About the Framework for the Project Toolkit

Introduction

Transformation Projects, led by Accountable Communities of Health (ACHs)[1], are a key component of Initiative 1 of Washington's Medicaid Transformation waiver and a critical lever to help the state meet its Medicaid transformation goals. The Medicaid Transformation waiver will build upon and accelerate the foundational delivery system transformation work underway in Washington State.

Through this waiver demonstration, the state is asking our federal partners to allow Medicaid funding to be used to incentivize providers to pursue activities in support of delivery system reform. These incentives are structured through transformation projects that are intended to address the state's vision for Healthier Washington and to support the delivery system in meeting the needs of our Medicaid population. To provide guidance and parameters for the transformation projects, the state is developing a project toolkit.[2]

The **transformation project toolkit** provides guidance on the transformation projects eligible for funding under Initiative 1 of the waiver demonstration. It will reflect the strategies—inspired by the submitted project ideas, chosen by the state and ultimately approved by CMS—that ACHs will use to develop Medicaid transformation project plans. Funding will be available for projects in the toolkit upon completion of pre-determined milestones and metrics.

The following framework draws heavily from the transformation project ideas submitted to HCA in January, as well as input from our stakeholders and partners. This framework has also been informed by the project toolkits approved by CMS for New York and California.[3] This document is not meant to be a comprehensive or limiting list of project details within each of the domains, and is not the final project toolkit. Rather, it outlines the key strategies the state believes are necessary in order to achieve the Medicaid Transformation goals.

Transformation Projects must promote systems-based approaches to improving health by incorporating and addressing social determinants of health and increasing the efficiency and effectiveness of healthcare. By making improvements in care and health for our Medicaid clients, we can catalyze improvements throughout the entire health care delivery system. While there are many gaps in our health system that need and deserve further investment, the Medicaid Transformation waiver will focus on activities aimed at changing the structure and incentives in the health care system that affect our Medicaid clients to encourage quality and efficiency, and promote more cost-effective care.

[1] Our use of the term ACH throughout this document includes participants and partners. It is not intended to mean the organization that performs administrative functions for the ACH and is also not meant to imply a preferential status for some in the region over others.

[2] *Project toolkit* is a term used in other states that are undertaking major Medicaid Transformation efforts through Section 1115 waiver authority. It is often a waiver demonstration requirement requiring approval by the Centers for Medicare & Medicaid Services (CMS).

[3] For example; New York Toolkit: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf; California Toolkit: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf.

Purpose of the Framework

This is not the final project toolkit. Rather, this framework document is an outline from which the final toolkit will be built. The final toolkit will serve as the guide for transformation projects after the waiver proposal is approved by CMS. This framework reflects the project elements we have prioritized for the toolkit, and the project-specific objectives and outcomes envisioned.

Value-based Payment

The movement toward value-based payment models is critical to the success and sustainability of this waiver demonstration. To ensure that progress toward a transformed care delivery system, funded through the waiver, is sustained well beyond the 5-year demonstration period, we must change the way we pay for services. The state and federal governments have an expectation that transformation projects will reinforce the shift to paying for value over volume. The transition to value-based payment models is an over-arching goal for Initiative 1. To that end, projects will need to support building provider and plan capacity to achieve systemic change in how services are reimbursed.

Project Idea Submissions

Consistent with our commitment to a process that is informed by our stakeholders and partners, we asked the community for project ideas to ensure that the transformation project toolkit reflects community needs as well as Medicaid Transformation goals. The level of interest and engagement in that exercise was astounding; we received over 180 project ideas from across the state. Those ideas are available on our website for viewing.

We appreciate the hard work that went into completing templates for those project ideas. In the course of developing the project framework and defining the project rationale, goals, and objectives, we drew heavily from the major themes present in the ideas that were submitted. Many of the core components that will be specified in the toolkit will be based on those identified in project ideas. It is important to note that, while many of the project elements are drawn from submitted ideas, *no project idea will appear in the toolkit in the same form as originally submitted*. We will continue to review the idea submissions as we build the project toolkit.

It is important to note that many of the details included in the idea submissions will not be reflected in the final toolkit. Some of the project ideas contained elements that would not be eligible for incentive payments under the Medicaid Transformation waiver because they included:

- Duplicate services funded under the Medicaid state plan.
- Activities that overlap with the Medicaid Alternative Care (MAC) and Targeted Supports for Older Adults (TSOA) benefits under Initiative 2 of the waiver proposal.
- Activities that overlap with targeted supportive housing and supported employment benefits under Initiative 3.
- Activities that do not support predominantly Medicaid-eligible populations.

We encourage community partners to continue to engage their Accountable Communities of Health (ACHs) in discussions about regional needs related to the project areas identified in this framework document. For ideas that are not reflected in this framework, regions may have other means to support the pursuit and achievement of those goals.

Project Toolkit Overview

The project toolkit will provides guidance on transformation projects and provide ACHs with the details necessary to develop transformation project plans. This framework document serves as the outline for the eventual project toolkit. In the toolkit, each project description will include:

- **Project** title denoting the key strategies and activities designed to support communities and provider organizations as they change care delivery to maximize health care value.
- **Rationale** for the proposed project (evidence base and reasoning behind the project).
- **Objectives and outcomes** of the project (the project-specific goals and expected project outcomes).
- **Core components**, or key project elements, to guide development and implementation.
  The core components will provide approaches or elements that participating providers will be expected to adopt as they develop and implement projects. Most of these elements will be necessary to achieve the required results. In this way, the core components will promote standardization across Medicaid Transformation activities, while allowing regional flexibility to tailor projects to meet local needs. For example, a core component of bi-directional integration of care might be to *implement an integration assessment tool to provide baseline information and annual progress measurement*.
- **Metrics** required for the project. Participating providers will earn incentive payments based on performance on the project metrics.

The **rationale** and **objectives and outcomes** of the projects are provided in this framework document.

The **core components** and **project metrics** are not included in this document but represent the critical next steps toward completing the project toolkit. We expect to use the common measure set because it is foundational to this work.

Tribal-specific Projects

The State takes seriously its government-to-government relationship with Tribes and its responsibility to seek advice from Indian Health Service, Tribally operated facilities, and Urban Indian Health Organizations (I/T/Us) on its waivers. While the Accountable Communities of Health (ACHs) are intended to lead the State's efforts with respect to Medicaid Transformation, the State has contracted with the American Indian Health Commission for Washington State (the Commission) to help determine whether and how the Tribes and I/T/Us in Washington State wish to engage with the ACHs and if the Tribes and I/T/Us would like a separate Tribal entity or entities with which to work on Medicaid Transformation. In connection with these efforts, the State and the Commission will gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost-effective care.

Next Steps

This framework document will be shared with CMS as part of ongoing negotiation discussions. We also invite our stakeholders to participate in a short survey to help inform the next steps of this process. The survey will be posted on our website on Wednesday, April 27, 2016 and will be available until Friday, May 27, 2016. If you have questions or comments regarding this framework, please send them to medicaidtransformation@hca.wa.gov.

We plan to address questions during our next webinar in the Medicaid Transformation series on April 26, 2016 from 10 a.m. to 12 p.m. For more information and registration details, please visit our website: http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx.

Thank you.

Framework for the Project Toolkit

Transformation Projects, led by Accountable Communities of Health, are a key component of Washington's Medicaid Transformation waiver and a critical lever to help the state meet its Medicaid transformation goals. Following is a draft project framework, drawing heavily from the transformation project ideas submitted in January, as well as input from our stakeholders and Tribal partners. This framework has also been informed by the project toolkits approved by CMS for New York and California.[4]

There are three domains and an over-arching expectation of support, across all of the domains, for the transition of Medicaid services to value-based payment. The domains for transformation projects are:

- Health systems capacity building
- Care delivery redesign
- Prevention and health promotion

The domains are not mutually exclusive. Projects in one domain may reference or support a project in another domain. This is particularly true for projects under Domain 1 which must directly reinforce other transformation projects. This means that projects related to workforce, primary care models, and data collection and analytic capacity must support and demonstrate a direct connection to activities undertaken in Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion).

The project framework is not meant to be a comprehensive or limiting list of project details within each of the domains, but rather an illustration of the key strategies the state believes are necessary in order to achieve the Medicaid Transformation goals.

Note that there is a placeholder section reserved for projects specifically targeted to American Indians/Alaska Natives (AI/ANs). The State has contracted with the American Indian Health Commission for Washington State to gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost-effective care; these projects and activities will be incorporated later in the project toolkit development process.

[4] For example; New York Toolkit: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf; California Toolkit: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf.

Support for the transition to value-based payment
Consistent with the Healthier Washington goal of having 80% of state payments tied to value by 2019, as well as CMS expectations for the Medicare and Medicaid programs, Medicaid transformation efforts must contribute meaningfully to moving Washington forward on value-based payment (VBP). Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation waiver. 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. To that end, significant financial incentives will be established for attainment of VBP targets over the five-year demonstration at the regional ACH and managed care plan levels. Incentives will support provider and plan capacity in achieving systemic change in how services are reimbursed. In addition, there will be opportunities to explore the relationship of each of the project domains to value-based payment.

Domain 1: Health Systems Capacity Building
Health system capacity must be enhanced in order to support the level of delivery system change called for in Washington's Medicaid Transformation waiver. This domain focuses on strategies and projects to build that system capacity, including health information technology to support integration and collaboration among providers and systems; data analytics capacity to track and improve quality and cost; and projects to increase the capability and flexibility of the provider workforce to ensure health care teams have the necessary composition to deliver team-based coordinated care. To ensure funds for transformation projects are effectively leveraged, all projects in Domain 1 must demonstrate a direct connection to Domain 2 (Care Delivery Redesign) and/or Domain 3 (Prevention and Health Promotion), or must support providers in developing the capabilities necessary to operate in value-based payment models.

Project	Rationale	Objectives and Outcomes
Primary Care Models	Primary care teams are undergoing substantial changes in order to deliver whole-person care efficiently and effectively, and to transition to value-based payment models. This strategy focuses on supporting existing efforts for primary care practices undergoing transformation.	• Implement evolved models for primary care practices to provide whole-person care. • Ensure health systems have efficient and reliable access to community resources that address social and personal needs for effective treatment. • Develop advanced care planning materials for client education to support care and treatment consistent with clients' goals and values. • Improve client experience of care. • Provide educational and coaching sessions on how to provide effective palliative care. • Ensure provider teams are well equipped with resources to facilitate seamless specialty referrals or behavioral health referrals. • Promote early identification, diagnosis and disclosure of cognitive impairment and dementia.
Workforce and Non-conventional Service Sites	Provides support for changes in the workforce, including training and education, or facilities needed to evolve systems to team-based, patient-centered care and ensure the equity of care delivery across the population.	• Expand use of telemedicine in rural and underserved areas. • Expand Community Health Worker/Peer Support/Long-term Care workforce. • Provide clinical and staff training/technical assistance to successfully implement care delivery redesign and prevention and health promotion projects. • Improve care quality and increase health systems capacity to prepare for future increases in our aging population.
Data Collection and Analytic Capacity	Support the evolution of electronic health records and health information exchanges to improve the speed, quality, safety, and cost of care. This includes linkages to community-based care models.	• Identify and evaluate necessary technology and tools for information exchange. • Implement health information technology and/or health information exchange projects to support coordinated,

	Improve data and analytics capacity to support health systems transformation, including combining clinical and claims data to advance value-based payment models and to achieve the triple aim.	person-centered care while incorporating relevant social determinants of health. • Ensure interoperability of health data to support care delivery.

Domain 2: Care Delivery Redesign		
Health care delivery systems are critical to achieving the goals of Medicaid Transformation. This domain focuses on system-wide connections to improve the quality, efficiency and effectiveness of clients' care and includes investments in projects that are the foundation of delivery system change. Strategies emphasized under this domain include integration of behavioral and physical health care; ensuring effective care coordination, including client outreach and engagement, that reaches those who need it most; improving transitions of care to improve outcomes and reduce costs; and supporting care models that are person-centered while strengthening partnerships between clinics and community-based supports.		
Project	**Rationale**	**Objectives and Outcomes**
Bi-directional Integration of Care	The Medicaid system aims to support person-centered care that delivers the right services in the right place at the right time. Challenges remain in achieving coordinated care across complex healthcare systems; these can be a major obstacle to care. Primary care services are a key gateway to the behavioral health system, and primary care providers need additional support and resources to screen and treat individuals for behavioral health care needs, and make appropriate referrals. Similarly, for clients not easily engaged in primary care settings, behavioral health settings should be equipped to provide for effective primary care as needed. The key point is that physical and behavioral health problems often occur together. Integrating services to treat both will yield the	• Spread and sustain effective models of integrated physical and behavioral health care. • Improve physical and behavioral health outcomes, care delivery efficiency, and client experience by establishing or expanding fully integrated care teams—i.e., primary and behavioral health care providers delivering coordinated, comprehensive whole-person care. • Enhance and more effectively support existing state programs, including Health Homes, without duplicating programs or services. • Address the needs of clients not easily engaged in primary care settings and support individuals needing a more intensive level of behavioral healthcare. • Improve clients' adherence to treatment regimens. • Improve population management and multi-tiered/stepped care

	best results and be the most effective approach for those being served. Effective bi-directional models of integrated care will include the systematic coordination of physical and behavioral healthcare. Integrating mental health, substance use disorder, and primary care services has been demonstrated to deliver positive outcomes and is an effective approach to caring for people with multiple healthcare needs.	approaches that provide increasing levels of specialty care involvement when a client is not improving as expected.[5] • Improve communications and protocols between different provider types and organizations. Provide basic health screening, access to physical health information, active coordination with primary care providers, and team-based care. • Reduce avoidable intensive services and settings. • Improve client experience with health services. • Improve crisis systems and diversion programs, reducing avoidable institutionalization in emergency departments and jail settings.
Care Coordination	Care coordination is essential for the health management of defined populations, especially those living with chronic health conditions. It involves bringing together various providers and information systems to coordinate health services, foundational community supports, and information to better achieve the goals of treatment and care. Care coordination efforts must be well-integrated at the regional level and collaboratively focused on improving the quality and efficiency of care coordination. If various coordination efforts are not linked, these well-intentioned efforts may perpetuate a fragmented and confusing health system. Many care coordination efforts face challenges in outreach and engagement that negatively impact client	*This strategy focuses on the implementation and/or improvement of care management models that facilitate the appropriate coordinated delivery of health care services and foundational community supports. Although projects cannot duplicate care coordination currently provided under Medicaid, they can link to and support these efforts as well as ensure local coordination. These activities must meet the clients' needs and preferences and result in improvements in clients' health outcomes.* *Outreach and Engagement* • Develop programs for outreach, engagement and retention of clients who are either not utilizing the health care system or who are utilizing the system ineffectively or inappropriately; link to care management activities. • Reduce unnecessary emergency department utilization by

[5] http://aims.uw.edu/all-hands-deck

	retention. Clients who are unwilling or do not understand how to access and effectively use the health care system cannot be expected to engage in the services necessary to meet their health care needs or access appropriate, less costly services as alternatives to emergency room care.	identifying high EMS utilizers and engaging community paramedics in care management efforts. • Support clients in accessing health care and in gaining self-confidence in managing their health. • Ensure clients' active participation in decision-making. • Assure cultural sensitivity. *Care Management* • Provide strong care coordination that does not duplicate existing services to better meet the needs of higher-risk clients. • Facilitate enhanced collaboration and efficiency between care coordination programs by linking and aligning care coordination efforts and providers. • Promote shared learning across providers by identifying best practices, shared resources, and technology solutions. • Develop reliable, replicable systems for linking people with both clinical care and community-based sources. • Increase referrals and use of community supports and services by creating clinical-community linkages. • Develop dementia-capable resources so health care professionals can support care coordination efforts. • Develop advanced care planning materials for client education to support care and treatment that is consistent with clients' goals and values.
	Connecting clients to dental care is a key priority for many regions across the state. Medicaid clients account for a significant portion of all ED dental visits. The incidence of oral disease is also disproportionately high among low-income communities.	*Oral Health Coordination (optional project as part of care coordination efforts)* • Increase the network of dental providers accepting Medicaid. • Connect clients with appropriate dental appointments and provide coaching to ensure clients are ready for appointments.

Care Transitions	Transitions out of intensive services and settings and into the community are critical intervention points in the care continuum. While some readmissions are appropriate, many are due to events that could have been avoided. Individuals discharged from intensive settings may not have a stable environment to return to or lack access to reliable care. Transitions can be especially difficult on clients and caregivers when there are substantial changes in medications or routines, or an increase in care tasks. Robust transition plans provide opportunities to help individuals avoid readmissions and achieve whole-person health. This strategy identifies system-specific gaps in care transition. It takes a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Investment in care transition programs will support parallel care coordination efforts.	• Improve the coordination and continuity of care as high-risk patients, with chronic health conditions, behavioral health conditions, and/or housing instability move out of intensive services and settings. • Improve individuals' ability to care for themselves and providers' ability to effectively hand off health care responsibility to the appropriate provider, • Optimize an individual's course of chronic illness, ultimately reducing avoidable utilization of intensive services and settings. • Improve referral pathways to housing providers so those in need of medical respite are connected to permanent supportive housing. • Ensure that interruptions in client housing and/or employment as a result of hospital or institutional stays do not result in homelessness or long-term unemployment after discharge.

Domain 3: Prevention and Health Promotion		
This domain focuses on prevention and health promotion for Medicaid beneficiaries with a strong focus on improving health equity. These strategies will target clinical and community prevention that is coordinated and whole-person centered. A transformed delivery system design will contain improved approaches to engage individuals in personal health behavior change based on their needs and service preferences at the time.		
Project	**Rationale**	**Objectives and Outcomes**
Chronic Disease Prevention and/or Management	A wide array of chronic health conditions is prevalent among Washington's Medicaid clients, and the number of individuals with or at risk of chronic disease is increasing. Disease prevention and effective self-management is critical to individuals' quality of life and longevity. However, many individuals face cultural and linguistic barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health. Improving health care and health behaviors is only part of the solution. Washington State recognizes the impact that factors outside the health care system have on health and is committed to a "health in all policies" approach to effective health promotion and improved treatment of disease. This strategy will focus on supporting those living with chronic health conditions, engaging them in active management of those conditions, and preventing chronic health conditions by working across sectors.	• Support those living with chronic health conditions, such as asthma, depression, high blood pressure, and diabetes to effectively manage their conditions to improve their health and prevent complications. • Identify existing community resources that provide targeted services for clients with chronic health conditions, creating linkages and connecting or referring clients to those resources, including those that address the social determinants of health. • Take an interdisciplinary approach to identifying culturally competent, cost-effective, evidence-based approaches to the prevention of and/or care for clients with chronic disease. • Reduce disparities in receipt of targeted prevention services. • Increase rates of screening and completion of follow-up across targeted prevention services. • Expand the availability of chronic disease self-management programs and assist individuals in increasing their self-management skills. • Implement obesity and food insecurity screening tools and procedures for referral to treatment and community resources for pediatric and adult populations.

Maternal and Child Health	Maternal and child health is a focus for the Medicaid program since it funds more than half the births in the state and provides coverage to more than half of Washington's children. This strategy focuses on supporting and promoting better health for this population and targeting unmet health needs that contribute to high costs in the health system, including interventions to mitigate the prevalence of adverse childhood experiences for vulnerable populations.	*Promoting improved birth outcomes and early childhood health* • Promote a "no wrong door" approach to ensure that women can get their needs met wherever they come into contact with the health system. • Increase provider training on how to incorporate reproductive life planning into routine health screening to help women fulfill their pregnancy intentions. • Identify and offer health education and increased access to treatment or services for women at risk for poor health or birth outcomes. • Reduce avoidable poor pregnancy outcomes and improve maternal and child health through the first years of a child's life. • Increase support programs for maternal and child health. • Improve maternal and child health outcomes through home visits, pre-natal screenings, and postpartum health status assessments. • Combine case management and preventive services for mothers and children. *Promoting Trauma-Informed Approaches to Care* • Focus on interventions to mitigate the instances and intergenerational transition of Adverse Childhood Experiences (ACEs). • Expand outreach and engagement to children and families affected by ACEs. • Increase system awareness and skills for addressing trauma from ACEs. • Promote the uniform application of practice skills informed by trauma care principles.

Tribal Specific Strategies/Project(s)
Health care for American Indians/Alaska Natives (AI/ANs) presents different strengths and challenges and needs different investments to encourage quality and efficiency and promote more cost-effective care. The federal trust responsibility for AI/ANs applies to all federal agencies. While the Indian Health Service (IHS) is the primary agency to meet this trust responsibility with respect to health care, IHS has also suffered since its inception from severe underfunding. In contrast, over the years, Congress has expanded the ability of IHS to receive reimbursement from Medicaid—even clarifying that IHS is the payer of last resort. Within these historical developments, more and more Tribes have taken over the administration of their health care programs under the Indian Self-Determination and Education Assistance Act, as amended—enabling them to coordinate health care and social services. As a result of this complex history, IHS Service Units, Tribally operated facilities, and Urban Indian Health Organizations (together, the I/T/Us) have developed, to varying degrees, the very system-wide connections and whole person health care which the Medicaid Transformation Waiver is intended to help develop. The State takes seriously its government-to-government relationship with Tribes and its responsibility to seek advice from I/T/Us on its waivers. While the Accountable Communities of Health (ACHs) are intended to lead the State's efforts with respect to Medicaid Transformation, the State has contracted with the American Indian Health Commission for Washington State (the Commission) to help determine whether and how the Tribes and I/T/Us in Washington State wish to engage with the ACHs and if the Tribes and I/T/Us would like a separate Tribal entity or entities with which to work on Medicaid Transformation. In connection with these efforts, the State and the Commission will gather information on what projects and activities are needed to encourage quality and efficiency and promote more cost effective care. One likely candidate is infrastructure investment to improve the increasing number of data interfaces between the I/T/Us and the non-I/T/U providers and payers, including Medicaid.