Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Identify point person, telephone number, e-mail address:* **Jackie McPhee, Director, Children's Village, (509) 574-3200, JackieMcPhee@yvmh.org** *Which organizations were involved in developing this project suggestion?* **Greater Columbia Accountable Community of Health and Seattle Children's**
Project Title	*Title of the project/intervention:* **Coordinated care for Medicaid and dual eligible children with special health care needs (CSHCN)**

Rationale for the Project

Include:

- *Problem statement – why this project is needed.* **The U.S. Department of Health and Human Services defines CSHCN as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services [including care coordination] of a type or amount beyond that required by children generally."[1] Yet only 41.4% of publicly insured CSCHN in Washington State receive coordinated care.[2]**
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **The Washington State Institute for Public Policy (WSIPP) has identified "patient-centered medical homes [which includes coordinated care] for high-risk populations" as an evidence-based policy that can lead to better outcomes.[3]**
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) Increase and strengthen coverage of low income individuals as it will provide coordinated care for Medicaid and dual eligible CSHCN; 2) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations as it will coordinate care for Medicaid and dual eligible CSHCN across providers; 3) improve health outcomes for Medicaid and low-income populations as coordinated care improves behavioral health outcomes for CSHCN;[4] and 4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as coordinated care improves satisfaction for parents of CSHCN.[4]**

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

- ☑ **Reduce avoidable use of intensive services**
- ☐ Improve population health, focused on prevention
- ☑ **Accelerate transition to value-based payment**
- ☑ **Ensure Medicaid per-capita growth is below national trends**

Which Transformation Project Domain(s) are involved? Check box(es)

- ☑ **Health Systems Capacity Building**

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2009–2010.* Rockville, MD: Author, 2013.
[2] Source: Health Resources and Services Administration. Accessed December 2015 at http://www.childhealthdata.org/learn/NS-CSHCN.
[3] Source: WSIPP. Accessed December 2015 at http://www.wsipp.wa.gov/BenefitCost/Program/486.
[4] Wise PH, Huffman LC, Brat G. *A Critical Analysis of Care Coordination Strategies for Children With Special Health Care Needs.* Rockville, MD: Agency for Healthcare Research and Quality, 2007.

☑ **Care Delivery Redesign**

☐ Population Health Improvement – prevention activities

Describe:

- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).* **The project will impact Medicaid and dual eligible CSHCN in Yakima County.**
- *Relationship to Washington's Medicaid Transformation goals.* **The project will: 1) Reduce avoidable use of intensive services and settings as coordinated care decreases hospital admission, length of stay, and readmission for CSHCN;[4] 2) Accelerate the transition to value-based payment (payment model 2, encounter-based to value-based) as Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals provide services for CSCHN; and 3) Ensure that Medicaid per-capita cost growth is two percentage points below national trends as the benefit to cost ratio of patient-centered medical homes for high-risk populations is $8.16.[3]**
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity/reducing health disparities.* **The project goal is to coordinate care for Medicaid and dual eligible CSHCN in Yakima County. Care Coordinators will provide comprehensive care management, care coordination, health promotion, comprehensive transitional care (including appropriate follow-up), individual and family support, and referral to community and social support services; and will use health information technology to link services as appropriate. Expected project outcomes include a reduction in potentially avoidable emergency department visits, the percent of patients with five or more visits to the emergency room without a care guideline, annual state-purchased health care spending growth relative to state GDP, Medicaid per enrollee spending, and inpatient utilization. While 43.7% of non-Hispanic CSHCN in Washington State receive coordinated care, only 36.0% of Hispanic CSCHN in Washington State receive coordinated care.[2]**
- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.* **Part C of the Individuals with Disabilities Education Act and Title V of the Social Security Act provide limited care coordination funding for CSHCN.[5] The Health Home program provides care coordination funding for high-cost/high-risk Medicaid children, but at the time of submission, will only continue through June 2016.[6]**
- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.* **The project will engage business, community- and faith-based, consumer, education, food system, health care provider, hospital (including Seattle Children's), housing, local government, philanthropy, public health, social services, transportation, and tribal organizations in Yakima County.**

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* **Proposed activities include comprehensive care management, care coordination, health promotion, comprehensive transitional care (including appropriate follow-up), individual and family support, and referral to community and social support services; and the use of health information technology to link services as appropriate. The cost estimate is $283,986 per year (3,506 participants x $81 per participant.)**
- *Best estimate (or ballpark if unknown) for:*

[5] Association of Maternal and Child Health Programs. *Reaching the Children: The Relationship Between Title V and Part C.* Washington, D.C.: Author, 2003.

[6] Source: Washington State Health Care Authority. Accessed December 2015 at http://www.hca.wa.gov/medicaid/health_homes/Documents/continuation_of_health_homes.pdf.

  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. **The Children's Village will serve an estimated 3,506 Medicaid and dual eligible CSHCN per year.**
  - How much you expect the program to cost per person served, on a monthly or annual basis. **The WSIPP estimates that patient-centered medical homes for high-risk populations cost $81 per participant per year.[3]**
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* **The project is already operating in the region.**
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* **The WSIPP estimates that patient-centered medical homes for high-risk populations benefits minus costs (net present value) is $579 per participant per year, so the estimated ROI per participant per year is $660 total benefits - $81 costs / $81 costs = 715%.[3]**

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47.* **Process measures will include the number of Medicaid and dual eligible CSCHN in Yakima County who receive care coordination. Outcome measures will include the percentage of Medicaid and dual eligible CSHCN who have potentially avoidable emergency department visits, have five or more visits to the emergency room without a care guideline, and have inpatient utilization; and the annual state-purchased health care spending growth relative to state GDP and Medicaid per enrollee spending.**
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? **County-level benchmark performance data are available for the *Washington State Common Measure Set for Health Care Quality and Cost.***

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Contact Information	*Identify point person, telephone number, e-mail address:* **Bertha Lopez, Community Health Senior Director, Yakima Valley Memorial Hospital, (509) 249-5266, BerthaLopez@yvmh.org** *Which organizations were involved in developing this project suggestion?* **Greater Columbia Accountable Community of Health**
Project Title	*Title of the project/intervention:* **Care coordination for Medicaid and dual eligible beneficiaries with chronic disease**
Rationale for the Project	
Include: • *Problem statement – why this project is needed.* **Compared to the adult population in Washington State, the adult population in Yakima County is more likely to have asthma (12.5% compared to 9.7%), diabetes (10.3% compared to 8.8%), chronic obstructive pulmonary disease (8.1% compared to 5.7%), kidney disease (4.8% compared to 3.2%), depression (26.6% compared to 22.3%), had any permanent teeth extracted (44.0% compared to 38.5%), and had all natural teeth extracted (16.8% compared to 11.0%); and to be obese (31.4% compared to 26.8%) and current smokers (20.1% compared to 17.2%).[1] The National Prevention Council recommends enhancing the coordination and integration of clinical, behavioral, and complementary health strategies to reduce death and disability.[2]** • *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **The Washington State Institute for Public Policy (WSIPP) has identified "patient-centered medical homes [which include coordinated care] for high-risk populations" as an evidence-based policy that can lead to better outcomes.[3]** • *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) increase and strengthen coverage of low-income individuals as it will provide coordinated care for Medicaid and dual eligible beneficiaries with chronic disease; 2) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations as it will coordinate care for Medicaid and dual eligible beneficiaries with chronic disease across providers; 3) improve health outcomes for Medicaid and low-income populations as coordinated care reduces chronic disease morbidity and mortality;[4] and 4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as coordinated care reduces cost of care for adults with chronic disease.[4]**	

[1] Source: Centers for Disease Control and Prevention. Accessed December 2015 at https://chronicdata.cdc.gov/health-area/behavioral-risk-factors.
[2] Source: National Prevention Council. Accessed December 2015 at http://www.surgeongeneral.gov/priorities/prevention/strategy/clinical-and-community-preventive-services.html.
[3] Source: WSIPP. Accessed December 2015 at http://www.wsipp.wa.gov/BenefitCost/Program/486.
[4] Source: Agency for Healthcare Research and Quality. Accessed December 2015 at http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/evidence-based-reports/caregap.pdf.