required to actually engage Medicaid members in areas listed in the Toolkit, not simply demonstrate a "willingness" to do this. As we've seen over the last two years, an expression of a willingness to include authentic consumer voices in ACH projects and governance does not necessarily translate to a meaningful and timely realization of that expressed intent.

Additionally, within the implementation stage of the PCMH Model for integrating behavioral health into primary care settings, preventive care screenings including the PHQ-9 are to be implemented for all patients to identify unmet needs (Toolkit at 19). The PHQ-9 is a depression screening and is not a screen for other behavioral health conditions. Although depression is one of the more prevalent behavioral health conditions in Washington state, the narrow focus of the PHQ-9 will not serve to identify patients who suffer from behavioral health conditions other than depression. Further, while the PHQ-9 is still used in some practice settings to screen for depression, it is based on outdated DSM-IV diagnostic criteria; current diagnostic criteria are contained in the DSM-V. HCA should require the use of a broader behavioral health screen that is not restricted to depression that is based on current diagnostic criteria.

Domain 3: Prevention and Health Promotion

Maternal and Child Health

We are happy to see the draft Toolkit includes family planning within the Maternal and Child Health project. (Toolkit at 50). We recommend the name of the project be changed to "Reproductive Health" to more accurately reflect the focus areas within the project. We also recommend the target population be changed from "women of preconception age" to "women of reproductive age" as this is a more appropriate term and does not limit the toolkit projects only to those intending to become pregnant. (Toolkit at 49). Projects should target women of reproductive age generally, regardless of whether they intend to become pregnant, enabling them to obtain valuable and necessary women's health care.

Conclusion

On behalf of the undersigned organizations, thank you for your consideration of our comments. Please feel free to contact us with any questions about this document or other issues regarding ACHs and the MTP.

Sincerely,

Northwest Health Law Advocates

Northwest Justice Project

Solid Ground

Columbia Legal Services

Puget Sound Advocates for Retirement Action

Nurse-Family Partnership
Helping First-Time Parents Succeed®

February 1, 2017

Nathan Johnson, Chief Policy Officer
Washington State Health Care Authority
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA, 98501

Dear Mr. Johnson,

On behalf of the fifteen Nurse-Family Partnership (NFP) providers across the state, the NFP National Service Office appreciates the opportunity to comment on the Healthier Washington Medicaid Transformation Project Toolkit. As an evidence-based preventive home visitation program for low-income pregnant women and children operating in Washington since 1999, we look forward to working with the state and the Accountable Communities of Health (ACHs) to create better linkages between clinical and community-based services to improve maternal and child health in the state.

The Toolkit's focus on opioid abuse will be a vital opportunity for communities, and bridging efforts between projects 3A and 3B (on maternal and child health) could multiply the impact of efforts to address this epidemic. Nurse-Family Partnership can help advance this work. NFP Nurses develop long-term trusting relationships with their clients, and can provide front-line insights into home conditions and the ability to assess families for substance abuse issues. They also use motivational interviewing techniques to help clients identify issues, realize solutions, and connect them to appropriate community resources when they are ready. As ACHs implement projects through Healthier Washington, we hope there will be many opportunities for NFP to help coordinate efforts to combat opioid abuse.

We very much support the Toolkit's focus on evidence-based interventions like Nurse-Family Partnership for project 3B. The goals of our model—to improve pregnancy outcomes, improve child health and development, and improve family economic self-sufficiency—support the whole-person care that Healthier Washington is trying to achieve. NFP's outcomes are well documented and supported by rigorous evaluations, and may be helpful to you and the ACHs as project metrics are developed. For your convenience, we have attached an overview of NFP's evidence base.

Nurse-Family Partnership currently serves less than 13% of eligible families in Washington State. Many of Washington's NFP programs are ready to grow – both by hiring additional nurses to serve more families in their existing regions, and by expanding to serve neighboring communities. While we note the concern in the Toolkit (page 49) that valid justification is necessary for any expansion, building upon existing, high-performing programs in high-need communities is the fastest and most efficient way to increase access to Nurse-Family Partnership. We hope HCA will consider the added value such expansions could bring (without duplication of effort or expense) when considering projects for funding.

Finally, as a national organization supporting 600 programs across the nation, our National Service Office has unique expertise and a wealth of resources to offer the HCA and Accountable

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www.nursefamilypartnership.org

Communities of Health. We have included as an attachment an overview of the steps communities generally take, in consultation with the National Service Office, to develop an NFP program. **As your team continues to craft the project implementation stages, timeline, and progress measures, we would welcome the opportunity to share more about the steps it takes to develop a Nurse-Family Partnership program and help you think through appropriate progress measures and timelines.**

We very much support the work the HCA has done to focus on evidence-based, upstream programs as part of the Medicaid Waiver, and we thank you for including Nurse-Family Partnership in the Project Toolkit. Expanding access to this program will mean more babies are born healthy with the opportunity to grow up in a safe and supportive environment.

Sincerely,

Siobhan Mahorter, Business Development Manager
Nurse-Family Partnership National Service Office

Christian Heiss, Health Policy Director
Nurse-Family Partnership National Service Office

North Sound
Accountable Community of Health

February 2, 2017

To: Washington Health Care Authority

Comments on the Draft Medicaid Demonstration Project Toolkit

The North Sound Accountable Community of Health (ACH) appreciates the opportunity to comment on the Draft Medicaid Demonstration Project Toolkit. We value the HCA's recognition of the key role of ACHs in health system transformation as community-based, cross-sector collaborations. We continue to work toward a culture of all stakeholders and partners thinking in terms of "we" rather than 'you' and us.

Reasonable Timelines: We recognize that there are many deliverables approaching quickly and simultaneously. Given the pivotal role of ACHs in the state's Medicaid Transformation Demonstration, it is critical that timelines, deadlines and deliverables be structured in a way that ACHs can be ready to fully take on those tasks. Hitting the ground running is easier in some regions of the state than others, and since we will all be building capacity at the same time, we may find ourselves competing with a neighboring ACH for talent and expertise.

In addition, there are some steps where the ACHs are dependent on the State for data. In those cases, where the draft toolkit indicates that ACHs are expected to develop plans that depend upon state actions, we encourage that announced timelines factor in when the state can realistically fulfil their responsibilities.

One example is that a complete RHNI is required in advance of finalizing project implementation plans, it would be helpful to know when the initial data will be available so that we can move forward on addressing gaps and having that data inform our selections.

Additionally, there is an expectation of community engagement in project selection, which takes time and sequencing in order to allow for authentic input and engagement.

ACH Role vis-à-vis other key stakeholders/partners: In order to have sustainable success we must be collaborative with our partners, especially those who already have state contracts requiring them to play leadership roles with Medicaid enrollees. Partnerships work best when respective roles are clarified among all parties. If the ACH role is to be the same statewide then we recommend that the HCA establish those roles systemically for – and with – all ACHs. If the roles can vary depending on the regional partners and regional variation, then stating that up front would be helpful.

For example, the Practice Transformation Hub is listed as a resource, but their expected role in Domain 1 Value Based Payment efforts or in Bi-directional integration is not explicitly.

BHO Relationship: As a key stakeholder in the required Behavioral Health Integration project, we are fortunate to have the BHO on our governing body, and its director serving as our Chair. In such, the BHO has shared ownership of our work ahead, and it is critical that we all continue to have open and transparent discussions about the role of the BHOs moving forward.

Resource Transparency: A clear articulation of the initial allocation of resources is foundational to the ability of ACH to move implementation of the Demonstration forward in a timely manner. With some deliverables early and mid-spring, a commitment to revenue for the ACHs will allow us to bring on needed staff, consultants and tools to work on project plans simultaneously and in a thorough manner. The longer that the commitment and declaration of the level of commitment take, the harder it will be for ACHS to gear up quickly enough and meet the initial deadlines HCA has indicated.

We understand that ACHs may propose working on more than the required four projects. We recommend that there be a funding allocation developed, with our input, that details a fair and equitable way of allocating funds to each ACH for the four required projects. We can envision some kind of competitive evaluation to determine allocation of remaining funds, as they allow for ACHs to take on additional projects. Competition for the four required projects makes it more challenging to plan for the next 6-12 months.

In addition, in relation to **technical assistance (TA)**, we recommend that there be some baseline TA available to all ACHs so that we are not competing in areas such as learning best practices related to funds flow modeling, and other necessary core requirements.

Statewide Taskforces: We support the shift from regional task forces related to Workforce and Value Based Payment to statewide with ACH support and participation. Trying to approach these challenges statewide, while allowing the regions to incorporate region-specific needs and assets will enhance the process and allow regional differences, assets and challenges to be highlighted for our specific selected projects. We especially appreciate HCA's verbal clarification that the Workforce Task Force focus should be based on the projects selected.

Data Infrastructure: The Toolkit lays out the HCA's responsibility in relation to data infrastructure, yet many of the projects require identifying and implementing an evidence based tracking system, which is work to be done by the ACH. The state must specify what their responsibilities are for interoperability, and a clear timeline toward that end.

In efforts to avoid duplication of effort, and to not leave vestigial systems laying around, we encourage a statewide collaborative effort that includes HCA, ACHs and partners in creating and/or modifying this information infrastructure. The ability to measure performance is key to demonstrating success at the regional and state levels. It would be helpful as we move forward to commit to sharing and optimizing data capacity statewide, leveraging existing infrastructure where we can, and using the assets of our partner organizations and sectors to enhance interoperability.

Knowing the timelines as soon as possible for when the HCA will have data available for the ACHs will be critical to the ACHs moving forward.

Tribal Partners: As the North Sound ACH has eight tribal partners, we remain committed to collaboration with them and to having agreed upon policy in writing in the region. Clarity on when there is flexibility and discretion for variation would be extremely helpful, especially in these early months, as we work respectfully with the Tribal sovereign nations to identify the roles they see themselves playing.

Future Work: The Special Terms and Conditions make clear that the draft Toolkit is only one part of the DSRIP Planning Protocol. We all benefit from an inclusive and transparent process; as the finalization of Attachments C and D move forward, the North Sound ACH looks forward to working with HCA to identify the metrics and milestones to be defined in Attachment C. We ask that HCA partner with ACHs on relevant attachments including the remainder of the DSRIP Planning Protocol (Attachment C).

In addition, we look forward to a discussion of ACH certification and opportunities to provide feedback on relevant portions of Attachment D: DSRIP Program Funding & Mechanics Protocol.

We ask that HCA utilize an inclusive and transparent process for engaging with **all nine** ACHs in identifying the metrics and crafting the milestones to be defined in Attachment C. We look forward to a discussion of ACH certification and opportunities to provide feedback on relevant portions of Attachment D: DSRIP Program Funding & Mechanics Protocol.

The North Sound ACH and our partners are committed to health system transformation, and believe it works best when it is a process of co-creation and collaboration. We look forward to working with the HCA and the other ACHs to finalize timelines and deliverables as our work moves from general aspirations to concrete content and outcomes.

Comments on the January 3 "Draft for Public Comment Medicaid Transformation Toolkit"
Submitted by: Joe Valentine on behalf of the North Sound Behavioral Health Organization

Comment	Project Took Kit Reference Pages
1. What requirement will there be for the ACH to engage BHOs as a system partner? There are no references to BHOs anywhere in the document.	
2. Clarify the role of the ACH in developing a regional plan for fully integrated care. Parts of section 2A reference developing specific "projects" testing out models for bi-directional collaborative care. However, 2A also seems to assign the ACH as the lead role in developing the overall plan for moving towards 2020 full integration. Are they supposed to be working on both of these at the same time? The "Special Terms and Conditions" [STCs] do not reference this 2nd role. They reference "projects" but not developing the full regional plan for fully integrated care.	15-23 STCs- 19
3. Will counties be sending their binding letters of intent to the ACH rather than HCA? This seems to be implied on page 18. Does this mean that counties will not be given the choice to notify the state directly of their intent regarding the timeline for moving towards fully integrated care?	18
4. Many of the timelines for the regional plans depend on development of statewide plans first, e.g., for Value Based Payments, Workforce Development, Population Health Management. Will the regional timelines be adjusted based on the state's progress in meeting the timelines for the state Health IT plan, VBP Road map, etc?	Many sections
5. Value Based Payment targets. The regions have the same timeline targets as the state for implementation of the value based payment targets. The 2017 target of 30% seems overly ambitious given the amount of planning at the state level that would have to occur before any VBP strategies are implemented. We understand from the January 17 meeting of the	10
6. Population Health Management. The ability of the ACHs to achieve the necessary milestones for most projects is highly dependent on the development of the statewide infrastructure for *Population Health Management.* Some include the development of additional functionality even beyond the basic planning scope of work for PHM systems, e.g. health information exchanges, patient registry, opioid surveillance systems, etc. There needs to be an explicit recognition of this critical dependency in negotiating the performance milestones of the ACHs.	19.20.23,42, etc.

Evidentiary Foundations of Nurse-Family Partnership

Nurse-Family Partnership (NFP) is a program of prenatal and infancy home visiting for low-income, first-time mothers and their children. Nurses begin visiting families as early as possible during pregnancy and continue visiting until the child's second birthday.

NFP Nurse Home Visitors have three major goals:

- Improve pregnancy outcomes by helping women engage in good preventive health practices, including obtaining thorough prenatal care from their healthcare providers, improving their diet, and reducing their use of cigarettes, alcohol and illegal substances;

- Improve child health and development by helping parents provide responsible and competent care for their children; and

- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Leadership of Nurse-Family Partnership chose to offer the program for public investment only after they had:

- replicated evidence of program impact from at least two randomized controlled trials;
- evidence that the program improved outcomes of public health importance;
- evidence of enduring program impact;
- evidence of cost-savings;
- confidence that the essential elements of the program could be reliably reproduced; and
- a web-based information system that could help ensure quality program implementation, accountability, and continuous program improvement.[2]

These kinds of evidentiary and replication standards are advocated by the Coalition for Evidence-Based Policy,[3] Blueprints for Violence Prevention,[4] and the Society for Prevention Research.[5] They also are consistent with those required by the Food and Drug Administration before pharmaceutical companies are allowed to market new drugs.[6] They are founded on the conviction that scarce public dollars ought to be invested in programs that work and that have the infrastructure to ensure high quality implementation and on-going monitoring of performance.

Nurse-Family Partnership has consistent evidence, based upon replicated randomized controlled trials with different populations living in different contexts, that it:

- improves prenatal health [7-9]
- reduces childhood injuries [7, 10, 11]
- reduces the rates of subsequent pregnancies and births [7, 9, 12-14]
- increases the intervals between first and second pregnancies and births [7, 9, 12-14]
- increases maternal employment [7, 9, 14]
- reduces women's use of welfare [12-14, 25]
- reduces children's mental health problems [15, 16, 24]
- increases children's school readiness and academic achievement [9,16, 17]
- reduces costs to government and society [18, 19, 25]
- is most effective for those most susceptible to the problems examined [1]

Relative to Nurse-Family Partnership's program goals, the following outcomes have been observed among program participants compared to their counterparts assigned to the control group in at least one randomized trial:

Improved pregnancy outcomes

- 35% fewer cases of pregnancy-induced hypertension [7]
- 79% reduction in preterm delivery among women who smoke cigarettes [8]
- 31% reduction in very closely spaced (<6 months) subsequent pregnancies [12]

Improved child health and development

- 39% fewer healthcare encounters for injuries or ingestions in the first two years of life among children born to mothers with low psychological resources [22]
- 56% reduction in emergency room visits for accidents and poisonings in the second year of the child's life [11]
- 48% reduction in state-verified reports of child abuse and neglect by child age 15 [20]
- 50% reduction in language delays by child age 21 months [9]
- 5 point increase in language scores on a test with a mean of 100 and standard deviation of 15 among 4-year-old children born to mothers with low psychological resources [17]
- 3.95 point increase in receptive language (when averaged across age 2, 4, and 6) among children born to mothers with low psychological resources [27]
- 1.03 point increase in sustained attention when averaged across age 4, 6, and 9 among children born to mothers with low psychological resources[27]
- 67% reduction in behavioral and emotional problems at child age 6 [16]
- 9 percentile increase in math and reading achievement test scores in grades 1-3 among children born to mothers with low psychological resources [23]
- 67% reduction in 12-year-old children's use of cigarettes, alcohol, or marijuana [24]
- 28% reduction in 12-year olds' mental health problems (depression and anxiety) [24]
- 3 point increase in 12-year-old children's reading and math achievement test scores on a test with a mean of 100 and standard deviation of 15 among those born to mothers with low psychological resources [24]
- 6 percentile increase in group-based reading and math achievement test scores in grades 1-6 among children born to mothers with low psychological resources [24]
- 59% reduction in arrests by child age 15 [21]
- 90% reduction in adjudication as PINS (person in need of supervision) for incorrigible behavior [21]
- 33% fewer arrests among female children at age 19 [26]
- 80% fewer convictions among female children at age 19 [26]
- 73% increase in age at 1st arrest among female children at age 19 [26]
- 82% fewer current arrests (in the past year) among female children at age 19 [26]
- 89% fewer current convictions (in the past year) among female children at age 19 [26]
- Reduced childhood mortality from preventable causes at age 20 [27]

Increased self-sufficiency of the family

- 1 month increase in labor force participation during second year of child's life [9]
- 46% increase in father presence in household by child age 4 [12]

- 30-month reduction in use of AFDC-TANF among mothers who were poor and unmarried at registration [13]
- 7 month (or 82%) increase in labor force participation 4 years after delivery of first child among low-income unmarried mothers[14]
- 1.75 month reduction in use of AFDC-TANF between child age 5 and age 6 [16]
- 1.83 month reduction in use of Food Stamps between child age 5 and 6 [16]
- 61% fewer arrests of mothers by child age 15 [20]
- 72% fewer convictions of mothers by child age 15 [20]
- $12,300 discounted savings (2006 dollars) in Food Stamps, Medicaid, and AFDC-TANF from child age 0-12 compared to program cost of $11,511 (2006 dollars) [25]
- 13% increase in duration of mothers' relationships with current partners by child age 12 [25]
- Reduced all-cause maternal mortality rate when comparing control group participants with combined treatment groups of participants receiving pre-natal and 2 post-partum home visits and participants who received pre-natal, post-partum, and infancy/toddler home visitation [27]. Note: This finding is not significant when comparing the control group with participants who received the NFP intervention (i.e., prenatal, infancy, and toddler home visits), but it is observed in the expected direction ($P = .19$) [27]

The Nurse-Family Partnership National Service Office is responsible for helping agencies implement the program in their community. Learn more at: www.nursefamilypartnership.org.

Reference List

1. Olds DL. Prenatal and infancy home visiting by nurses: from randomized trials to community replication. **Prevention Science** 2002 Sep;3(3):153-72.

2. Olds DL, Hill PL, O'Brien R, Racine D, Moritz P. Taking preventive intervention to scale: the Nurse-Family Partnership. **Cognitive and Behavioral Practice** 2003;10(4):278-90.

3. Coalition for Evidence-Based Policy [homepage on the Internet]. **Council for Excellence in Government**;[cited 2007 Feb 1]. Available from: http://coexgov.securesites.net/index.php?keyword=a432fbc34d71c7.

4. Blueprints for Violence Prevention model program selection criteria [homepage on the Internet]. **Center for the Study and Prevention of Violence**; c2004 [cited 2007 Feb 1]. Available from: http://www.colorado.edu/cspv/blueprints/model/criteria.html.

5. Flay BR, Biglan A, Boruch RF, Castro FG, Gottfredson D, Kellam S, Moscicki EK, Schinke S, Valentine JC, Ji P. Standards of evidence: criteria for efficacy, effectiveness and dissemination. **Prevention Science** 2005 Sep;6(3):151-75.

6. Katz R. FDA: evidentiary standards for drug development and approval. **NeuroRx: The Journal of the American Society for Experimental NeuroTherapeutics** 2004 Jul;1(3):307-16.

7. Kitzman H, Olds DL, Henderson CR Jr, Hanks C, Cole R, Tatelbaum R, McConnochie KM, Sidora K, Luckey DW, Shaver D, et al. Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. **Journal of the American Medical Association** 1997 Aug 27;278(8):644-52.

8. Olds DL, Henderson CRJ, Tatelbaum R, Chamberlin R. Improving the delivery of prenatal care and outcomes of pregnancy: a randomized trial of nurse home visitation. **Pediatrics** 1986 Jan;77(1):16-28.

9. Olds DL, Robinson J, O'Brien R, Luckey DW, Pettitt LM, Henderson CR Jr, Ng RK, Sheff KL, Korfmacher J, Hiatt S, et al. Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. **Pediatrics** 2002 Sep;110(3):486-96.

10. Olds DL, Henderson CR Jr, Kitzman H. Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? **Pediatrics** 1994 Jan;93(1):89-98.

11. Olds DL, Henderson CR Jr, Chamberlin R, Tatelbaum R. Preventing child abuse and neglect: a randomized trial of nurse home visitation. **Pediatrics** 1986 Jul;78(1):65-78.

12. Kitzman H, Olds DL, Sidora K, Henderson CR Jr, Hanks C, Cole R, Luckey DW, Bondy J, Cole K, Glazner J. Enduring effects of nurse home visitation on maternal life course: a 3-year follow-up of a randomized trial. **Journal of the American Medical Association** 2000 Apr 19;283(15):1983-9.

13. Olds DL, Eckenrode J, Henderson CR Jr, Kitzman H, Powers J, Cole R, Sidora K, Morris P, Pettitt LM, Luckey D. Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. **Journal of the American Medical Association** 1997 Aug 27;278(8):637-43.

14. Olds DL, Henderson CRJ, Tatelbaum R, Chamberlin R. Improving the life-course development of socially disadvantaged mothers: a randomized trial of nurse home visitation. **American Journal of Public Health** 1988 Nov;78(11):1436-45.

15. Olds D, Henderson CR Jr, Cole R, Eckenrode J, Kitzman H, Luckey D, Pettitt L, Sidora K, Morris P, Powers J. Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial . **Journal of the American Medical Association** 1998 Oct 14;280(14):1238-44.

16. Olds DL, Kitzman H, Cole R, Robinson J, Sidora K, Luckey D, Henderson C, Hanks C, Bondy J, Holmberg J. Effects of nurse home visiting on maternal life-course and child development: age-six follow-up of a randomized trial. **Pediatrics** 2004;114:1550-9.

17. Olds DL, Robinson J, Pettitt L, Luckey DW, Holmberg J, Ng RK, Isacks K, Sheff K. Effects of home visits by paraprofessionals and by nurses: age-four follow-up of a randomized trial. **Pediatrics** 2004;114:1560-8.

18. Aos, S.; Lieb, R.; Mayfield, J.; Miller, M.; Pennucci, A. Benefits and costs of prevention and early intervention programs for youth. Olympia, WA: **Washington State Institute for Public Policy**; 2004.

19. Karoly, L. A.; Kilburn, M. R.; Cannon, J. S. Early childhood interventions: proven results, future promise. Santa Monica, CA: **RAND**; 2005.

20. Reanalysis Olds et al. **Journal of the American Medical Association** 1997 Aug 27;278(8):637-43.

21. Reanalysis of Olds et al. **Journal of the American Medical Association** 1998 Oct 14;280(14):1238-44.

22. Reanalysis of Kitzman et al. **Journal of the American Medical Association** 1997 Aug 27;278(8):644-52; See also Memphis Year 9 results, citation #23, finding that nurse-visited children as a trend were less likely to die from birth through age 9, an effect accounted for by deaths due to potentially preventable causes, such as preterm delivery, Sudden Infant Death Syndrome, and injuries.

23. Olds DL, Kitzman H, Hanks C, Cole RE, Anson EA, Sidora-Arcoleo KJ, Luckey DW, Henderson CRJ, Holmberg J, Tutt RA, et al. Effects of nurse home visiting on maternal and child functioning: age-nine follow-up of a randomized trial. **Pediatrics** 2007;120(4).

24. Kitzman HJ, Olds DL, Cole RE, Hanks CA, Anson EA, Arcoleo-Sidora KJ, Luckey DW, Knudtson MD, Henderson CR Jr., Holmberg JR. Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. **Archives of Pediatrics and Adolescent Medicine** May 2010, 164(5):412-418.

25. Olds DL, Kitzman HJ, Cole RE, Hanks CA, Arcoleo-Sidora KJ, Anson EA, Luckey DW, Knudtson MD, Henderson CR Jr., Bondy J, Stevenson AJ. Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years. **Archives of Pediatrics and Adolescent Medicine** May 2010, 164(5):419-424.

26. Eckenrode J, Campa M, Luckey DW, Henderson CR Jr., Cole RE, Kitzman HJ, Anson EA, Arcoleo-Sidora KJ, Powers J, Olds DL. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths 19-Year follow-up of a randomized trial. **Archives of Pediatrics and Adolescent Medicine** January 2010;164(1):9-15.

27. Olds DL, Holmberg JR, Donelan-McCall N, Luckey DW, Knudtson MD, Robinson J. Effects of home visits by paraprofessionals and nurses on children: Follow-up of a randomized trial at ages 6 and 9 years. **JAMA Pediatrics** February 2014; 168(2):114-121.

28. Olds DL, Kitzman H, Knutdson M, Anson E, Smith JA, Cole R. Effect of home visiting by nurses on maternal and child mortality. **JAMA Pediatrics**; July 2014; doi: 10.1001/jamapediatrics.2014.472.

Evidence-Based Home Visiting and Nurse-Family Partnership: A Critical Component to Achieving the "Triple Aim" for At-Risk Women and Children

April 16, 2013

What it is: Nurse-Family Partnership® (NFP) is an evidence-based, community health home visiting program for first-time, low-income moms and their babies with over 30 years of randomized controlled-trial research documenting its effectiveness. Through ongoing home visits from registered nurses, NFP clients receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. From pregnancy until the child turns two years old, NFP Nurse Home Visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

How Home Visiting Can Impact Health Outcomes:

- Nurse home visiting programs are a long-standing, well-known prevention strategy used by states and communities to improve the health and well-being of women, children and families, particularly those who are at risk.
- NFP is a cost-effective prevention program that stands on the weight and power of over thirty years of scientific evidence demonstrating its effectiveness in helping to improve the health and well-being of low income, first time mothers and their children. NFP's primary goals are to improve birth outcomes, child health and development and parental economic self-sufficiency.
- Results from one or more randomized controlled trials demonstrate that NFP can result in:
    - 35% fewer cases of pregnancy-induced hypertension;
    - 79% reduction in preterm delivery among women who smoke;
    - Fewer subsequent births on Medicaid
    - 31% reduction in very closely spaced (<6 months) subsequent pregnancies;
    - 39% fewer health care encounters for injuries or ingestions in the first two years of life among mothers with low psychological resources;
    - 48% reduction in state-verified reports of child abuse and neglect by child age 15;
    - 56% reduction in emergency room visits for accidents and poisoning at age 2;
    - 50% reduction in language delays by child age 21 months; and
    - 67% reduction in behavioral and emotional problems at child age 6.
- NFP is also cost effective. Independent studies have confirmed that NFP saves scarce public resources.
    - A RAND analysis found that for every $1 invested in NFP to serve high risk families, communities can see up to $5.70 in return due to savings in social, medical and criminal justice expenditures.

The Case for Integrating Home Visiting into a Comprehensive Integrated Care Model:

NFP can help integrated care models like MCOs, ACOs, CCOs, CCNs and FQHCs with:

- Compliance with perinatal care standards;
- Care coordination /care management for first-time pregnant women and their children;
- Ongoing health and psychosocial assessments;
- Anticipatory guidance and preventive services based on need;
- Early identification of problems and swift intervention;

- Referral to and coordination of other care and services as needed; and
- Timely patient-centered communication and information exchange.

Integrated care models and evidence-based home visiting programs like NFP measure, monitor and analyze metrics and use such data to drive improvements. NFP monitors many of the same quality and outcome measures that integrated care models are accountable for, including those used by HEDIS, CHIPRA and NCQA's criteria for Patient-Centered Medical Homes.

Quality Measures	**NFP/MIECHV**	**HEDIS**	**CHIPRA**	**NCQA-PCMH**
ED utilization	X		X	X
Access to primary care	X	X	X	X
Access to behavioral/mental health	X	X	X	
Developmental screening	X		X	
Well child visits in first 15 months	X	X	X	
Birth weight < 2500 grams	X		X	
Preterm Births <39 weeks	X		X	
Timeliness and frequency of prenatal care	X	X	X	
Postpartum care	X		X	
Immunization status	X	X	X	
Depression screening	X		X	
Lead screening	X			
BMI Assessment	X	X	X	
Connection to community resources	X		X	X
Culturally/linguistically appropriate care	X			X

From this important perspective, it is evident that priorities for evidence-based home visiting programs are well aligned with those of the new integrated care models, making us natural partners going forward.

The potential benefits of partnering with evidence-based home visiting programs like NFP may include:

- Improved access to home visiting services for high risk moms and children;
- Improved outcomes;
- Reductions in risk factors that lead to chronic conditions;
- Reductions in costs due to ED visits;
- Better patient compliance with medical provider's instructions;

- Improvements in HEDIS and other quality metrics;
- Improved opportunities to take advantage of pay for performance and other quality incentives;
- Less member churning and more continuity of care; and
- Competitive advantage in the market place.

Strategies for Taking NFP to Scale Within Medicaid and Health Care Reform:

- Statewide Strategies:
    - Include Medicaid coverage and reimbursement for evidence-based MCH home visiting services as part of a state's Medicaid and health care reform initiatives;
    - Develop policies that support integration of evidence-based MCH home-visiting programs within new integrated care models;
    - Create incentives for integrated care models to contract with evidence-based MCH home visiting programs to provide services to those who might benefit most from them; and
    - Evaluate the effectiveness of evidence-based home visiting services in improving maternal and child health outcomes and the experience of care as well as cost offsets to Medicaid over time.
- Community-level Strategies:
    - Work with integrated care models to integrate NFP into the continuum of maternal and child health services.

Nurse-Family Partnership Program Implementation Roadmap

The Journey from Initial Inquiry to Active Implementation*

Shared Activity - Agency Activity - NSO Activity -

First Contact Regarding NFP Model

Prospective implementing agency connects with Nurse-Family Partnership National Service Office (NSO).

Agency meets with business developer (BD) to share information about the agency and community and to learn about the NFP model.

BD and agency discuss the feasibility of an implementation, including assessing the number of eligible births within the area to be served, other programs operating within the community, funding and capacity/ability of agency to implement with fidelity to the NFP model. Nurse consultant (NC) will work with the agency and BD to assess the nursing capacity in the community.

BD shares overview materials, budget and Implementation Plan template.

Next Steps to Becoming an NFP Implementing Agency

Agency brings together a group of community representatives for a presentation by the BD on the NFP model. Additional outreach by agency to insure that NFP will be an accepted, welcome addition to the continuum of services.

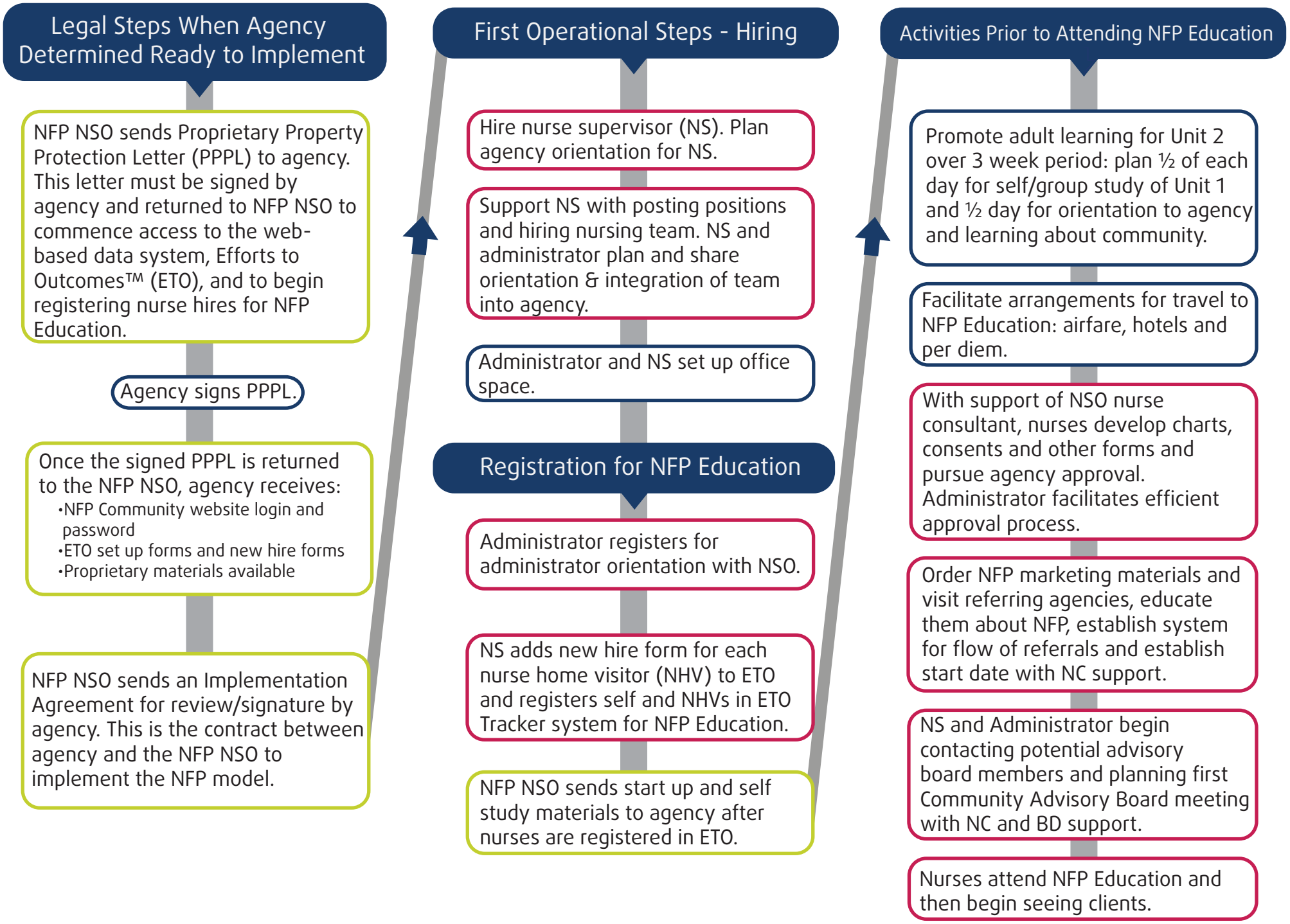
After detailed reviews/revisions of the draft Implementation Plan in consultation with BD and NC, the completed Plan and all attachments are submitted via the BD to the NFP NSO Agency Review Team (ART) three weeks before the review. ART reviews are usually held two times per month.

Within two-to-three days of submission, BD will advise the agency of the review date/time. The reviewers may submit written questions to the agency approximately four days before the review, which the agency will respond to in writing and verbally during the review call.

Within seven days of the ART review, agency will receive via email, and in hard copy, correspondence from the NFP NSO advising that ART has determined agency is "Ready to Implement" or "Requires Further Planning."

Nurse-Family Partnership

Helping First-Time Parents Succeed®



*This is a map of the typical process but this is a fluid, dynamic process and the timeline will be unique for each implementing agency.

Olympic
COMMUNITY of HEALTH

345 6th Street, Suite 300
Bremerton, WA 98337

CLALLAM • JEFFERSON • KITSAP

January 9, 2017

Dorothy Teeter
Office of Health Innovation and Reform
Washington State Health Care Authority
Olympia, WA 98504

Dear Ms. Teeter:

On behalf of the Olympic Community of Health (OCH), it is our pleasure to submit this letter in support of the Washington State Medicaid Waiver Demonstration Tool Kit that was released for public comment on January 3, 2017. We see many of our Waiver project proposals reflected in this document. We are pleased that each project proposed in the tool kit will help us address one or more of our regional health priorities within our Medicaid population.

We have one vital request for your consideration: **latitude to choose evidence-based programs that will work best for our communities beyond what may be listed in the tool kit. For example:**

- For project 3B, Maternal and Child Health, we would like to see Parent-Child Assistance Program (PCAP), an evidence-based program out of the University of Washington, for addicted mothers. This aligns well with project 3A, Addressing the Opioid Use Public Health Crisis.
- For project 3C, Access to Oral Health Services, we would like the opportunity to propose local approaches to this issue that have the potential for a far greater impact than what is proposed in the Tool Kit.
- For project 3D, Chronic Disease Prevention and Control, there are numerous evidence-based programs beyond the Chronic Care Model that can be considered to address this issue. While other programs are listed as 'additional', they are not included in the planning and implementation section.

One point of clarification: categories such as 'evidence-based programs', 'specific strategies', and 'additional resources' are listed separately for various projects. It remains unclear whether all programs listed under any of these categories would be fundable Medicaid Demonstration activities. We also recommend that NEAR (Neuroscience, Epigenetics, ACEs and Resilience) Science be a consideration for all projects.

Adequate funding for infrastructure development is essential for small, rural regions to succeed and for our work to be sustained. This will be reflected in our project plans. One example is data support for population management at a regional level. We welcome information about and an opportunity to inform this plan.

We look forward to working with the HCA on this next phase of Waiver implementation. As always, thank you for your flexibility, partnership, and continued investment in our Medicaid communities.

This letter was reviewed and approved by the OCH Board of Directors (January 9, 2017) and Regional Health Assessment and Planning Committee (January 6, 2017).

In Partnership,

Elya Moore, PhD
Executive Director, Olympic Community of Health

Roy Walker
Executive Director, Olympic Area Agency on Aging
Board President, Olympic Community of Health

To: Washington Health Care Authority

From: Pierce County Community Health Worker Committee

Date: February 2, 2017

Re: The Toolkit for Medicaid Demonstration Projects

The undersigned are members of the Pierce County Community Health Worker Committee convened several years ago as part of our local Accountable Community of Health (ACH) to work on the redesign of the healthcare delivery system. We support the ideas outlined in Domain 1 of the Toolkit for Medicaid Demonstration Projects (toolkit) to advance the use of a value-based payment system, to develop and train a workforce that includes Community Health Workers (CHWs), and to improve population health through shared use of electronic health information. We look forward to having our members invited to participate on the state and local workforce development task forces identified in the toolkit.

We applaud the work and the thought that went into the development of the toolkit. By weaving together the three strands of work in **Domain 1 – Health and Community Systems Capacity Building,** the toolkit builds a strong infrastructure for the redesign of the health care delivery system. We also support the work identified in **Domain 2 – Care Delivery Redesign** - Project 2A -Bi-directional Integration of Care and Primary Care Transformation. We note the language used to explain this project: *Through a whole-person approach to care, physical and behavioral health needs will be addressed in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through managed care organizations, for people enrolled in Medicaid.* We suggest that a "whole-person approach to care" needs to include identification of the social determinants of health and we recommend that the Integrated Care projects include a plan to address them.

We are writing to urge the Health Care Authority to change the language in the Toolkit for Medicaid Demonstration Projects to **require** all ACHs to develop and implement a Pathways Community Hub type model under Domain 2 Care Delivery Redesign - 2B. Community-based Care Coordination.
There are several important reasons for requiring ACHs to weave together a plan to implement a Pathways Hub model to address the social determinants of health while simultaneously implementing an integrated care approach and a value–based payment system:

- The health care system spends a disproportionate amount of funding on patients with clinically complex conditions – 10% of patients account for 65% of healthcare costs. People with complex healthcare needs often have greater unmet behavioral health and social determinants of health needs than other patients. They require greater support to address their medical and non-medical needs. In order to improve patient health while simultaneously reducing costs, healthcare delivery systems must be able to assess patients' comprehensive needs, provide increased access to care and improve how they communicate with patients.

- Fragmented approaches to care coordination are usually not effective. Pathways programs have reported situations where clients have had 10 or more care coordinators at one time. At-risk individuals have reported that it is challenging to have multiple people and agencies in their homes collecting personal information and sometimes offering conflicting information. This duplication of care coordination is a burden to the budget and the individual served. A Pathways "Hub" can prevent this costly duplication.

- CHWs are trusted members of the community. The HUB model recognizes the significant importance of trusting relationships. The individuals capable of serving as effective CHWs are most often found within the communities at greatest risk. Published research shows that CHWs can successfully find and engage the right individuals, complete a comprehensive risk assessment, and then partner with them to overcome barriers to their health. The HUB provides centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie payments to outcomes.

- CHWs are the foot soldiers who are better connected to the community and able to unravel and help address identified social determinants of health that weigh so heavily on so many in the targeted population. There is no better time than now to have Community Health Workers recognized as a part of a team that has been proven to have better patient outcomes, cut down on cost and emergency room visits from patients etc.

We need to build a system of care with incentives to seek out and effectively serve those at greater risk instead of our current system with unintentional financial incentives to avoid them. It takes less time, expense, and cultural competency skills to serve lower risk populations. Contracts that do not require services to those at greatest risk encourage agencies to "cherry pick" by serving low-risk individuals and avoiding those with the greatest need. Fixing these problems requires a fundamental change in the way care coordination contracts are written. Payments need to be scaled to recognize the number of risk factors an individual has and the time, resources, cultural competence, and skills needed to effectively serve those at greatest risk. (Pathways Manual)

Building a Pathways Community HUB will bring together a team of community-based agencies that deploy CHWs to reach out to those at greatest risk, assess their risk factors, and ensure that they are connected to care. As individual risks are reduced, population-level health improves and overall costs are reduced. The Pathways manual recommends communities starting a new initiative should work to find individuals who are known, trusted, and already connected to the most at-risk communities and grow the program based on their foundation of experience and leadership. The Pathways Manual says "It was the wisdom and insight of the CHWs that led to the basic principles and priorities of comprehensive assessment and a focus on social determinants in addition to health care needs. The latest national recommendations for care coordination now support their wise recommendations."

The Pathways Manual also cautions us that when funders, such as Medicaid managed care organizations, are trying to develop contracts and payment approaches with communities, it becomes very difficult to develop and implement pay-for-performance contracting strategies when every

community in the State is using a completely different set of Pathways. Research becomes more meaningful if all programs across the State are using the same basic Pathways, because then it is possible to demonstrate the significance of obtaining stable housing, food, clothing, a medical home, and employment for at-risk individuals and families. This information can be documented and demonstrates how many individuals are having difficulty and significant time delays in achieving the risk reduction outcomes demonstrated in each Pathway.

The HUB model of care coordination provides the tools, outcome reporting, and payment strategies to help improve quality and outcomes while reducing costs. Through communication, collaboration, and built-in incentives, the HUB increases the efficiency and effectiveness of care coordination services. If ACHs can choose whether or not to use a Pathways type project, many will not do so. The system has to be mandatory to rein in the less effective approaches to service delivery and provide incentives for greater collaboration. Programs will only succeed in saving money if they are engaged in creating systems that use a care coordination approach -to do otherwise will provide opportunities for healthcare systems to continue "business as usual."

Thank you,

Rosa Franklin, R.N. (Ret.)
Rosa Franklin, Chair
Pierce County Community Health Worker Committee

Pierce County Community Health Worker Committee Members:

Janet Runbeck, RN, MN
Cathy Takkio, PhD, RN
Lori M. Guttuzo, MPH, Community Health Worker Leaders in Women's Health
Siniva Driggers RN, BSN Samoan Nurses Org. in WA (SNOW)
Johanna Wolf Community Health Advocate for Leaders in Women's Health
Debra J Saint RN, BSN Nurse Coordinator - Congregational Health Ministries

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Planned Parenthood Columbia Willamette

Dorothy Teeter & Medicaid Transformation Team
Washington Health Care Authority
626 8th Avenue SE
Olympia, Washington 98501

February 2, 2017

Dear Dorothy,

Thank you for the opportunity to engage with the Health Care Authority as it launches a new phase of the Medicaid Transformation under a federal section 1115 Medicaid waiver, and to write with comments on the Project Toolkit Draft.

We are pleased to see that the current draft includes reproductive health under the optional section on Maternal and Child Health. We submit these comments in regards to this section:

1. Change the name of the section on Maternal and Child Health to "Reproductive Health." Language throughout the section referring to women's health only in relation to their potential future pregnancies should also be changed to simply refer to reproductive health or family planning. *Women need access to high quality reproductive health care throughout their lives, not just when they become pregnant.*

2. The language of the section as written indicates a value on women's health only if they actively intend to become pregnant, and while the state has an interest in healthy pregnancies and births, the state also has an interest in healthy women who have the care, privacy, and respect to determine when and whether to become pregnant.

3. The section on Maternal and Child Health / Reproductive Health should be made a required project, not optional, due to the tremendous benefits to public health and health care spending that are achieved when women have access to reproductive health and family planning services.

4. Furthermore, the target population should be enlarged to include all adult women of reproductive age, typically defined as 18-44 years of age.

For women, reproductive health is basic health. Washington has the opportunity to be a leader in making sure all women have access to high quality health care. Sexual and reproductive health providers such as Planned Parenthood play a crucial role in providing high-quality family planning care to the most underserved members of our community. Any plan to improve Washington's health care system must acknowledge the basic health care needs of all women and invest in the providers that are able to meet these needs.

We ask the State of Washington to make a real commitment to improving women's health by increasing access to basic health care such as breast and cervical cancer screenings, contraceptive counseling, and access to a wide range of effective contraceptive methods so that women can choose the birth control method that is right for them.

We are pleased that the Toolkit draft includes suggested performance measures on unintended pregnancies, chlamydia screening, access to long acting reversible contraceptives (LARC), HPV vaccines, and other family planning-related items. However, we strongly support additions and adjustments to better reflect a more robust set of measures relevant to reproductive health as well as maternal and infant outcomes:

1. Pre- and post-natal care quality measures, (which are captured in the Regional Health Needs Assessment), BMI screening, breast and cervical cancer screening, STI screenings, and tobacco use screening and cessation counseling.

2. Use a contraceptive care measure that covers a range of effective methods so that one method is not prioritized or incentivized over another. NQF#2903 and its companion NQF#2902 for post-partum care are generally more appropriate for measuring clinical quality of contraceptive care. They both measure provision of a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method.

3. Consider adding a measure related to contraceptive counseling, such as the 11-item Interpersonal Quality of Family Planning Care (IQFP) scale OPA is proposing to develop for endorsement.[1]

In addition to these suggestions, we recommend adding a project to reduce unintended pregnancies statewide. This would be consistent with the state's Common Measure Set, which includes unintended pregnancy as a key performance objective.

Sexual and reproductive health care providers serve a critical and unique role in supporting the goals of Transformation. We urge that the reproductive health projects and measures in the Toolkit be maintained and improved, and that the role of reproductive health be more explicitly stated throughout the toolkit as a key part of many of the projects included and a critical component of a sustainable transition to value-based payment and achievement of the triple aim of better care, lower costs, better health.

Make women's health a priority in healthcare reform.

Sincerely,

Adrienne Quintana
Chief Operating Officer
Planned Parenthood Columbia Willamette

[1] See University of California San Francisco, Bixby Center, https://fcm.ucsf.edu/program-woman-centered-contraception

WA Transformation Toolkit Responses

Comments Due February 2, 2017

Addressee
Dorothy Teeter & Medicaid Transformation Team
Washington Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Submit electronically to Dorothy.teeter@hca.wa.gov & medicaidtransformation@hca.wa.gov

- We appreciate the opportunity to provide comments to the Health Care Authority about Medicaid Transformation under a federal section 1115 Medicaid waiver and the Project Toolkit Draft.
- First, we want to commend the inclusion of reproductive health in this toolkit. However, we strongly suggest changing the section on Maternal and Child Health to "Reproductive Health" in order to encompass the state's interest in the reproductive health of all women, regardless of their plans or ability to have children. In addition, the current language throughout this section suggests that women's health is limited only to women who are actively planning to become pregnant. The health of women, their pregnancies, and their children is essential to the interests of the individual and the state, as is the health of women who do not become pregnant or give birth.
- We also recommend that the section on Maternal and Child Health/Reproductive Health not be optional. The public health and health care spending benefits of increased access to reproductive health and family planning services are well-documented. Therefore we suggest that this be made a required project and that the target population be expanded to include all adult women of reproductive age (18-44 years).
- We support that the Toolkit includes suggested performance measures on unintended pregnancies, chlamydia screening, HPV vaccines, access to long-acting reversible contraceptives (LARC), and other family planning elements. However, in order to include a stronger set of measures in regard to reproductive health and maternal and infant outcomes, we recommend that the following adjustments be made:
    - BMI screening, breast and cervical cancer screening, sexually-transmitted infection (STI) screenings, pre- and post-natal care quality measures captured in the Regional Health Needs Assessment, and screenings for tobacco use and cessation counseling.
    - In order to prevent one contraceptive method being prioritized or incentivized over others, we recommend the use of a contraceptive care measure that covers a range of effective methods. NQF#2903 and NQF#2902 for post-partum care are typically more appropriate for measuring the clinical quality of contraceptive care. They both measure provision of FDA-approved methods that are most effective, such as implants, intrauterine devices or systems (IUD/IUS) or sterilization, or moderately effective methods like oral pills, ring, patch, injectable, or diaphragm.
- Additionally, we recommend adjusting the Toolkit draft in the following ways:

    - Consider adding a measure related to contraceptive counseling, such as the 11-item Interpersonal Quality of Family Planning Care (IQFP) scale OPA is proposing to develop for endorsement.
    - The Toolkit would be strengthened by the inclusion of a statewide project to reduce unintended pregnancies. This would support the state's performance objective to reduce unintended pregnancies, as outlined in the Common Measure Set.
    - Throughout the toolkit, explicitly acknowledge the role of family planning and reproductive health care providers as key project partners.
    - There would be significant benefit in including ACH projects aimed at strengthening access and quality of reproductive health care for women of reproductive age. A strong emphasis on addressing the needs of the state's women and youth would better support the goals of the Transformation. Additionally, investing in community providers that are providing high-quality, culturally-competent reproductive health care and coordination would also support the interests of the state.
- Reproductive health care providers are essential to the Transformation, as they fill a critical and specialized role. We suggest that by strengthening the reproductive health projects and measures – as well as more explicitly stating the key role of reproductive health in these projects throughout – the Toolkit will best be able to drive a successful transition to value-based payment statewide, and will truly provide a framework for better care, lower costs, and better health for women and families.

Submitted by Planned Parenthood of

Greater Washington & North Idaho.

Planned Parenthood Votes Northwest and Hawaii

February 2, 2017

Dorothy Teeter & Medicaid Transformation Team
Washington Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Submitted electronically to Dorothy.teeter@hca.wa.gov & medicaidtransformation@hca.wa.gov

Cc: Governor Jay Inslee

Dear Ms. Teeter and the Medication Transformation Team,

Thank you for continued opportunities to engage with the Health Care Authority as it launches a new phase of Medicaid Transformation, under a federal section 1115 Medicaid waiver. We appreciate the state's concerted effort to engage stakeholders and providers throughout this process. Planned Parenthood affiliates in the state of Washington have embraced the goals of a transformed health system. We have interacted positively with Accountable Communities of Health (ACHs) and look forward to engaging on Transformation projects.

As a primary provider of reproductive health and preventive care to women in Medicaid, we are excited about the opportunities suggested by the draft Project Toolkit. The comments below are recommendations for a final Toolkit that can significantly improve women's access to high-quality care.

Focus on Reproductive Health
First, we are pleased to see that the current draft includes reproductive health under the optional section on Maternal and Child Health, but we urge that the name of the section on Maternal and Child Health be changed to "Reproductive Health." Language throughout the section referring to women's health only in relation to their potential future pregnancies should also be changed to simply refer to reproductive health or family planning. The language of the section as written indicates a value on women's health only if they actively intend to become pregnant, and while the state has an interest in healthy pregnancies and births, the state also has an interest in healthy women who have the care, privacy, and respect to determine when and whether to become pregnant.

Similarly, we strongly suggest that Maternal and Child Health/Reproductive Health be made a required project. Tremendous benefits to public health and health care spending are achieved when women have access to reproductive health and family planning services. Requiring this project would serve the needs of women and families statewide, regardless of the ACH region in which they happen to live. In addition, consistent with the goals of Transformation, there is a need to build infrastructure and capacity uniformly throughout the state support the delivery of

high-quality reproductive health care. Furthermore, the target population should be enlarged to include all adult women of reproductive age, typically defined as 18-44 years of age.

This project would also be strengthened with more of a focus on preconception care and care coordination, promoting a patient-centered approach that recognizes the unique care needs and preferences of women of reproductive age. The project should seek to improve access to a range of services that women need to stay healthy, such as preventive care, referrals to specialists, and connections to community supports.

Address Unintended Pregnancies

The Toolkit should directly address the rate of unintended pregnancies among reproductive-age women and adolescents statewide, consistent with the state's Common Measure Set and Governor Inslee's Results Washington goal. By one estimate, 48 percent of all pregnancies in WA are unintended.[1] Reducing this rate would not only have a positive impact on maternal and child outcomes, but would also help bend the cost curve in Washington, where 49 percent of births are Medicaid-financed.[2] Pregnancies are a key driver of Medicaid costs, and an estimated $7 is saved for every $1 invested in family planning services.[3]

Measure Progress on Women's Health

We are pleased that the Toolkit draft includes suggested performance measures on unintended pregnancies, chlamydia screening, long acting reversible contraceptives (LARC), HPV vaccines, and other family planning-related items. However, we strongly support additions and adjustments in order to more fully reflect a more robust set of measures relevant to reproductive health as well as maternal and infant outcomes:

- Add pre- and post-natal care quality measures, (which are captured in the Regional Health Needs Assessment), BMI screening, breast and cervical cancer screening, STI screenings, and tobacco use screening and cessation counseling.
- Use a contraceptive care measure that covers a range of effective methods so that one method is not prioritized or incentivized over another. NQF#2903 and its companion NQF#2902 for post-partum care are generally more appropriate for measuring clinical quality of contraceptive care. They both measure provision of a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method. Furthermore, any measure related to LARC must focus on measuring access to LARC and not number of LARC insertions, to avoid any unintentional suggestions of reproductive coercion.
- Consider adding a measure related to contraceptive counseling, such as the 11-item Interpersonal Quality of Family Planning Care (IQFP) scale OPA is proposing to develop for endorsement.[4]

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[1] 2010 data from Guttmacher Institute, State Facts About Unintended Pregnancy, Washington, https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-washington

[2] 2015 data from Kaiser Family Foundation, State Facts, http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22washington%22:%7B%7D%7D%7D

[3] Guttmacher Institute. "Publicly Funded Family Planning Services in the United States." (Mar. 2016). https://www.guttmacher.org/fact-sheet/2015/publicly-funded-family-planning-services-united-states#15

[4] See University of California San Francisco, Bixby Center, https://fcm.ucsf.edu/program-woman-centered-contraception

We also hope to see more performance measures relevant to reproductive health so that the value of these services will be reported and rewarded across Transformation domains. For instance:

- Teen pregnancy rates should be measured as a community health indicator;
- Access to family planning services should be included as an outcome metric for behavioral health integration.

Elevate Women's Access to Behavioral Health Care

We also recommend that the Toolkit clarify and affirm that reproductive health providers can participate in behavioral health projects (specifically Projects 2A and 3A), in order to allow integration of behavioral health within the family planning encounter. Reproductive health providers like Planned Parenthood are positioned to provide:

- Screenings for behavioral health conditions including depression, anxiety, grief, family and intimate partner violence, eating disorders, obesity, and substance use including alcohol, tobacco and other drugs; and
- Referral or limited direct services for management of these behavioral health conditions;
- Assessment and clinical support for transitioning transgender patients.

In closing, sexual and reproductive health care providers serve a critical and unique role in supporting the goals of Transformation. We urge that the reproductive health projects and measures in the Toolkit be maintained and improved, and that the role of reproductive health be more explicitly stated throughout the toolkit as a key part of many of the projects included and a critical component of a sustainable transition to value-based payment and achievement of the triple aim of better care, lower costs, better health. Thank you for the opportunity to comment.

Sincerely,

Jennifer M. Allen, Director of Public Policy
Planned Parenthood Votes Northwest and Hawaii

1111 Harvard Ave * Seattle, Washington, 98122 * www.projectaccessnw.org
Telephone: 206.788.4204 * Fax: 206-382-3507 * info@projectaccessnw.org

DATE: Feb. 1, 2017

TO: Healthier Washington

RE: Comments on the Project Toolkit.

I am impressed with the breadth and depth of the effort undertaken to develop the Medicaid Transformation Project Toolkit just as I have been impressed with the number of people coming together in nine ACHs to improve the local health of our various communities. While it is clear that the state wants to allow local autonomy, providing basic infrastructure at the state level will assist in moving forward on the local plans.

Domain 2: Care Delivery Redesign

This domain recognizes the potential of telemedicine yet doesn't differentiate between various modalities and the potential value of each. The state has made progress in the past few years in putting initial pieces of legislation in place to support telemedicine. The Transformation Demonstration should be the mechanism to move this along significantly. Much of telemedicine recognizes telephysiatry yet there is much more value to be had than with this singular focus.

eConsult allows for asynchronous advice and guidance between primary care and specialty care. LA County Health District has implemented a system that supports over 13,000 referrals per month – and in over sixty different specialties. They have experienced a significant increase in completed care, in access to specialty visits when required and in provider satisfaction.

A primary care provider can often best serve his/her patients by simply seeking advice from an appropriate specialist by using the store and forward capabilities within eConsult. The primary care provider is in the best position to manage a patient's whole care. With the availability of electronic advice within a defined narrow window of time, the patient gets the care he/she needs, the primary care provider can care for his/her patient more holistically, the specialist's more expensive time is not used when not entirely necessary, insurance companies can avoid the facilities fee when a patient can be cared for in primary care. For the patient living in a rural community, getting care closer to home is highly preferred. For primary care providers, the chance to get timely advice and guidance enables the provider to provide a broader spectrum of care as well as learn from specialists over time. For specialists, their time is best spent on the more complex and complicated patient. Determining how to reimburse specialists for asynchronous advice, while avoiding unnecessary facility fees, improves timeliness for the patient as well as saves money for the insurance systems.

eConsult could be started in one region then expanded statewide if the goal of expansion was recognized in the initial design and implementation. But the reimbursement and payment for the specialist needs to be addressed at the state level.

Domain 2, Project 2B: Community-Based Care Coordination –

Within this domain, HCA recognized the value of care coordination and coordinating the coordinators. A centralized approach is recognized as reducing potentially redundant services and better serving the patient. Pathways Community Hub model is referenced repeatedly. To effectuate the goal of improving value, Healthier Washington should be the convening entity so that one software version is deployed across the state. Having nine different ACHs tackle this alone will be more costly, will not support patients who move between regions and will result in differences in design and date definitions that won't allow easy analysis or comparison across different parts of the state. Additionally, Washington state hospitals and managed care organizations rely on and work with Collective Medical Technology's EDIE while other care settings work with Collective Medical Technology's Pre-Manage. By having Washington State working directly with Pathways Community Hub on behalf of the nine ACHs, the potential of working successfully to build an electronic link between Pathways and Collective Medical Technology is much more likely to have the weight to force a shared solution.

Providence Health & Services
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February 2nd, 2017

MaryAnne Lindeblad
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, WA 98504-5502

Comments provided via email: MedicaidTransformation@hca.wa.gov

Dear Director Lindeblad:

Re: Medicaid Transformation Project Toolkit, Public Comment Period

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide comments on the Transformation Project Toolkit that has been released as part of the implementation strategy for Washington State's Global 1115 Medicaid Waiver. As stated in previous comments, we see this potential waiver as a critical piece to implementing innovative strategies that will contribute to the health and well-being of Washington's citizens over the long-term, and we know that the projects included in the Project Toolkit will be a significant component of the waiver in terms of care delivery redesign. As always, we provide the following comments in the spirit of collaboration on this crucial piece of Medicaid Transformation.

For reference, Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. In Washington state, Providence and its secular affiliates – including Swedish Health Services, Pacific Medical Centers (PacMed) and Kadlec – comprise 15 hospitals, 268 physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. The combined health system is the largest health care provider in Washington and employs more than 32,000 people statewide. In 2015, Providence and our affiliates provided $450 million in community benefit, including $54 million in free and discounted care for Washingtonians who could not afford to pay and over $60 million in support for education and research across Washington's communities.[1] Together, we are working to improve quality, increase access and reduce the cost of care in all of the communities we serve.

This range of services and our mission to care for the poor and vulnerable drive leaders across our system to be continually engaged in Washington's proposed 1115 Medicaid Transformation Waiver. We believe that a global Medicaid waiver represents an opportunity for true transformation of care within

[1] Community benefit and charity care data is consolidated based on financial reporting.

our state, especially for those vulnerable citizens with complex health needs that could be better served through wrap-around approaches to care.

Overall, we are very encouraged by the overall approach the Health Care Authority has taken within the Project Toolkit. It's a difficult process to walk the fine line between giving communities enough guidelines that they can easily navigate the requirements under the waiver, while giving room for community choice so that the Accountable Communities of Health can prioritize their regions most pressing issues, and we think the overall structure of the toolkit does this well. In particular, we are very supportive of the emphasis on behavioral health integration, as we believe this is a crucial area needing additional resources and community approaches. We were also pleased to see that HCA is encouraging widespread adoption of fewer approaches to transformation rather than allowing for an overwhelming number of approaches that then become difficult to track, measure, and sustain throughout the grant period. Providence has been a strong voice for the balance between standardization and innovation, and we appreciate that this Toolkit seems to support this as well.

Finally, we want to highlight that the projects and approaches in the toolkit overall are reflective of where we believe we need to be moving as a system overall. From value-based payment design, to initiatives addressing workforce needs and systems for population health management, Providence has efforts underway that are well aligned with the projects outlined in the Toolkit, which ultimately enables us to continue to be a thoughtful and engaged partner in the work ahead through Accountable Communities of Health and any statewide discussions that take place to support the work on the ground, such as the work of the Statewide Value-Based Payment Transition Taskforce and the Statewide Workforce Development Taskforce.

In addition to this support and general areas of alignment described above, we offer the following comments that we hope the HCA will consider in discussions regarding implementation of the waiver:

Allow room for innovation, along with the implementation of evidence-based approaches. We know it's a difficult balance between ensuring that Washington invests in proven approaches in order to produce the level of return on investment needed to meet the agreement behind the waiver and encouraging new approaches to care. We also know we've been vocal proponents of an increased focus on evidence-based approaches, which we were very pleased to see reflected in the Toolkit. However, we think there could be room for the HCA to clarify that these proven approaches listed in the toolkit could be enhanced with the addition of innovative approaches to the issue to encourage the implementation of tested strategies that are still on the leading edge, going above and beyond the current accepted norm for approaches to care.

Within project 2C, for example, the HCA could include language that is more supportive of innovation to encourage approaches like telepsychiatry to be embedded alongside one of the evidence-based approaches to care management. Especially when thinking about transitions for the incarcerated population, telepsychiatry has become a crucial resources to give medical staff within the jails and patients access to mental health providers without the providers having to jump through the requirements to be physically present at the jail.

Telepsychiatry/telemedicine is also not mentioned under project 2A, where use of technology to connect patients to consultations from other providers is a crucial option for many providers to integrate physical and behavioral health care in a practice setting where it may be a lower-cost option than co-location.

Similarly, we would encourage the HCA to include in its work with the Statewide Workforce Development Taskforce language that calls out discussions regarding innovative approaches to utilizing existing staff, which we think would be well-aligned with the statewide planning activities already included in the toolkit. Encouraging strategies that allow health care professionals the flexibility to practice at the top of their license is certainly a piece of the workforce infrastructure that would benefit from encouragement and leadership at the HCA- and statewide-levels.

To avoid duplicative processes, we urge the HCA to **provide additional, more formal guidance to encourage ACH's to coordinate with hospitals and public health departments when completing their Regional Health Needs Inventory**. Collecting this information can be time-intensive, and we want to ensure that ACHs are aware of resources which have already done this work so that they may avoid recreating something that already exists. Nonprofit hospitals are required to do a health needs assessment as part of their community benefit decision-making to maintain their tax exempt status, and Providence and its affiliates would be happy to share our assessments with the ACHs so that the information does not need to be re-collected.

Create linkages with other statewide initiatives that are underway to eliminate duplicative work and spread effective strategies that can enhance community approaches. For example, WSHA has an initiative under their Patient Safety Committee to help address opioid abuse. Could the state partner with WSHA to create an innovative approach that can help ACHs take advantage of the economies of scale?

Give ACHs clear guidance on any areas of the Toolkit which relate to other federal regulations, so that stakeholders are aware of legal barriers to certain approaches or can be assured that CMS is allowing for innovation to occur outside of the current legal requirements. For example, projects aimed at ER diversion can be tricky as they need to adhere to the regulations of the Emergency Medical Treatment and Labor Act (EMTALA). Are there certain provisions with EMTALA that are waived under the 1115 waiver program? Similarly, we know there are rules and regulations governing how much we can steer patients towards a provider once they are signed up for Medicaid, however, this seems to be a crucial opportunity to get patients linked to care as soon as possible. Are there requirements guiding the current process that are suspended under the waiver? Are there other federal regulations that overlap with other areas that would be impacted by projects listed in the Toolkit that stakeholders should be aware of? If so, it would be very helpful for stakeholders to have more information so that innovation can move forward while adhering to legal requirements.

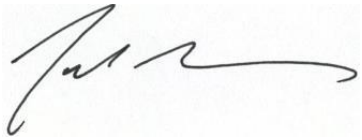
Continue to support the implementation of projects at a community level with ACH regions. In presentations and discussions, HCA staff has been thoughtful in recognizing that there are care patterns that exist at a smaller geographic level than the regions included in the ACH structures, and that the HCA would allow for projects that may be targeted to a sub-geography of the ACH region. We agree that there are some cases that may need this flexibility in order to effectively meet the needs of communities that exist within an ACH, and want to ensure that moving forward, the HCA continues to be supportive of such an approach where appropriate.

Consider adding the Police Assisted Addiction and Recovery Initiative (PAARI) model as an approach allowed under the Project 3A. This program encourages opioid users to seek recovery and connects addicts with treatment and recovery programs through empowering and resourcing our police departments, which are often on the front lines of this fight against opioid addition. We had included

comments that we would like to see this program included as an allowable program under the waiver in our letter dated February 16th, 2016 and we continue to see promise in this program and have regions within Providence interested in implementing it with the support of other ACH members.

Again, we thank you for the opportunity to review and comment on the many exciting transformation projects represented in this Toolkit. As stated in our previous comment letters, we look forward to being an engaged partner with you as you undertake decision-making processes to continue moving forward with health care transformation activities, and are very encouraged overall by the approaches included in this Toolkit. For more information, please contact Lauren Platt, state advocacy program manager, at (425) 525-5734 or via e-mail at lauren.platt@providence.org.

Sincerely,



Joel Gilbertson
Senior Vice President, Community Partnerships and External Affairs
Providence Health & Services

February 2, 2017

To: Medicaid Transformation Project Toolkit Committee:

We respectfully submit our recommendations for the draft of the Transformation Project Toolkit, January 2, 2017. This letter is also submitted as a 12 page attachment. Please excuse any formatting changes in the email version.

Thank you for your hard work and all your efforts to serve Washingtonians and improve public health throughout the state.

Katharine Harkins, CNM, MPH

Valerie Tarico, PhD & Katharine Harkins, CNM, MPH
Resilient Generation – Washington Families 2030
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Medicaid Waiver Project Toolkit – Recommendations

Goal: Update and expand primary prevention through preconception care that reliably aligns pregnancy timing with patient desires and health needs to improve the health of women, children and families. This begins with routine pregnancy intention screening such as One Key Question (OKQ), which enables the following best practices:

- Prioritize offerings according to preventive power – Primary prevention requires that preconception care (as defined below) be the first offering in the Maternal Child Health Section.
- Ensure universal access to effective contraceptive options – This includes prompt access to LARC methods per patient desires
- When pregnancy is desired, iniitiate preconception care, including the option to delay conception if patient desires to first address chronic or acute health concerns best addressed prior to pregnancy

Please note edits and additions — including an additional evidence base -- follow [Insert] in blue:

p 41 **Recommended Approach:**

Project 3A: Addressing the Opioid Use Public Health Crisis (Required)

Rationale: Washington State, along with the nation, is in the midst of a crisis. The opioid epidemic affects communities, families, and overwhelms law enforcement, health care and social service providers. Opioid use disorder is a devastating and life-threatening chronic medical condition and access to treatments that support recovery and access to lifesaving medications to reverse overdose needs to be improved. Through this project, ACH will support achievement of the goals outlined in Executive Order 16-09 and the state interagency opioid working plan. Stakeholders across Washington State have been building capacity to reduce opioid-related morbidity and mortality. State agencies, public health, Tribal governments, and other partners are coming together to focus on strategies for implementing the state opioid response plan. This project aligns with this plan, and focuses on strategies under four of the plan goals: (1) prevent opioid misuse and abuse by improving prescribing practices, (2) expand access to opioid dependence treatment, (3) intervene in opioid overdoses to prevent death, and (4) use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions. [Insert] (5) Ensure, that as in other primary care settings treatment includes access to preconception care: pregnancy intention screening is routine and includes the option to delay or prevent pregnancy per patients' wishes with access to effective contraception available without delay.

Clinical Guidelines

1. AMDG's Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
2. Guidelines on the Provision of Family Services for Preconception Care, Recommendations of CDC and U.S. Office of Population Affairs, MMWR April 25, 2014 / 63(RR04);1-29:

   https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w

[Insert]

3. **Unintended pregnancy in opioid-abusing women.**

J Subst Abuse Treat. 2011 Mar;40(2):199-202. doi: 10.1016/j.jsat.2010.08.011. Epub 2010 Oct 30. Heil SH[1], Jones HE, Arria A, Kaltenbach K, Coyle M, Fischer G, Stine S, Selby P, Martin PR.

https://www.ncbi.nlm.nih.gov/pubmed/21036512

4. Substance Use during Pregnancy: Guidelines for Screening and Management, http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/13_PregSubs_E16L.pdf

p44 or P45 **Demo 3: Opioid Prevention**

Section 2 Education [Insert] – immediate preconception health options:

- Screen for pregnancy desires with One Key Question
- When pregnancy is not desired, offer effective, same day, contraception – including LARC methods
- When a pregnancy is desired offer option to delay conception until treatment stable and health are stable as needed

p46 [Insert] **Strategy 5: Offer preventive care by screening women at risk for unintended pregnancy and ensuring access to services as defined below:**

- Screen with One Key Question and, per patient desires and needs, offer:
- effective, same day, contraception – including LARC methods
- when a pregnancy is desired offer option to delay conception with immediate provision of effective contraception – including LARC methods until treatment stable and health are stable as needed
- **Strategy [Insert] 6: Identify and treat opioid use disorder among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns; explain how ACH will support or take steps to:**

p47 Progress Measures [Insert]

- Primary care services on site include staff trained in clinical reproductive healthcare/preconception services

p49 **Maternal Child Health (may select one or more approaches)**

Rationale: Maternal and child health is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington's children.

[Insert new paragraph]

To provide optimal maternal and child health outcomes, preconception care must span the reproductive years, and enable optimal pregnancy timing or prevention per patient desires and health needs. This can best be accomplished by offering routine pregnancy intention screening in primary care, behavioral health, and chronic health care settings for patients of reproductive age. Where pregnancy is not immediately desired, priority must be given to the timely provision of effective contraception, including LARC methods. When pregnancy is desired but patients face relevant health challenges such as depression, behavioral health concerns,

domestic violence risks or chronic illness such as diabetes, patients must be given the option to delay pregnancy while their condition or illness is being addressed. When pregnancy is immediately desired then preconception care, to support a near term pregnancy, should begin without delay.

Intentional parenthood is foundational for health and well-being. By fostering optimal birth circumstances as defined by parents-to-be, intentional parenthood amplifies all downstream – post-conception -- health interventions, and will likely (may reduce) toxic stress/ACEs exposure. Effective preconception care supports intentional parenthood providing the best start for children and their families, building resilience and, at the same time, saving resources which may be concentrated on downstream interventions such as the following postpartum options.

[Insert] A secondary (postpartum) focus-- providing mothers and their children with home visits-- has been demonstrated to improve maternal and child health. Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatal health care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child's safe and healthy development. [Insert] A third focus, child health promotion is a state priority to keep children as healthy and safe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments. ~~A third focus is to ensure beneficiaries access ongoing well-women care and improve utilization of effective family planning strategies through implementation of the CDC's recommendations to improve women's health before a first, or subsequent, pregnancy~~

P50

~~3.~~ 1. Implementation of recommendations to Improve Preconception Health and Health Care, ~~http://www.cdc.gov/MMWR/PDF/rr/rr5506.pdf~~.

[Insert 2014 CDC recommendations]

Recommendations of CDC and U.S. Office of Population Affairs, MMWR April 25, 2014 / 63(RR04);1-29:
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w

National Quality Forum Measures: 2903, 2904 and 2902

ACHs should consider evidence-based models to improve utilization of effective family planning strategies.
a. If applicable, ACHs could leverage the Family Planning Pathway to align with Project 2B.

Additional Resources:

[Remove and add to evidence base at the end of document]

🕐 *Long Acting Reversible Contraception: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception*

P51-53

[This is to align with: https://www.cdc.gov/preconception/hcp/recommendations.html]

- **Recommendations to Improve Preconception Health and Health Care**. The CDC has provided 10 recommendations that aim to improve a woman's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas listed below.

  Washington has acted on these recommendations by providing insurance coverage (Take Charge, http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/apple-health-take-charge-family-planning) and grants (Personal Responsibility and Education Plan, http://www.doh.wa.gov/CommunityandEnvironment/Schools/PersonalResponsibilityandEducationPlan), and through other actions. This project builds on current efforts, and provides a mechanism for communities to further the implementation of the recommendations.

  The recommendations to be implemented as part of this project, at the regional level, and CDC's identified action steps, are shown below. Activities should be designed to improve utilization of effective family planning strategies, including long-acting reversible contraception methods (LARCs), where applicable, and in consumer awareness campaigns and professional curricula.

1) ~~Individual responsibility across the lifespan~~: [Insert]

   Increase reproductive health agency across the lifespan:

   Screen for pregnancy intention in primary care visits in all healthcare settings, with a same day offering of effective contraception or preconception care per patient desires and needs

   Include a pregnancy intention screen in prenatal care and the option to select immediate post-partum LARC per patient desires and needs

   Ensure patient autonomy through care that is patient-centered, properly consented and culturally appropriate.

o ~~Develop, evaluate, and disseminate reproductive life planning tools for women and men in their childbearing years, respecting variations in age; literacy, including health literacy; and cultural/linguistic contexts.~~

2) Consumer awareness:

o Develop, evaluate, and disseminate age-appropriate educational curricula and modules for use in school health education programs. Integrate reproductive health messages into existing health promotion campaigns (e.g., campaigns to reduce obesity and smoking).

o Conduct consumer-focused research to identify terms that the public understands and to develop messages for promoting preconception health and reproductive awareness.

o Design and conduct social marketing campaigns necessary to develop messages for promoting preconception health knowledge and attitudes, and behaviors among men and women of childbearing age.

3) Preventive visits:
o Increase health provider awareness regarding the importance of addressing preconception health among all women of childbearing age. Develop and implement curricula on preconception care for use in clinical education at graduate, postgraduate, and continuing education – [Insert] including training on LARC methods.

levels.
o Consolidate and disseminate existing professional guidelines to develop a recommended screening and health promotion package.
o Develop, evaluate, and disseminate practical screening tools for primary care settings, [Insert] beginning with pregnancy intention screening with emphasis on the 10 areas for preconception risk assessment (e.g., reproductive history, genetic, and environmental risk factors).
o Develop, evaluate, and disseminate evidence-based models for integrating components of preconception care to facilitate delivery of and demand for prevention and intervention services.
o Apply quality improvement techniques (e.g., conduct rapid improvement cycles, establish benchmarks and brief provider training, use practice self-audits, and participate in quality improvement collaborative groups) to improve provider knowledge and attitudes, and practices and to reduce missed opportunities for screening and health promotion. Use the federally funded collaborative for community health centers and other Federally Qualified Health Centers to improve the quality of preconception risk assessment, health promotion, and interventions provided through primary care. Develop fiscal incentives for screening and health promotion.

4) Interventions for identified risks:
o Increase health provider awareness concerning the importance of ongoing care for chronic

conditions and intervention for identified risk factors.
o Develop and implement modules on preconception care for specific clinical conditions for use in clinical education at graduate, postgraduate, and continuing education levels.
o Consolidate and disseminate existing guidelines related to evidence-based interventions for conditions and risk factors. Disseminate existing evidence-based interventions that address risk factors that can be used in primary care settings (i.e., [Insert] unintended pregnancy, isotretinoin, alcohol misuse, antiepileptic drugs, diabetes [preconception], folic acid deficiency, hepatitis B, HIV/AIDS, hypothyroidism, maternal phenylketonuria [PKU], rubella seronegativity, obesity, oral anticoagulant, STD, and smoking).

o Develop fiscal incentives (e.g., pay for performance) for risk management, particularly in managed care settings.

o Apply quality improvement techniques and tools (e.g., conduct rapid improvement cycles, establish benchmarks, use practice self-audits, and participate in quality improvement collaborative groups).

5) Inter-conception care:
o Monitor option for 48 hour post-partum LARC in hospital settings to ensure access

Monitor the percentage of women who complete postpartum visits (e.g. using the Health Employer Data and Information Set measures for managed care plans and Title V Maternal Child Health Block Grant state measures), and use these data to identify communities of women at risk and opportunities to improve provider follow-up.
o Develop, evaluate, and replicate intensive evidence-based inter-conception care and care coordination models for women at high social and medical risk. Enhance the content of postpartum visits to promote inter-conception health [Insert] and birth spacing per patient desires and needs.
o Use existing public health programs serving women in the postpartum period to provide or link to interventions (e.g., family planning, home visiting, and the Special Supplemental Nutrition Program for Women, Infants, and Children).

6) Pre-pregnancy checkup:

o Consolidate existing professional guidelines to develop the recommended content and approach for such a visit. Modify third party payer rules to permit payment for one pre-pregnancy visit per pregnancy, including development of billing and payment mechanisms.

o Educate women, [Insert] men and couples regarding the value and availability of pre-pregnancy planning visits.

For all approaches, implementation must include the following core components:

🕐Establish guidelines, policies, protocols, and/or procedures as necessary to support consistent implementation of the model.

🕐Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.

🕐Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan.

🕐Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs.

🕐Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.

🕐Establish a performance-based payment model to incentivize progress and improvement.

[Insert] Recommendations 7-10 of **CDC Recommendations to Improve Preconception Health and Health Care**.

7. Health Insurance Coverage Women with Low Incomes

Increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and interconception care.

8. Public Health Programs and Strategies

Integrate components of preconception health into existing local public health and related programs, including emphasis on interconception interventions for women with previous adverse outcomes.

9. **Research**

Increase the evidence base and promote the use of evidence to improve preconception health.

10. **Monitoring improvements**

Maximize public health surveillance and related research mechanisms to monitor preconception health.

Addendum:

Evidence Base for Birth Timing as Primary Prevention for Medicaid Waiver Transformation Project Toolkit

The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial consequences, and fetal death.

Hillis SD[1], Anda RF, Dube SR, Felitti VJ, Marchbanks PA, Marks JS.

https://www.ncbi.nlm.nih.gov/pubmed/14754944

The Contraceptive CHOICE Project: Reducing Barriers to Long-Acting Reversible Contraception
Gina M. Secura, PhD, MPH, Jenifer E. Allsworth, PhD, [...], and Jeffrey F. Peipert, MD, PhD,
AJOG, 2010
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2910826/

The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children, Guttmacher Institute, 2013
https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children

Contraception Drives Decline in Teen Pregnancy—and Expanded Access to LARC Methods Could Accelerate this Trend, Guttmacher Institute
https://www.guttmacher.org/article/2014/10/contraception-drives-decline-teen-pregnancy-and-expanded-access-larc-methods-could

The Center for the Developing Child: http://developingchild.harvard.edu
Report, p5, and summary statement on brain architecture:
Best Practices to Breakthrough Impacts
http://developingchild.harvard.edu/resources/from-best-practices-to-breakthrough-impacts/

Adverse Birth Outcomes in Colorado: Assessing the Impact of a Statewide Initiative to Prevent Unintended Pregnancy. Am J Public Health. 2015 Sep;105(9):e60-6. doi: 10.2105/AJPH.2015.302711. Epub 2015 Jul 16.
Goldthwaite LM1, Duca L1, Johnson RK1, Ostendorf D1, Sheeder J1.
http://www.ncbi.nlm.nih.gov/pubmed/26180990

Fam Plann Perspect. 1995 Nov-Dec;27(6):228-34, 245.
Consequences for children of their birth planning status.
Baydar N1.
http://www.ncbi.nlm.nih.gov/pubmed/8666086

Preconception mental health predicts pregnancy complications and adverse birth outcomes: a national population-based study.

Matern Child Health J. 2012 Oct;16(7):1525-41. doi: 10.1007/s10995-011-0916-4.
Witt WP1, Wisk LE, Cheng ER, Hampton JM, Hagen EW.
http://www.ncbi.nlm.nih.gov/pubmed/22124801

Am J Public Health. 2014 Aug;104(8):e125-32. doi: 10.2105/AJPH.2014.301904. Epub 2014 Jun 12.
Preconception stress, birth weight, and birth weight disparities among US women.
Strutz KL1, Hogan VK, Siega-Riz AM, Suchindran CM, Halpern CT, Hussey JM.
http://www.ncbi.nlm.nih.gov/pubmed/24922164

The roles of **DNA** methylation of NR3C1 and 11β-HSD2 and exposure to maternal mood disorder in utero on newborn neurobehavior.
Conradt E, **Lester** BM, Appleton AA, Armstrong DA, Marsit CJ.
Epigenetics. 2013 Dec;8(12):1321-9. doi: 10.4161/epi.26634.
https://www.ncbi.nlm.nih.gov/pubmed/24135662

Depression During Pregnancy: Treatment Recommendations
A Joint Report from APA and ACOG
August 21, 2009
http://www.acog.org/About-ACOG/News-Room/News-Releases/2009/Depression-During-Pregnancy

A systematic review and meta-analysis of the association between unintended pregnancy and perinatal depression.

J Affect Disord. 2016 Mar 1;192:56-63. doi: 10.1016/j.jad.2015.12.008. Epub 2015 Dec 17.
Abajobir AA[1], Maravilla JC[2], Alati R[3], Najman JM[4].
https://www.ncbi.nlm.nih.gov/pubmed/26707348

Unintended pregnancy in opioid-abusing women.

J Subst Abuse Treat. 2011 Mar;40(2):199-202. doi: 10.1016/j.jsat.2010.08.011. Epub 2010 Oct 30. Heil SH[1], Jones HE, Arria A, Kaltenbach K, Coyle M, Fischer G, Stine S, Selby P, Martin PR.
https://www.ncbi.nlm.nih.gov/pubmed/21036512

How experience gets **under** the **skin** to create gradients in developmental health.
Hertzman C, Boyce T.
Annu Rev Public Health. 2010;31:329-47 3p following 347. doi: 10.1146/annurev.publhealth.012809.103538. Review.

Abused boys, battered mothers, and male involvement in teen pregnancy.

Pediatrics. 2001 Feb;107(2):E19.

Anda RF[1], Felitti VJ, Chapman DP, Croft JB, Williamson DF, Santelli J, Dietz PM, Marks JS.
https://www.ncbi.nlm.nih.gov/pubmed/11158493

Adverse childhood experiences and risk of paternity in teen pregnancy.

Obstet Gynecol. 2002 Jul;100(1):37-45.
Anda RF[1], Chapman DP, Felitti VJ, Edwards V, Williamson DF, Croft JB, Giles WH.
https://www.ncbi.nlm.nih.gov/pubmed/12100801

CDC Contraceptive Action Plan (CAP):
https://www.cdc.gov/teenpregnancy/projects-initiatives/contraceptive-action-plan-project.html

American Academy of Family Physicians, Preconception Care Position Paper, Dec 2015:
http://www.aafp.org/about/policies/all/preconception-care.html

ACOG Long Acting Reversible Contraception*: http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception*

ACOG Committee Opinion No. 654, Feb 2016 (Committee on health Care for Underserved Women): https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co654.pdf?dmc=1&ts=20160202T0904511965

ACOG Committee Opinion No. 670 Summary: Immediate Postpartum Long-Acting Reversible Contraception, Obstetrics & Gynecology: August 2016 - Volume 128 - Issue 2 - p 422–423
http://journals.lww.com/greenjournal/Fulltext/2016/08000/Committee_Opinion_No__670_Summary___Immediate.52.aspx

ACOG Committee Opinion, Number 678, November 2016 (Committee on Adolescent Care):
http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Comprehensive-Sexuality-Education

ACOG Committee Opinion, Number 642, October 2015, Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy:
http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Increasing-Access-to-Contraceptive-Implants-and-Intrauterine-Devices-to-Reduce-Unintended-Pregnancy

Samoan Nurses Organization of Washington
4851 South Tacoma Way, Tacoma, Wa 98409 Ph. 253-292-1475 Fax:253-292-1551

January 31, 2017

To: the Washington Health Care Authority

Re: the Toolkit for Medicaid Transformation Projects

As a resident of Washington, the President and a community health worker of a small community based organization of the Samoan Nurses Organization in Washington (SNOW), I am writing this letter to urge, support and request that a Pathway type model of Care Coordination that include community health workers need to be a required project through-out in all the State ACHs transformation projects.
I am speaking from a perspective of an educator and a community health worker that actually face to face with individuals and people groups that are benefit from the services I provide.
To better explain myself as a community health worker, an advocate, navigator, connector and a foot soldier just to name few of what I am and what I do, I have 2 example stories:

Story 1
I was contacted by a social worker through one of my colleagues looking for a nurse in the community that can help with a family in need of a home care infusion treatment. I was contacted by the family on the phone and this family is an 80 year old mother and a 50 year old daughter is the one who needed the treatment. The mother was told by the daughter's doctor she needs 3 months of iv antibiotics twice a day to treat her lung infection. The insurance case worker told the mother the home infusion treatment does not cover by the insurance. She was told that she has to bring the daughter in the clinic for 3 months twice a day for the treatment or she has to learn how to do the procedure at home. The mother was so worried with the thought of many trips to the clinic is very tiring, and the idea of her learning something she knows she can't do it. She said, "I don't think I can do it, or try to do it". I agree to meet them and on the day the home health care nurse come in to see and show the procedure to her and myself to see how the nurse do it. After the morning treatment I agree to come back to help them with the evening dose. That evening, I ask them if they are willing to learn how to do the procedure themselves, they were hesitant but I assured them not to worry if they can't I will be there to help and support them as long as they need me. The second day, they agree they will try learn and because they saw I have taken the time to explain and go through steps by steps slowly in the way they can pick it up and notice I am not in a rush. I spent a week with them and that's how long it took them to build trust in me, and I for them that they are ready and comfortable to manage on their own. So they did it on their own until the completion of the treatment without problem nor any complication. We agreed I will check them weekly and they will contact me if any question or need before I come in again. Both the mother and daughter work together in assisting each other in doing the procedure and did it well. They were very happy and thankful not only they save money and time, but they are grateful that there are people out there doing what they do without compensation.

Story 2
A 60 year old female patient was told by her provider at Sea-Mar she needs to go to Harborview Medical Center to see a woman doctor. The patient only understand the date she needs to go and to HMC but

not exactly where and what clinic she needs to go to. The husband approached me because of the language barrier and they need transportation. I asked her for the summary sheet from her provider so I can have some understanding of what she needs. I call and confirm from Sea-Mar that she has an appointment with the oncology doctor. The patient did not know why she needs to go to Harborview but I can tell she does not understand she has cancer. According to her she has infection in her uterus. So I explain the plan of care and the process of what the doctor is going to do to both the patient and her husband during that visit. From then on I have been accompanied her to all her pre-surgery and post-surgery appointments. She had a successful surgery and a good doctor's report. Most of the cancerous cells was removed and chemotherapy treatment is not required. She is on an ongoing every 3 months follow-up appointments at this time. The couple were very happy and grateful for the help and support I provided in their time of need.

I believe this is the right time to officially consider community health workers to be part of the health care delivery system and recognize as a valuable and needed service not only help identify social determinants of health but showed better outcomes as you read my stories above. As an educator, I was able to teach and the family learned how to do the iv infusion on their own at home. As a connector, I was able to connect the patient to the clinic she needs to go. As a community health worker, I provide service in the community they live. For a foot soldier, I was able to provide them transportation to and from the doctor's visits.

I would like to see that Community Based Coordinated Care should be mandatory instead of optional part of the Medicaid Transformation Demonstration Project. Your goal of this project is creating ways for a healthier Washington, but if it is optional that will limit the community voices and there will be no consistency in delivering the care, because not everyone is on the same understanding. There will be no overall measurable out-comes through-out the State because everyone is in silo of operation and that will soon become business as usual rather than a new Re-designed health care delivery system.

The toolkit will require that all ACHs begin to develop and implement integrated physical and behavioral health services. It would make sense to include a requirement to have Care Coordination so individuals would receive a comprehensive risk-assessment that would include addressing social determinants of health such as housing and food, as well as physical and behavioral issues.

Therefore, if ACHs given the option to choose using of the Pathway type of model, I believe many will not choose so, they will continue do what they have been doing, then to square one of a very fragmented system like it is now. The system should be mandatory to control less effective approaches to service delivery and provide incentives for greater collaboration. Programs will only succeed in saving money if they are engaged in creating systems that use an overall Care Coordination approach.

Thank you,

Siniva Driggers

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Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

February 2, 2017

Washington State Health Care Authority
626 8th Avenue SE
Olympia, WA 98501
medicaidtransformation@hca.wa.gov

Dear Dorothy, MaryAnne and Nathan,

Based upon my role in community health at Seattle Children's and my participation on the King County ACH Interim Leadership Council representing hospitals in partnership with Elyse Chayet from Harborview, I am writing to thank and congratulate you for securing the $1.5 billion Medicaid Waiver for health transformation in Washington State! Through tremendous dedication and effort, you are setting the stage for exciting innovations and results. The comments below are my own and are based upon my perspectives as a result of my privilege in serving in these capacities.

Thank you for including the child and youth population in both the required and optional transformation projects and carrying their inclusion forward in the final toolkit.

I support efforts to ensure ACHs have the capacity and access to technical expertise to achieve the Value-Based Purchasing (VBP) goals, including development of a template to guide success in VBP.

Please consider allowing evidence-based projects not mentioned within the toolkit currently, as some flexibility is important to accommodate opportunities and/or needs that exist in some ACHs but not all.

Thank you for including coordinated care as one of the toolkit focus areas. The option of an evidence-based national program like Pathways provides an opportunity to build towards a statewide approach to coordinated care. At the same time, there may be populations such as youth with complex conditions who may do better with another evidence based model. I hope that ACHs can work together to serve the care coordination needs of patients who need to travel to or between urban centers to receive care.

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Thank you for looking at a statewide approach to data and the ability to look at information consistently categorized at both the state and local level.

Finally, thank you for including families in your community engagement strategies. Your equitable and inclusive principles continue to add great value and are appreciated.

Sincerely,

Elizabeth 'Tizzy' Bennett, MPH, MCHES
Director, Community Benefit and Guest Services

City of Seattle
Edward B. Murray, Mayor

~~Human Services Departm~~ent
Catherine Lester, Director

Dear Ms. Teeter:

As others, specifically our partners at King County, have shared with you their comments, I will not duplicate their thoughts but instead focus on a specific area of the Medicaid Transformation Project Toolkit.

As you are aware, a recent Heroin and Prescription Opiate Addiction Task Force was convened in King County that was sponsored by the King County Executive and the Mayors of the cities of Seattle, Renton and Auburn. We are pleased to see that the State is equally aware and committed to tackling this epidemic affecting our communities. By requiring Accountable Communities of Health (ACH) to address opioid use under Domain 3, we will be able to take the recommendations of this Task Force toward our desired outcomes much quicker.

Here are my comments regarding Domain 3: Prevention and Health Promotion; Project 3A: Addressing the Opioid Use Public Health Crisis:

- Under "Recommended Implementation Partners"; please include "Local Governments" to this list. Through items such as zoning statutes, local governments can be important players in broadening access to treatment.
- Under Goal 1; Strategy 3, please consider adding a bullet that specifically calls out prescribing practices of opiates to those under the age of 20 years as recommended by the Washington Health Alliance and the Bree Collaborative. While this may be mentioned in the referenced "Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan, it is worth highlighting directly.
- Under Goal 1; Strategy 5, it is not readily clear how educating law enforcement about the Prescription Drug Monitoring Program will prevent the supply of illegal opioids. This Strategy needs to be made clearer.
- Under Goal 2; Strategy 2, while it is appreciated that the need for supportive services, such as case management, will be needed to enable providers to implement and sustain buprenorphine treatment, the same should be called out for other medication assisted treatment such as methadone.
- Under Goal 3; Strategy 2, while it is important to increase the availability and use of naloxone, wide-spread distribution of the kits is being hindered by the rising cost of the drug. There

needs to be some statewide effort to provide naloxone at an affordable price to local communities in order for this goal and strategy to be effective.

Thank you,

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February 2, 2017

Sent via Email

Healthier Washington
Medicaid Transformation Team
Washington State Health Care Authority
medicaidtransformation@hca.wa.gov

RE: Draft Project Toolkit for Medicaid Transformation Demonstration

Dear Medicaid Transformation Team:

SEIU Healthcare 1199NW, a union of 29,000 healthcare workers, is pleased to share these comments in order to strengthen the Medicaid Transformation Demonstration Project Toolkit. Overall we continue to strongly support the goals and focus areas of the Demonstration.

Specifically, we support the focus on workforce development. Many in the healthcare field have begun to refer to the "quadruple aim", adding provider experience to the formerly three-legged stool of the triple aim: better health, better care, lower costs. Provider fatigue in health reform threatens to exacerbate and create shortages of healthcare workers, the foundational resource in our state's healthcare delivery system. We appreciate that unions have been specifically called out as key partners for the workforce development task force; as frontline healthcare workers, unions offer critical expertise and input.

We also appreciate the pledge by the state to collaborate closely with communities on data needs. The Demonstration's performance-based work will rely on data from a variety of sources: with support of and integration with state health data sources, communities will have capacity to track and improve their work.

Likewise, we welcome the focus on behavioral health integration and strengthening our current behavioral health system: these efforts will provide much-needed support to many Washingtonians who face a variety of challenges to navigate and access services under our current behavioral health system.

However, we are concerned that the requirements of the waiver – pursuing systems change work in the three focus areas of Domain 1 and conducting at least four projects in Domains 2 and 3 – put a heavy burden on Accountable Communities of Health that may not be proportionate to available ACH resources.

Sincerely,

Sybill Hyppolite | Healthcare Policy Specialist
SEIU Healthcare 1199NW

Spokane Neighborhood Action Partners (SNAP) - Public Comments on Health Care Authority Medicaid Transformation Project Toolkit Draft

Page 60: Project 3D: Chronic Disease and Prevention Control *(Optional)*

We recommend adding ***Weatherization Plus Health and Healthy Homes interventions*** into the 'Specific Strategies to Consider Including within Chronic Care Model Approach'

Weatherization Plus Health: **http://www.commerce.wa.gov/growing-the-economy/energy/weatherization-and-energy-efficiency/matchmaker/weatherization-plus-health-wxh/**

Weatherization Plus Health: **http://www.nchh.org/Policy/1000Communities/1KCPolicy/WeatherizationPlusHealth.aspx**

Page 61: Project Implementation Strategies

We recommend adding the following language under Stage 1 Planning (see text in ***bold italics*** at end of paragraph)

Stage 1 – Planning
ACH will guide and support implementation of evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control and address obesity in their region. Planning steps will include:

- Select specific target population(s), guided by disease burden and overall Regional Health Needs Inventory findings, ACH will identify the population demographic and disease area(s) of focus (for example: children age 0-17 with asthma, adults ages 18-64 with or at risk for diabetes), ensuring focus on population(s) experiencing the highest level of disease burden.
- Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations ***including those delivering healthy home evaluations and services. (note: as an alternate, we suggest HCA cataloging or identifying key community partners and including healthy homes services on the list)***

Page 61: Workforce Section

We recommend adding the following language (see text in ***bold italics***)

Workforce: Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:

- Shortage of Community Health Workers, Certified Asthma Educators ***and Certified Healthy Home Evaluators***, Certified Diabetes Educators, Home Health Care Providers;

Page 63:

We recommend adding the following language (see text in ***bold italics***)

- **Community-based Resources and Policy** strategies to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as: Community Paramedicine, tobacco free policy expansion, tobacco cessation assistance, nutritional food access policies, National Diabetes Prevention Program, home-based and school-based asthma services ***including home asthma trigger evaluations,*** worksite nutritional and physical activity programs behavioral screen time interventions.

Page 65:

We recommend adding the following language (see text in ***bold italics***)

Stage 3 – Scale & Sustain: Progress Measures

- Identify number of partner organizations and implementation teams implementing the project
- Identify number of new or expanded nationally recognized self-managed support programs, such as CDSMP and NDPP
- Identify number of home visits for asthma services, hypertension
- ***Identify number of in-home asthma trigger evaluations***
- Identify percent of documented, up to date Asthma Action Plans
- Identify number of health care providers trained in appropriate blood pressure assessment practices
- Identify percent of patients provided with automated blood pressure monitoring equipment
- Begin pay for performance of select outcome metrics

Date: February 2, 2017

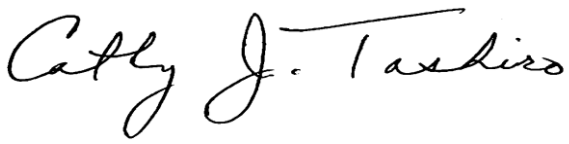
To: The Health Care Authority

Re: The Toolkit for Medicaid Demonstration Projects

I am writing to urge you to restore Community-Based Care Coordination to its rightful place as a core component of the Toolkit for Medicaid Demonstration Projects, and to remove its "optional" status. Based on many years of community health practice, I believe that Community-Based Care Coordination utilizing Community Health Workers (CHWs) is the key to improved health for the Medicaid population. In fact, care coordination is essential for anyone with complex medical and social needs. It is especially crucial for people who face barriers of poverty, lack of access to fundamental resources for healthy life, insufficient availability of translation, or a myriad of other obstacles experienced daily by far too many people in our state. Models such as the Pathways Community Hub can overcome our fragmented system and save money too. Community Health Workers (CHWs), trusted members of their communities, are the key to care coordination, and they have the knowledge, will, and experience that uniquely positions them to connect people with what they need to achieve health.

Please remove the "optional" status for Community-Based Care Coordination and include CHWS prominently as the key to achieving the goals of the Medicaid Demonstration Projects.

Thank you,



Cathy J. Tashiro, PhD, RN
Associate Professor Emerita, Nursing and Healthcare Leadership Program
University of Washington, Tacoma

February 2, 2017

Ms. MaryAnne Lindeblad
Director
State of Washington, Health Care Authority
626 8th Avenue PO Box 45502
Olympia, WA 98504-5050

Dear Director Lindeblad,

I am pleased to submit the following comments on behalf of UnitedHealthcare Community Plan of Washington (UHC) in response to Healthier Washington's Draft Medicaid Transformation Project Toolkit. UHC has been a proud partner with the Washington Health Care Authority (HCA) for 5 years and we value our partnership in improving the health of Washington's citizens. UHC currently serves more than 240,000 of Washington's Medicaid beneficiaries, and 1 in 7 Washingtonians, doing our best to help them live healthier lives.

The HCA has UHC's full support for the Medicaid Transformation Project. We are honored to be a key participant in the work of transforming Medicaid in the State of Washington and we are excited about the potential the Transformation Project holds for improving health while flattening the growth in the cost of the Medicaid program and making it sustainable well into the future. In our efforts to be active and supportive participants in the Transformation, UHC serves on the boards, councils and subcommittees of every Accountable Health Community. We look forward to the challenging work ahead.

UHC commends the HCA on this thoughtful and detailed Toolkit. It lays the framework that Washington's communities need in order to be successful in driving and supporting the transformation of the Medicaid program and for its ongoing sustainability. I hope the following comments are helpful in creating the most effective Toolkit possible.

UHC supports the HCA's creation of statewide taskforces to support Medicaid transformation in the state. We believe that these taskforces are critical underpinnings

for the success of the transformation. Not surprisingly, UHC strongly supports the inclusion of Medicaid managed care organizations (MCOs) as recommended participants in the Value-Based Payment Transition Taskforce. As payers, MCOs can be valuable and active participants on the taskforce. MCOs can bring our experiences with value-based purchasing arrangements, including lessons learned, as well as deep expertise and insight to the Taskforce. UHC also stands ready to participate in regional task forces organized by the ACHs on these topics.

UHC found the initial, high-level description of the Statewide Workforce Development Taskforce to be somewhat confusing and not as detailed as the overviews of the Value-Based Payment Transition Taskforce and the Practice Transformation Support Hub. We suggest that this overview be expanded to be similar to the other overviews. In addition, in the overview of the Statewide Workforce Development Taskforce, MCOs are not included in the list of stakeholders participating on the Taskforce, yet in the Workforce Project in Domain 1 (page 11) MCOs are listed as participants. UHC proposes that MCOs be listed participants in the Statewide Workforce Development Taskforce.

In addition, the existence of a Statewide Workforce Development Taskforce seems to add confusion to the Workforce Project in Domain 1. Our confusion is similar to what we've heard from ACHs across the state. It is not clear how the Taskforce and the Project are related, if at all and the ACHs perceive that many of the activities in the Project itself are duplicative. UHC suggests that the Toolkit would benefit from more clarity here.

UHC is very supportive of the Practice Transformation Support Hub. However, stakeholders that will participate in the hub are not listed in the Toolkit. UHC suggests that participants in the Support Hub be listed and that the Medicaid MCOs be included in the work of the Support Hub.

UHC strongly supports the Systems for Population Health Management project in Domain 1. Data and access to data are essential to the success of the Medicaid Transformation. It is not clear which stakeholders will be involved in this project nor how they will be involved. UHC recognizes MCO encounter data is a key part of the needed data, and we suggest that given MCO expertise with data and analytics, the MCOs be active participants in this group. In addition to our organization's expertise with encounters and analytics, UHC has recently entered into data sharing arrangements with a county jail system and a housing initiative so we can also bring our experiences in these domains to the Systems for Population Health Management project. In addition, we suggest the creation of a separate Data Taskforce to create a support structure for the ACHs. Taskforce goals should include the creation of a streamlined process for data

requests, coordination for request fulfillment and a management process for analytical support.

Financial sustainability is a key consideration and planning activity in all projects in Domains 2 and 3. UHC is in full agreement that planning for the financial sustainability of the projects is essential to the long-term success of the overall Medicaid transformation. We look forward to participating with the ACHs in designing financially sustainable projects. UHC suggests that the description of the financial sustainability element includes the ongoing well-being of key health institutions in the ACHs, particularly rural hospitals. As inpatient admissions and emergency department utilization are expected to decrease, hospitals will need to be supported in adapting their business models so they are able to continue to serve their communities in the transformed delivery and payment environment. Through our work in communities around the state with value-based purchasing models, UHC understands the importance of supporting providers in creating business models that assure their ongoing viability.

UHC also suggests the need for a formal exploration of how MCO rate-setting considerations and processes will need to be modernized to address the changes in patterns of health care utilization and expenditures as the transformation proceeds. We look forward to robust discussions on this topic and believe these discussions should begin as transformation begins so that the work is proactive and well thought out, rather than reactive.

UHC is very pleased to see the inclusion of the Pathways Community Hub as the model for the Community-Based Care Coordination optional project. UHC has had extensive experience over the past decade with the Pathways model in Ohio and understand how effective it is. We were pleased to be able to join Dr. Redding at the HCA last year to discuss Pathways and are looking forward to supporting its implementation in the Better Health Together region. UHC looks forward to supporting other ACHs that decide to implement a Pathways Community Hub.

We also want to express our strong support for the required project “Addressing the Opioid Use Public Health Crisis”. Through our representation on a number of initiatives focused on opioid use in Washington, including the Bree Collaborative’s Work Group on AMDG Opioid Guideline Implementation, and our experiences in Washington communities, we truly understand that this serious public health issue must be attacked from all angles and we are anxious to fully participate in the ACH projects addressing opioid use.

UHC believes that the HCA has supplied good evidence-based and promising practice model choices for the ACHs, though we also believe flexibility for local conditions, such as workforce supply, community size or cost is a good practice. We suggest if an ACH proposes an evidence-based or promising practice model for its project that is not on the list but can demonstrate it is better suited to the local conditions, the HCA should consider approval. If the HCA has intended that the listed evidence-based and promising practices are the only ones that the ACHs can choose, UHC suggests that language be very clear that the listed programs are the only options for the ACHs, so that the ACHs don't spend time looking at other programs.

Finally, we would like to share our thoughts on performance measures. Appendix 1: lists "…potential measures that have been identified based on the evidence-based and promising practice models outlined in the toolkit." The measures listed are important to understanding the performance of a project but the list is far from comprehensive. Are the performance measures that can be used by the ACHs in their projects limited to the list in Appendix 1 or can others that are relevant to the toolkit's practice models be used? For example, in the area of maternal and child health, a measure for early/timely access to prenatal health care is not included in Appendix 1 though this measure is well-established as a link to healthy birth outcomes. UHC suggests that other performance measures proposed by the ACH should be considered and approved as long as evidence supports that the measure is linked to the expected and desired outcomes of the Toolkit's practice models. Whether the measures used are restricted to the list or not, UHC suggests that clarity is needed as to the flexibility of the list.

Thank you again for the opportunity to comment on the draft Toolkit. My team and I look forward to further discussions on all aspects of the Medicaid Transformation. We are more than ready to support the HCA's efforts in whatever way possible.

Sincerely,

Douglas Bowes

Douglas Bowes

CEO, UnitedHealthcare Community Plan WA

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February 2, 2017

Dorothy Teeter and Medicaid Transformation Team
Washington Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Submitted electronically to Dorothy.teeter@hca.wa.gov and medicaidtransformation@hca.wa.gov

Dear Director Teeter and the Medicaid Demonstration Team:

Thank you for the opportunity to provide feedback on the Medicaid Transformation Project (MTP) draft Project Toolkit (Toolkit). The Washington Association of Area Agencies on Aging (W4A) commends the Health Care Authority for the many hours of work and the broad cross-section of stakeholder input that are reflected in this draft. We offer our feedback from the perspective of the Area Agencies on Aging, who have over 40 years of experience as publicly accountable trusted resources in local communities across our state. It is in that spirit that W4A recommends the following changes to project requirements in the final Toolkit.

1. Maximize benefits by requiring that new ACH projects build on the strengths of the current local infrastructure.
2. Coordinate and consult with the existing service delivery system to ensure non-duplication of services. New ACH projects must expand on the strengths of existing programs and services.
3. Recognize the value of local innovations, particularly in expanding current evidence-based programs (EBP). The EBP programs identified in the toolkit are only a small sample of what could be available in any given community. Local communities should be able to exercise choice in selecting evidence-based programs, and not be restricted to just those listed in the toolkit.

We appreciate these ongoing opportunities to engage with the Health Care Authority as it develops additional waiver protocols and policies.

Sincerely,

Lynn Kimball, Chair
Washington Association of Area Agencies on Aging

- Stage 1: Presumably “healthcare providers” includes dental. However, calling out the inclusion of dental more explicitly here is necessary to disrupt the current paradigm of our siloed health care system, and remind ACHs to consider dental in developing their workforce plans.

Systems for Population Health Management

- In order to support projects within Domain 2 and Domain 3, including the Access to Oral Health project 3C, ACHs will need to convene key providers and health system alliances, to share information with the state regarding the status of systems for population health management. This is why it is important to reference dental in the prior sections – otherwise this opportunity is likely to be missed as projects are developed.

Domain 2

Project 2B: Community Based Care Coordination

- The Pathways Community Hub model can include an oral health pathway, which WDS Foundation is willing to develop. The foundation is also committed to providing implementation support to ACHs pursuing care coordination projects.
- In order to do this, it’s important to remind ACHs that this is possible by including in the toolkit, periodontal disease and caries (tooth decay) among the Target Populations, and dentists among the Recommended Implementation Partners.

Project 2D: Diversion Interventions.

- Pleased to see ED Diversion includes dental

Domain 3

Project 3A Addressing the Opioid Use Public Health Crisis

- Pleased to see the inclusion of dental providers among the Recommended Implementation Partners.

Project 3B Maternal & Child Health

- The American Congress of Obstetricians and Gynecologists recommends regular dental care during pregnancy. There are unfounded fears that prevent pregnant women from getting regular dental care during pregnancies. This often leads to a significant missed opportunity to prevent the transmission of caries from mother to baby, which is almost entirely preventable.
- This is why it’s important to include dental care in the Rationale, and dental providers in the Recommended Implementation Partners. Otherwise ACH partners may miss the opportunity to include this important component in a Maternal & Child Health project.

Project 3C Access to Oral Health Care

- WDS Foundation will provide technical support to ACHs and their partners interested in pursuing this project. We will seek to offer support directly to ACHs and their partners, and would also advocate for the inclusion of at least connecting support via the Practice Transformation Hub, to identify those who are interested so they can access our support.
- Inclusion of Access to Baby & Child Dentistry as an example of a community based resource for this project, serves to educate that this kind of support is available, and also illustrate that an oral health care coordination pathway is possible.
- Change Primary Care Providers to Medical Care Providers, so as not to inadvertently exclude prenatal or other medical specialty providers whose patients benefit from coordinated oral health care.
- Inclusion of schools as a potential partner, either via health centers providing primary care, or as partners to mobile dental programs.
- Inclusion of project level outcome examples that would represent progress toward population oral health data.

Project 3D Chronic Disease Prevention & Control

- Caries (tooth decay) is the most common chronic disease in the pediatric Medicaid population, and yet it is almost entirely preventable. And there is a significant backlog of dental care needs among the adult Medicaid population. Consequently, this project would be improved by including periodontal disease and caries, as well as a reference to the pediatric preventive oral health services measure from the State's Common Measure Set.
- The act of listing periodontal disease and caries in the list of chronic disease examples serves to educate. Another way to message the importance of oral health would be to include dentists among the Recommended Implementation Partners.

Including a reference to diagnostic coding in dental will provide the necessary links between the Access to Oral Health Project, population health, and transition to VBP. It would also significantly accelerate the spread and use of population oral health data and the movement to value based models. Two FQHCs in King County are implementing the use of dental diagnostic coding to assess and document severity levels for both caries and periodontal disease. These diagnosis codes are subsets of existing ICD-10 codes, and enable bidirectional data sharing between dental and medical settings. Measuring and documenting changes in a patient's disease severity as well as corresponding changes in other health conditions is necessary to enable value based care and payment models in dental. Inserting a reference in the toolkit to this opportunity, as a population health component, will enhance the current Oral Health Access Project 3C, and accelerate the spread of an important population health tool. See **Section A for in depth rational.**

Section A:

Including dental diagnostic coding as a population health link to the Oral Health Access project in the Demonstration Project Toolkit, can significantly accelerate the spread and use of population oral health data and movement to value based models.

Thus far, oral health integration has focused largely on primary care office visits, with the role of dentists being that of consultants, accepting referrals from the medical teams. Without the ability to measure dental disease severity, oral health quality metrics are limited to process measures. By implementing a collaborative approach to oral health in which dentists contribute to the measurement of clinical outcomes, the set of questions that can be asked about the target population is expanded significantly to include:

- What is state of the target population's oral health?

- What are the most effective interventions taken collaboratively between Medicine and Dentistry in improving the oral health of a population?

- To what extent does collaborative oral health care reduce
  - The use of emergency services for children with caries?
  - The use of emergency services for adults with acute dental needs?
  - Exposure of young children to general anesthesia for dental care?
  - Diabetes severity?
  - Adverse pregnancy outcomes?
  - Cost of care?

Two FQHC delivery systems, serving large populations of Medicaid enrollees in King County, are beginning to implement diagnostic coding using SNODENT codes for dental visits that will map to disease severity scales, for measuring a population's oral health. In the case of caries, this effort will use an adaptation of the ADA's caries classification system (CCS) to measure the impact of an intervention on oral health in a target population of children and adolescents. In the case of periodontal disease, a diagnostic classification system from the American Academy of Periodontology has been adapted to assess and track the severity of periodontal disease in a defined population.

This effort builds upon recent experience integrating oral health preventive services into primary care practice, and is designed to take collaborative care for oral health to the next level – by generating actionable population health data. This effort will measure the impact of combining the preventive efforts of primary care with restorative & prophylaxis dentistry, on caries or periodontitis severity in a target population.

This approach will enable measurement of the extent to which, integrated, collaborative oral health care:

1) Increases the use of fluoride varnish, lowers the severity of caries in a population, and leads to a reduction in emergency services and general anesthesia for preventable complications of caries.

2) Increases rates of oral health screenings/referrals in a population of higher risk adults (e.g. diabetes, pregnancy), and leads to a reduction in the severity of periodontal disease, improvements in overall health, and ultimately reductions in medical costs.

3) Has a significant role to play in "value based" care delivery and payment models of the future

It is time to connect dental providers to the rest of the health care team, for integrated, whole person care. This is already considered a promising practice, based on the available evidence, and spreading this approach to population oral health should be encouraged by inclusion in the Demonstration Toolkit.

1. Disease severity/control scales have become an accepted part of population health for chronic disease
    a. Depression (Arroll 2010)[2]
    b. Asthma (Juniper 1999)[1]

2. These validated symptom-based metrics are very similar to biologic markers reflecting control of chronic disease such as HbA1c for diabetes and blood pressure for hypertension that are used to drive evidence-based clinical interventions for individuals to improve their control. These same markers are useful in describing the health of populations as well as individuals

3. Severity scales for caries and periodontal disease have been developed and validated by prestigious organizations (ADA & AAP) however they have not been widely used largely because dentists bill only for procedures, not on disease severity. Value based arrangements require this approach.

4. The least disruptive way to have dentists gather information for the disease severity scales is to have them enter SNODENT diagnostic codes that can be mapped to the severity scales.

References:

The Washington Chapter of the AMERICAN ACADEMY OF PEDIATRICS

4616 25th Ave NE, #594
Seattle, WA 98105
wcaap.org

February 2, 2017

To: MaryAnne Lindeblad and Nathan Johnson
From: Sarah Rafton, Executive Director, WCAAP

Congratulations on your hard work and careful process to obtain the 1115 Demonstration Waiver to improve health and reduce costs under our state's Medicaid program! Thank you for the opportunity to comment on the Medicaid Transformation Project Toolkit. We have appreciated our partnership with you over these past two years and the increased focus on children in the Common Measure Set, the waiver, and now the Project Toolkit.

It is essential that Waiver Projects in all domains of the Project Toolkit are dedicated to the unique needs of children, who are about half of Medicaid recipients in our state. It is necessary to support pediatric projects in Capacity Building, Delivery Redesign, Equity/Prevention & Promotion so we understand what is effective to improve child health and reduce cost**.** We are keenly interested in pediatric foci in: value-based payment, bidirectional integration of care, and preventive care to improve child health. Our highest priority requests for the next iteration of the Project Toolkit are 1.) supporting pediatric providers in value based payment and, 2.) requiring ACH bidirectional integration projects specific to children's unique needs.

1.) **Regarding Health and Community Systems Capacity Building, we respectfully ask for a seat on the Statewide Taskforce for Value-based Payment Transition Taskforce.**

As we have discussed, WCAAP is uniquely positioned to contribute to this work as we have partnered with Molina on the establishment of a quarterly pediatric dashboard of claims based data (including clinical, cost, and utilization data) which is reported to providers and we are now educating pediatric providers statewide about what this data means and how to use this information to improve care. Furthermore, five members of the WCAAP Health Care Transformation Committee contributed to the Ad Hoc Workgroup on Pediatric Measures (for the Common Measure set.)

Regarding Community Systems Capacity Building at the regional level, we support your proposal to educate ACH's about value-based payment and provide ACH's with technical assistance in the area of value-based payment (VBP). **It is critically important that providers are at the table with ACH's to help with this education and process to VBP.** In our experience ACH meetings to date have been held weekdays, midday, and practicing providers who have the most to contribute to the opportunities and challenges of VBP are not able to participate in ACH work. We have ideas to increase successful partnerships and engagement with providers and are happy to contribute to the support you give ACH's to increase provider engagement. Furthermore, we have one pediatric Physician Champion in each of the ACH's who is well versed in VBP. **We request that these Physician Champions are incorporated into ACH regional VBP teams under the Project Toolkit.**

2.) **Under bidirectional care we respectfully ask that each ACH be *required* to have a minimum of one project that is dedicated to the unique needs of children.**

We encourage you to specify types of bidirectional integration for children in the toolkit, from which ACH's may choose a required project.

Bidirectional Integration for Children *(cont.)*

a. Off-site, Enhanced Collaboration

As we have discussed, through Pediatric TCPI we are already engaged in identifying and promulgating best practice for providers to make effective referrals, share patients and share information across the silos of behavioral health and primary care. The Project Toolkit is a meaningful way for ACH's to support primary care and behavioral health providers to establish referral and information sharing agreements.

As the state's Accountable Communities of Health plan how to address child mental health issues specific to children's unique needs, the state's Partnership Access Line of available child psychiatrists should be pointed to as a potential resource for supporting local therapeutic care teams with telepsychiatric support services in a continuum of care. **We ask that you include this in the toolkit.**

For smaller pediatric and family practice clinics which do not have economies of scale for embedded behavioral health, we also ask for incorporation into the Project Toolkit expanding the PAL Plus model (currently in Benton Franklin) to provide rapid access to evidence-based care for children's mental health needs. **We ask that you include this in the toolkit.**

b. Collaborative Care Model

For medium to large pediatric practices, it is important that we modify and evaluate the use of the Collaborative Care Model **for children in particular**, with an increased emphasis on children with mental health needs which impact their functioning who do not yet have a mental health diagnosis, as well as for children who have diagnosed, mild or moderate mental health needs. The UW Aim Center has expressed interest in collaborating with us on such a model. **We ask that you include this in the toolkit.**

3.) Clinical Data Repository

We have grave concerns about the current costs being proposed for providers to participate in the CDR and are certain this will result in many more providers closing doors to Medicaid beneficiaries. We have already heard from several of our members that they will drop Medicaid if this proceeds as currently proposed.

4.) Maternal and Child Health

We applaud inclusion of projects to increase well child care and immunization rates as these are the cornerstones of preventive and cost effective care which lead to a lifetime of health. We also appreciate the inclusion of Nurse Family Partnerships as such investments in the earliest years of life are shown to have positive health outcomes over the life course.

5.) Workforce

It is essential that workforce development address how clinics can support and sustain roles on their teams to assure consistent use of data to improve care.

6.) Health Equity and Chronic Disease

We are pleased to see asthma included in this domain and suggest that the Toolkit support use of non-traditional roles, such as community health workers, who have been shown time and again in to improve child health by impacting social determinants of health and the environments in which children live.

WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

Comments on the Medicaid Transformation Project Toolkit
WASHINGTON COUNCIL FOR BEHAVIORAL HEALTH

The following comments are submitted on behalf of the Washington Council for Behavioral Health, the statewide association of licensed community behavioral health agencies.

Statewide Workforce Development Taskforce (p. 7)

How will this work coordinate with other related system workforce initiatives such as the Governor's Behavioral Health Workforce Stakeholder Group and other work of the Health Workforce Council?

Domain 1: Health and Community Systems Capacity Building

Timeline: We are not clear on the implementation timeline or mechanism for these strategies. While it appears that the Statewide Value Based Payment Transition Taskforce would play a key role in this regard, we are concerned that we could lose valuable time in reaching tangible strategies for education, training and technical assistance.

Focus areas vs. projects: We appreciate the importance of the three Domain 1 focus areas as system-wide foundational capacities essential to overall transformation. However, with respect to value based payment and community behavioral health providers, we believe a more targeted approach is warranted. In the rationale on page 8, the toolkit states that *"A transition away from paying for volume may be challenging to some providers, both financially and administratively. Because not all provider organizations are equipped at present to successfully operate in these payment models, providers may need assistance to develop additional capabilities and infrastructure."* These statements are especially applicable to community behavioral health providers for several reasons:

- As with many aspects of health system evolution and transformation, community behavioral health has not been brought along with the rest of the healthcare industry as value-based payment pilots, mechanisms and models emerged (e.g. MACRA Quality Payment Program, or the Medicaid Adult Quality Measures or in-state commercial VBP initiatives).
- Health systems have worked for decades with an evolving set of quality metrics (HEDIS, NCQA), but behavioral health metrics – particularly those related to serious mental illness and addictions – have been slow in coming. Behavioral Health practitioners and payers alike have had limited experience with reporting and accountability for standardized metrics.
- The state of the art of performance measures for behavioral health, and the types of measures needed are different than for physical health conditions and need to be chosen carefully when developing VBP mechanisms for behavioral health providers.

- There has been limited investment in HIT and associated infrastructure for community behavioral health providers; these are essential building blocks in shifting to value-based payment.
- Yet, these behavioral health providers are critical to the overall success of physical and behavioral health integration, getting control of the state hospital crisis, and achieving overall health system transformation.

We need to provide targeted training, technical assistance and practice transformation support for these providers to be full participants in an integrated delivery system that is transitioning to value-based payment.

The toolkit further indicates that Domain 1 strategies are not *"individual projects, but rather three required focus areas to be implemented and expanded* ***across the delivery system, inclusive of all provider types, to benefit the entire Medicaid population****."* However, It seems unlikely that broad health system strategies woven through a variety of different regional ACH transformation projects will provide the kind of relevant measures, incentives and practice transformation support to enable behavioral health providers to make the cultural and operational changes needed to transition to a value based mindset.

We suggest that a targeted statewide value-based payment strategy be developed for behavioral health providers. This could be vetted through the Statewide Value Based payment Transition Taskforce and then be offered to behavioral health providers in each ACH. Through an industry-specific 'practice transformation academy approach' behavioral health providers could learn from in-state and national experts, with and from their peers. The activities could be structured in a manner that ties the selected 'value measures' to specific Domain 2 or 3 ACH transformation projects.

Domain 2: Care Delivery Redesign

<u>Project 2A: Bi-directional Integration of Care and Primary Care Transformation (page 15)</u>

- We don't understand why this title only calls out primary care transformation. **Both** primary care and behavioral health settings need to be transformed to embody a whole person approach to care in an integrated network of providers. Perhaps some other wording such as "Bi-directional Integration of Care through Care Transformation."
- We recognize that models for integrating primary care into behavioral health are not as well established or researched as those for integrating BH into primary care, and that it is important to maintain flexibility during this developmental stage. However, Option 1 (page 21) seems barely different from the status quo. We would like to see more rigor attached to the options for integrating primary care into behavioral health settings. Perhaps there could be a common expectation across all models (Options 1-3) that all project participants must select at least one health indicator (chosen from a list of key health metrics that impact the morbidity and mortality of people with serious mental illness and/or addiction disorders such as smoking, diabetes screening and management, blood pressure, obesity/BMI) so that whatever the model or level of integration, there is measurable focus on improving the health outcomes of patients.

- On pages 22, for the bullet point "Systematic Psychiatric Case Review & Consultation, we suggest the following change to emphasize the routine review of chronic physical health in addition to psychiatric issues which are already routinely monitored in behavioral health settings:
    - o Systematic Psychiatric **and Physical Health** Case Review & Consultation:
        - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who**se physical health conditions** are not improving.
        - Provide specific recommendations for additional diagnostic work-up, treatment changes, **more active involvement with primary or specialty medical care** or **other** referrals.

Project 2B

Many of our member agencies have raised questions and concerns about the potential for adding another layer of care coordination responsibilities to the system. These agencies represent hospital systems, care coordinating agencies that are part of Washington's health home program and have voiced concern about yet another platform and stand-as lone system that does not tie into existing systems such as EDIE, Pre-Manage, EPIC or other case management tools currently used by providers. We understand that the intention of a community-based care coordination model like the Pathways Community HUB is in fact to orchestrate and leverage the other community and health system case managers, care managers and care coordinators. It will be critical to clarify how this can be a streamlining rather than a complicating mechanism.

Other General Questions

1. How will Medicaid Transformation Demonstration resources be distributed across the three domains?
2. Who will provide training and TA tied to the specific transformation projects being designed and implemented by ACHs?

For more information, contact Ann Christian at achristian@thewashingtoncouncil.org

February 2nd, 2017

To: WA Health Care Authority

From: Washington Dental Service Foundation

RE: Public comments on draft Demonstration Toolkit

Washington Dental Service Foundation would like to commend the Health Care Authority for its inclusion of the Access to Oral Health Service Project 3C, based on the *Oral Health in Primary Care Framework*; field tested and validated in diverse care delivery settings across the country. This is an important step toward full integration of medical and dental care within a whole person model of care.

Modest additions to the Demonstration Toolkit, described below, would significantly advance the adoption and spread of this integrated approach to whole person care, and ultimately enable population oral health and value based models.

Due to the inherent challenge in breaking out of the current health care paradigm, it is critical to provide stakeholders with an expansive view of the transformational opportunities presented by the Demonstration Toolkit, related to oral health. That is why we are proposing additional ways to highlight every opportunity to weave in sensible connections to oral health across the toolkit. This more expansive perspective of what's possible would enable greater levels of visibility for oral health, as well as greater partnership potential and support for ACHs by WDS Foundation.

Please contact us if you have questions or would like additional information.

Sincerely,

Diane Oakes
CEO, Washington Dental Service Foundation

Domain 1

Financial Sustainability through Value Based Payment

- Stage 1: The Statewide Value-based Payment Transition Taskforce could include representation from dental.
- Stage 2: Include the use of dental diagnostic coding for bi-directional medical/dental data sharing and population health, among the viable tools listed for regional planning by ACHs. This would enable ACHs to include dental in performance based goals that pave the way for VBP.

Workforce

- Stage 1: Presumably “healthcare providers” includes dental. However, calling out the inclusion of dental more explicitly here is necessary to disrupt the current paradigm of our siloed health care system, and remind ACHs to consider dental in developing their workforce plans.

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Domain 2

Project 2B: Community Based Care Coordination

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- In order to do this, it’s important to remind ACHs that this is possible by including in the toolkit, periodontal disease and caries (tooth decay) among the Target Populations, and dentists among the Recommended Implementation Partners.

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Domain 3

Project 3A Addressing the Opioid Use Public Health Crisis

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Section A:

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- What are the most effective interventions taken collaboratively between Medicine and Dentistry in improving the oral health of a population?

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References:

1. Juniper EF, O'Byrn PM, Guyatt GH, Ferrie PJ, King DR. Development and Validation of a Questionnaire to Measure Asthma Control. Eur Respir J. 1999; 14: 902 – 907.

2. Arroll B, Goodyear-Smith F, Crengle S, Gunn J, Kerse N, Fishman T, Falloon K, Hatcher S. Validation of PHQ-2 and PHQ-9 to Screen for Major Depression in Primary Care. Ann Fam Med. 2010; 8(4):348 – 353.

February 2nd, 2017

To: WA Health Care Authority

From: Washington Dental Service Foundation

RE: Public comments on draft Demonstration Toolkit

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Due to the inherent challenge in breaking out of the current health care paradigm, it is critical to provide stakeholders with an expansive view of the transformational opportunities presented by the Demonstration Toolkit, related to oral health. That is why we are proposing additional ways to highlight every opportunity to weave in sensible connections to oral health across the toolkit. This more expansive perspective of what's possible would enable greater levels of visibility for oral health, as well as greater partnership potential and support for ACHs by WDS Foundation.

Please contact us if you have questions or would like additional information.

Sincerely,

Diane Oakes
CEO, Washington Dental Service Foundation

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Financial Sustainability through Value Based Payment

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Workforce

Washington State Hospital Association

February 2, 2017

Dorothy Teeter
Director
Washington State Health Care Authority
P.O. Box 45502
Olympia, WA 98504

Dear Ms. Teeter,

RE: WSHA COMMENTS ON THE HCA PROPOSED TRANSFORMATION PROJECT TOOLKIT

WSHA appreciates the chance, on behalf of our 107 hospitals and health systems, to review and comment on the Medicaid transformation project toolkit.

We are pleased to see the Health Care Authority providing specificity and guidance for the work that will be undertaken. We applaud the reliance on evidence-based strategies and the desire to tackle a limited, but important, set of barriers to improving health. WSHA had requested the initial focus be on behavioral health. We are pleased all Accountable Communities of Health (ACHs) are required to do a project on behavioral health integration (under care redesign). With the current opioid crisis and the work from the Governor's office and partners around the state, we also appreciate the requirement that all ACHs undertake work on the opioid prevention (under prevention and health promotion). Our hospitals, other providers, and communities can benefit enormously by being able to invest in care delivery redesign and improvements in health promotion and prevention.

We also recognize the importance of building health systems and community capacity to tackle these projects. We ask that the Health Care Authority take a hard look at the capacities and resources needed. Some of the resource needs will be similar across the state. Examples are enhancements to the prescription monitoring program and connectivity between the Pathways notes and medical providers EHRs. In these cases, we think the resources can be provided most efficiently by development at the statewide level. It would be inefficient and costly to have many ACHs all attempting to create the same tools in each region. We understand from the Authority that the ACHs are in charge of the work done in these specific project areas and that requests need to come through the ACHs. We can appreciate the importance and strength of having local input in requests and development of tools. At the same time, we think there should be a process through which ACHs can surface items that may have broad benefits across multiple areas and have the work done once through a unified structure, rather than have many local areas spending resources on duplicative work.

As this work proceeds, we are interested in understanding better the demarcations between the work funded here and the work funded through the managed care organizations. Under value-based purchasing, both managed care organizations as well as providers may be working on better care coordination. Several of the projects here also focus in that area. The work in all organizations needs to complement each other to provide an efficient use of resources and make the work successful and sustainable.

Finally, we hope the work undertaken through this waiver transformation process supports rather than competes with many similar transformation initiatives already underway in Washington State. We hope that will be considered as part of the project approval process.

Specific section-by-section comments are attached.

We and our member hospitals look forward to working with the Authority and the ACHs on this work.

Sincerely,

Claudia Sanders

Claudia Sanders
Senior Vice President, Policy Development
Washington State Hospital Association

cc: Nathan Johnson, Marc Provence, MaryAnne Lindeblad

WSHA SECTION BY SECTION COMMENTS

PERFORMANCE MEASUREMENT (PAGE 5)

The toolkit requires project-level and statewide measures to track performance. It suggests, when possible, that project-level measures be applicable at the practice level and reported frequently. Having these measures at the provider level is extremely important to drive improvement. ***We suggest that the measures need to be reported at least quarterly for providers to be able to make improvements.***

REGIONAL HEALTH NEEDS INVENTORY (PAGE 6)

It is important that each of the accountable communities of health has a needs assessment and inventory of resources. ***We would encourage all participants to use the many needs assessments that have been completed by the health systems and public health entities already within the borders of the communities.***

STATEWIDE VALUE BASED PAYMENT TRANSITION TASKFORCE AND WORKFORCE DEVELOPMENT TASKFORCE (PAGE 6)

It is important to address value-based payment and workforce at a statewide level***. We are interested in how these two new groups intersect with some of the structures already in place, such as the Health Innovation Leadership Network, and the state's workforce efforts.*** If new taskforces are created, we ask that hospitals have representation on both, since both of these issues are critical ones for our members.

The value-based payment transition taskforce is tasked with developing a survey to report on value-based payment arrangements across the provider spectrum. It may be difficult to get an accurate picture of such a complex issue through a survey. If value-based payments are focused on the MCOs, a better picture might be obtained by getting provider and plan feedback through interviews on the impact of these specific provisions.

FINANCIAL SUSTAINABILITY THROUGH VALUE-BASED PAYMENT (PAGES 8 THROUGH 10)

As noted in our general comments, we are interested in understanding better how the work of the ACHs will support the state's move to value-based payment. We appreciate the toolkit outlining the different roles for the statewide planning activities and regional planning activities. We think some additional detail may be needed to differentiate roles and determine data sets that will be used to track progress at the different levels. We also think that the move to value-based payment needs to be done in synergy with other activities to enhance value such as the Partnership for Patients.

WORKFORCE (PAGE 11 AND 12)

Workforce is a major issue for hospitals to enable them to deliver care in new ways. We request that any issues of workforce address additional issues such as barriers to deploying the current work force due to scope of practice issues. We think it is possible to address some of these issued through more flexibility in scope as a way to address shortage needs. We also think it is important to consider the use of and barriers to the appropriate use of technology, such as telemedicine, to support local areas with provider shortages. Workforce planning also needs to account for the aging of the current workforce.

SYSTEMS FOR POPULATION HEALTH MANAGEMENT (PAGE 13)

We believe that one of the most important barriers in population health management is the lack of information for providers on where else their patients are being seen and served. Link4Health holds

great promise, but we are unsure of the implementation time frame for access to a robust data set for an individual provider. For example, our understanding is that behavioral health providers often do not have an electronic record, and therefore are not able to share information. We also know that many of our smaller hospital systems do not have good information on where else their patients are receiving services. Having individual patient information from within the provider's system is critical, but it is also important to be able to have standardized checklists and reports easily on care for the patient rendered by other providers. ***Support for population management systems that can be used and can be populated with information is an important focus.***

We would also note that for information to be actionable by the ACHs and its providers, data needs to flow on a timely basis. We support the development of and access to standard care plans. These plans need to be an integrated through a single system, and easily accessible to primary care providers, management, payers and others delivering care to patients.

PROJECT 2A: BI-DIRECTIONAL INTEGRATION OF CARE AND PRIMARY CARE TRANSFORMATION (PAGES 15 THROUGH 23)
We are very interested in the opportunities afforded to providers through this work. We think the work should appropriately be titled bi-directional integration of behavioral health care and primary care. We are encouraging many of our hospitals and health systems to explore providing integrated behavioral health care either through a patient centered medical home or through the collaborative model.
To sustain this work after the waiver, we believe there needs to be a funds flow to the providers doing this work. We are asking the legislature to fund new care collaboration codes for Medicaid patients.

We also would encourage the Authority to adopt a more precise measure of success for this project than the larger measure of adult mental health status as obtained from the BRFSS data. A better measure may be progress in dealing with depression among patients treated. This may be more likely to show movement rather than a global population based measure, especially if the interventions are targeted at a select number of sites in the community. As this work has links with value-based payment, we also think it may be important to have outcome measures available by health plan.

We applaud the focus on evidence-based programs and we think the ones identified are appropriate. We believe, however, over the five years of the waiver there may be other evidence-based approaches that may emerge. As a result, we hope there is an opportunity to incorporate other approaches in the future if they will help deliver on the overall goals.

In terms of specific comments on the section:

1) It appears there are a couple of critical pieces missing on the Collaborative Care Model on page 20, including: hiring or re-training of the psychiatric specialist; hiring of the clinical care coordinator; and training both of these providers, along with the primary care physicians in the clinical practice about the model. These steps are critical to the success of the project and should be included.

2) Referenced on page 16, the term telemedicine has strict definition in state law and should be expanded in the toolkit to include telephonic communication when necessary. State law

requires real-time audio and video technology, which could be limiting, especially for interactions between clinical care managers and psychiatric specialists.

3) In the planning discussion on page 18, we think it is important to include hospital systems and other large primary care providers in the group convened to address regional solutions.

4) On stage 1 of planning, it is concerning to us that the ACH will be selecting the Patient-Centered Medical Home and/or the Collaborative Care Model without input from the provider community who will be the ones implementing the clinical changes. We would request ACHs be required to engage providers prior to this choice and the requirement of a project implementation plan.

5) WSHA is concerned the Collaborative Care Model may need to be more flexible when it comes to providing psychotherapy. Only limited mental health providers are available to provide these interventions and some clinics may need to refer the patient for prolonged or ongoing treatment. Clinical care managers, depending on licensure, may or may not be able to provide this treatment and we are concerned deploying psychiatrists to do so may be prohibitive to practices trying to implement the clinical model.

6) While we understand this toolkit is written for the ACH, the toolkit is also the blueprint for the providers who will be participating in the projects. We believe it would be clearer if the ACH and provider roles were specified in the project stages. For example, page 19 under option one: identification of a physician champion with knowledge of PCMH implementation. Typically, a physician champion is critical for practice transformation within a clinical practice. It is unclear from the toolkit if identifying a physician champion would be for the entire ACH region or for the provider engaged in the new model. WSHA hopes the toolkit would clarify that the physician champion is done at the clinical, not regional level.

7) Option 1 on page 19 describes a gap analysis but it is unclear what the ACH should do with this analysis once complete. If a significant gap has been identified, the information needs to be shared with the relevant providers in the area that could be involved in helping to bring more resources to the region.

PROJECT 2B: COMMUNITY-BASED CARE COORDINATION (PAGES 24 THROUGH 28)

WSHA supports improved care coordination as a promising method for reducing unnecessary medical care services. We are striving to learn more about the Pathways HUB model and how it is functioning in other areas. Has it been implemented in other regions with managed care organizations and how are payments for Pathways' outcomes, such as behavioral health referral, development screening, and immunization screening, covered under value-based contracts?

The Pathways HUB model developed by Dr. Redding addresses many significant areas of focus for this work. While the work and focus seem valuable, we are concerned that this may lead to another care coordinator with another tool, and this tool is not connected to the health care providers or managed care plans. For example, how does the provider know that a coordinator has completed the

immunization pathway or that there are issues in medication management? We believe this tool could potentially have much added value if it is linked in some fashion to the patients' medical record and care plan.

Our state already is well served by a care coordination tool that provides real time information to providers through a standard care plan. This tool, Pre-manage, is in use by plans and providers and coordinates with many health care system EHRs. ***We believe the state could be well served by linking Pre-manage to the Pathways HUB work so that information can flow easily between the medical care coordinators and social service agencies working to coordinate care in the communities.***

The Pathways are capturing important information, but there is no systematic way of reporting the information at a regional or statewide level. Completion of the Pathway is a marker of success. It would, however, also be extremely valuable to understand the reasons that the Pathway was not completed, and to be able to easily compile that information at the ACH and across all ACHs. It would provide a feedback loop to understand if there are resource needs not currently being addressed in the area.

PROJECT 2C: TRANSITIONAL CARE (PAGES 29 THROUGH 35)

This also is a very promising area of focus. In several communities, with WSHA support, local providers have met to implement better communication and collaboration for patients discharged from the hospital to alternative care settings. Additional resources will help this work progress. There seems as if there could be overlap between the work done here and the work done in project 2B. Will the work be coordinated?

PROJECT 2D: DIVERSION INTERVENTION (PAGES 36 THROUGH 40)

As noted in the description, this project can build on the strong work done in ER for Emergencies that has been launched by WSHA, HCA, WA ACEP and WSMA. The project looks to divert patients from the ER through both work centered at the ER as well as community paramedicine. Are their current rules or laws or state payment practices that prevent transport services from taking patients to settings other than an ER? If so, this work would be enhanced if the state worked to address this issue upfront.

PROJECT 3A: ADDRESSING THE OPIOID USE PUBLIC HEALTH CRISIS (PAGES 41 THROUGH 48)

WSHA thinks some elements of this work should be supported by the state, via requests and potentially funding from the local areas, rather than through individual projects at the local level. For example, the state is best positioned to explore funding and regulatory enhancements to sustain and evaluate Drug Take Back programs. We also think that provider education, improved access to prescription data and reports could be better supported with enhancements to the Prescription Monitoring Program. ***These enhancements to the PMP should be implemented at the state level with support from the local ACHs. The state should help provide a venue for the ACHs to coordinate a discussion in order to determine if they would be well served by giving providers and public health officers in the community have access to better information.***

Dissemination and adherence to prescribing guidelines is essential to addressing the opioid crisis. While the AMDG and CDC guidelines are very similar there are slight differences. ***We believe both the AMDG and CDC guidelines are supported by strong clinical evidence and that communities should have flexibility in choosing what guidelines to adopt into their intervention strategy.***

We appreciate the acknowledgement of WSHA as a collaborative partner in helping to address the opioid crisis and look forward to working with our members, ACHs and other stakeholders in advancing meaningful policies or clinical practice change.

PROJECT 3B: MATERNAL AND CHILD HEALTH (PAGES 49 THROUGH 54)

WSHA, working with the Department of Health and other important partners, has created a safe deliveries roadmap. We ask that the Authority incorporate the important components of that roadmap into this work. For example, one important determinant for healthy babies can be achieved through an assessment, including depression screening, for the pregnant mother. This is an evidence-based approach to improving outcomes. It was not apparent to us that this has been included in the work under this project.

PROJECT 3C: ACCESS TO ORAL HEALTH SERVICES (PAGES 55 THROUGH 59)

Many rural areas do not have easy access to oral health services. WSHA is working with a number of our members that have rural health clinics and interested in providing this service, and supporting it through an enhanced clinic rate. We hope that options, such as this approach, can be considered as the Accountable Communities of Health look to increase services in their region.

PROJECT 3D: CHRONIC DISEASE PREVENTION (PAGES 60 THROUGH 64)

Many of our members, both rural and urban, are focused on better chronic care management, especially around diabetes. We appreciate the opportunity for enhanced support and collaboration at a regional level. One of the tools identified in this work are population health management/HIT tools. We are interested in how tools deployed here will interact with the tools used in the work for care coordination, transitions, and diversions. As we have stated above, we believe the tools need to be ones that work from a standard care plan, integrate easily with system's electronic health records, and can be used by multiple providers and coordinators.

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February 2, 2017

Washington State Health Care Authority
Via email: medicaidtransformation@hca.wa.gov

Re: Public comment - Medicaid Transformation Project Toolkit

The Washington State Medical Association appreciates the opportunity to provide comments on the draft Medicaid Transformation Project Toolkit.

As a general observation, the WSMA found the "*Context*" explanation (Page 1) to be useful. However, regarding "*Incentive Payments*" it is a concern that "*Additional information for how incentive payments are calculated and earned will be forthcoming but is not reflected in this toolkit*." For the Health Care Authority, and by extension the accountable communities of health (ACHs), to effectively engage the physician practice community, it is essential to offer sufficient details so that physician practices and other providers have a clear understanding of what will be expected of them in this initiative and the financial conditions affecting that participation.

The WSMA understands that those details are an adjunct to the core purpose of the Project Toolkit, yet those financial details ideally would have been made available concurrently during the commentary period for the Toolkit, so that both the Toolkit and the financial conditions could have been reviewed in tandem.

The WSMA did provide comments to the HCA in August 2016 on the Value-based Road Map (*copy attached*) regarding provider incentives, quality withholds, challenge pool, reinvestment pool, etc. So at this juncture, it is unclear if such mechanisms will be components of the financial conditions affecting the ACHs and their relationships with physician practices and other providers. It would be informative if the HCA could offer clarification on these points.

Here for your consideration are additional comments on the Project Toolkit.

Domains and strategies (Page 4)

As each ACH gets it footing, in both creating its own infrastructure and governance as well as engaging with the provider community within its region, we note the requirement "*ACHs must evaluate priorities and implement projects concurrently across all domains, as opposed to approaching the domains as sequential undertakings."* A concern is whether an ACH could potentially be overwhelmed in managing projects across all three Domains. What oversight process will HCA conduct to ensure that an ACH is effectively managing its projects concurrently? What mitigation strategies might HCA consider, should an ACH be experiencing difficulties in meeting its expectations?

Performance measurement (Page 5)

We note that Systemwide measures "*are to be monitored and reported at the state level and, where possible, at the ACH level. These measures should be reported at least annually, but if possible, at the same frequency as the project-level measures*" and that Project-level measures "*should be reported at the ACH level and, if possible and applicable, at the practice level. They should be reported as frequently as feasible and relevant; frequency may vary by measure*."

Whereas Project 3A: Addressing the Opioid Use Public Health Crisis is a "required" project, there is a concern that the *measures identified* so far specifically for this project, and the *frequency of reporting*, may be problematic. These measures are:

- Opioid Related Deaths (Medicaid Enrollees and Statewide) per 100,000
- Opioid Related Overdoses for Medicaid Enrollees per 100,000
- Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer
- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Opioids from Multiple Providers in Persons Without Cancer

The concern is that monitoring "deaths" and "overdoses" are after-the-fact measures and, while important for monitoring, will not allow providers to intervene and prevent such outcomes. Does HCA envision a more frequent monitoring and reporting schedule for opioid-related conditions?

We also note that related measures appear in Appendix I, yet those are associated with Project 2:

- Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence
- Substance Use Disorder Treatment Penetration
- Percent Arrested

So it is unclear how the coordination of these varying measures, in this opioid use example, will be monitored - and how frequently - and coordinated across Projects 2 and 3. We appreciate HCA's guidance noted on Page 4, and referenced above, "*ACHs must evaluate priorities and implement projects concurrently across all domains, as opposed to approaching the domains as sequential undertakings*."

That expectation that all Projects should be implemented concurrently is helpful, but it still leaves open as to how such coordination and monitoring can be effectively accomplished. We would appreciate knowing HCA's strategy on that point.

Regional Health Needs Inventory (Page 6)

We note the expectation "*Each ACH will be required to complete a comprehensive Regional Health Needs Inventory (RHNI) ahead of finalizing project implementation plans*" and *"(HCA) will package and provide relevant information to the ACH from various statewide data sets, to the fullest extent possible, to populate the RHNI*." It is unclear as to how these preliminary assessments fit with HCA's envisioned framework of ongoing monitoring and assessment.

What would be ideal we believe is a form of dashboard that captures the initial needs assessment, incorporates the monitoring of measures, and illustrates fluctuations in measures across a time continuum. Using a dashboard to illustrate those data would be a useful tool to all parties in assessing progress over time, compared to having a variety of standalone non-integrated reports. We encourage HCA to undertake the use of a dashboard for such reporting and monitoring mechanisms.

Statewide Value Based Payment Transition Taskforce and Workforce Development Taskforce (Pages 6&7)

While having advisory bodies can be informative, HCA and the ACHs should cautiously manage expectations, particularly when seeking the engagement of very busy physicians and practice staff. A key criticism we have heard relates to having "meetings" scheduled during patient contact hours, when it is fairly impossible for physicians and other practitioners to take time out of practice, as it limits their availability to see patients. We have found that early evening meetings, after practice hours, and ideally with teleconference or webinar access (to avoid any travel) can be successful in engaging physicians. Still, such scheduling can infringe on personal time. So, convening meetings only as frequently as are genuinely necessary is an important consideration.

Regarding the Statewide Value Based Payment Transition Taskforce, we note the responsibility of "*Serving in an advisory capacity to the further development and implementation of the HCA Value-based Roadmap and alignment to federal VBP/APM efforts*." We are very pleased to see this expectation. Physicians and practice staff are currently faced with learning the intricacies and requirements of the Medicare Part B MACRA program. So from their perspective, the concurrently implemented requirements of our state's Healthier Washington initiative are placing an extreme set of challenges onto physician practices and other providers. The degree to which these numerous requirements can be "aligned" (and preferably, identical, to avoid having too many competing requirements in play) across the Medicare and Medicaid universes would go far in lessening the administrative burden.

Regarding the other two bullet points on "*conducting a statewide assessment of value-based payment transition and readiness*" and "*identifying and recommending strategies to address stakeholder needs for education, training, and technical assistance*", the WSMA serves as a trusted education resource for physicians and practice staff and wishes to work closely and collaboratively with HCA and the ACHs on these goals.

Regarding the Statewide Workforce Development Taskforce, it is unclear as to whether this would be a newly created body or if HCA is referring to the Health Workforce Council of the state's Workforce Training and Education Coordinating Board (www.wtb.wa.gov/HealthWorkforceCouncil.asp) and its Health Workforce Sentinel Network (www.wtb.wa.gov/HealthSentinel/). If HCA is proposing a new entity, it is unclear as to how that new entity would interface and potentially overlap with the already existing state entities, and why there would be a need to create that new entity. We would appreciate HCA's clarification on those points.

Practice Transformation Support Hub (Page 7)

The WSMA has been working very closely with the Hub and its leadership. As the Hub is nearing its launch, the WSMA looks forward to its continued collaboration with the Hub.

Project 2B: Community –Based Care Coordination

Regarding this "*hub-based (or similar) model*" we note the remark "*The preferred model that includes these elements is Pathways Community HUB*." While the use of a standard platform has advantages for the management of data, our understanding is that Pathways Community HUB is a proprietary product, and therefore raises a question as to whether the HCA is effectively promoting a sole source vendor. We would appreciate HCA's clarification on that point.

The WSMA appreciates the opportunity to provide these comments.

Sincerely,

Bob Perna, MBA, FACMPE
Director, Practice Resource Center

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August 23, 2016

Dorothy Teeter
Director
Washington State Health Care Authority
626 8th Avenue SE; P.O. Box 45502
Olympia, WA 98507

Re: Value-based Road Map

Dear Ms. Teeter:

The Washington State Medical Association appreciates the opportunity to offer these comments and questions to you on the Health Care Authority's Value-based Road Map, which lays out the framework by which the state will move away from fee-for-service payments.

As that report explains, Washington state seeks to align value-based payment methodologies with the efforts of the Centers for Medicare & Medicaid Services already under development as part of the MACRA alternative payment models. The WSMA's understanding is that the Health Care Authority anticipates that its negotiations with the Centers for Medicare and Medicaid Service (CMS) for a Medicaid transformation waiver are expected to be finalized soon, with CMS' decision expected sometime in September. That waiver would allow the state to amend its current Medicaid plan with CMS and introduce the desired innovation strategies. If approved, HCA would move forward with "delivery service reforms and reward regionally-based care redesign approaches," and ultimately, by 2021, reach a threshold of 90 percent of its provider payments linked to quality and value.

Here are some facets of the state's Value-based Road Map on which the WSMA would appreciate receiving your office's further clarifications.

Withholds
Page 5 of the Road Map says, "To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums to be returned based on achieving a core subset of metrics from the statewide common measure set."

Managed care organizations are paid directly by HCA, and then most of those dollars should flow from the MCOs to the physician practices and other providers in return for providing services. In this new model, HCA would withhold a percentage of the premium dollars. Yet physician practices need to be paid for services they provide to pay their overhead expenses. It is unclear whether the MCOs may, in turn, withhold dollars from physician practices and assess the performance of physicians and practices on their achieving those quality and performance thresholds.

In the traditional fee-for-service model, HCA pays for services and assesses performance after the fact. In the value-based model, it appears the MCOs and the providers will need to wait for the measurement and reconciliation process to play out, in the hope of ultimately being paid what is due. Also, it is not clear how much additional operational expense that physician practices will incur in adapting to this model, including the added labor to perform those ongoing back-end reconciliation processes.

Time–limited incentives for MCOs and ACHs
Pages 5 and 6 state that the nine accountable communities of health *"*will also be able to structure incentive programs regionally to reward providers…" Under the Road Map redesign, the ACHs will have considerable latitude to devise region-specific incentive programs. Absent further details, it is not clear how those processes will function, and whether physician practices will be able to effectively participate. Will each ACH have its own unique system, or will the HCA provide some standardized structure for all ACHs to follow?

Provider incentives; quality withhold
Page 6 notes that "Beginning in 2017, MCOs must ensure that at least 0.75 percent of their premium is going to providers in the form of incentives…" In a subsequent communication, HCA staff explained that providers' ability to earn the incentive will be connected to their ability to "demonstrate quality improvement against the set of metrics either by hitting or exceeding a yet-to-be-determined target." HCA continues to develop those specifics. When might the provider community have access to those details?

Common measures
Page 6 addresses use of the state's common measures set. HCA staff subsequently explained they had identified the seven measures that will be tied to incentives via the 1 percent withhold for all 2017 Apple Health Medicaid contracts:

For children ages 20 and under:

1. Childhood immunization status (combo 10).
2. Well-child visits for children 3--6 years of age.
3. Medication management for asthma.

For adults age 21 and up:

4. Controlling high blood pressure.
5. Comprehensive diabetes care (HbA1c), poor control.
6. Comprehensive diabetes care: blood pressure control.
7. Antidepressant medication management: effective acute phase treatment and effective continuation phase treatment.

Yet it is still unclear as to how these measures will be linked to the incentives' calculations.

Challenge pool, reinvestment pool
Page 7 notes the funds for these two pools would be drawn from *"Unearned VBP incentives from the waiver and uncollected withhold payments from managed care premiums."* This appears to say that HCA does not expect all targets to be met, and as a result, some dollars will not be earned and therefore remain unclaimed via the mechanisms noted above. Those dollars would be redirected to these two pools, from which it appears HCA will draw dollars unclaimed by losers to reward winners. Yet it is not clear how transparent the HCA's process will be in assigning funds to these two pools.

Thank you for considering these points. We look forward to your reply.

Sincerely,

Ray Hsiao, MD
President

cc: WSMA Executive Committee
MaryAnne Lindeblad
Preston Cody
Nathan Johnson