Washington State Innovation Models (SIM) Operational Plan Update
Award Year 4

Round 2 Model Test Awardee – December 1, 2017

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Contents

A. SIM Project Summary Award Year 3

1. Summary of Model Test

The Healthier Washington State Innovation Models (SIM) grant has been a crucial investment in transforming the health system in our state to deliver better care, realize healthier populations and achieve smarter spending. Washington State is grateful for the $65 million in investment, allowing us to catalyze much of the work that had already been started, or was in idea form awaiting the arrival of resources.

A LOOK BACK

While health systems transformation and innovation work had already begun in Washington State before SIM resources were available, the SIM round 1 planning grant and the SIM round 2 test grant set in motion these efforts to be structured, scaled, and maximized. Throughout this work, our guiding stars have remained the same: Using our three strategies of health care integration, value-based payment, and community partnership. These strategies would lead us to achieve the Triple Aim of better health, better care, and lower costs for all Washingtonians. By design, there is significant overlap in the strategies, which allows for a systems approach to transformation. For example, integration of physical and behavioral health involves innovative and value-based financing approaches, which are achieved through the strengthening of community partnerships to care for the whole person and support financial risk through provider and community supports.

We started our four-year SIM grant with a pre-implementation year, focused on building upon the pre-test assessment of the landscape for transformation in our state, getting our flagship programs up and running, and planning for how the majority of the SIM investment would be coordinated. As can be read about in detail from our Award Year 1 Annual Report, highlights from the pre-implementation year include the designation of all nine Accountable Communities of Health (ACHs) aligned with the state's regional service areas for purchasing, design and implementation of our Healthier Washington governance structure across agencies, active participation from health system leaders as part of our Health Innovation Leadership Network, the launch of our Accountable Care Program (Payment Model 3) for PEBB members and their dependents, and the final assessment report of the Legislative Adult Behavioral Health System Task Force, which paved the way for Payment Model 1, or integrated managed care across Washington State by 2020.

SIM year 2, the first test year of the program, continued our efforts to move strategy to action, and was a balanced mix of both planning and implementation. Highlights from the first implementation year include greater maturity and functioning of ACHs, the go-live of integrated managed care in the Southwest region, the establishment of a financial model for our rural value-based payment demonstration, the expansion of our Accountable Care Program, a definitive direction for our value-based payment data strategy pilot, and the selection of a contractor for our Practice Transformation Support Hub services, Qualis Health, as well as the beginning of Hub coach/connector services and the unveiling of the Hub provider resource portal.

SIM Award Year 3 has largely been focused on implementation, impact, value, and partnership. We've launched all of our projects, including payment models 2 and 4, our Accountable Communities of Health are mature and self-governing, and we've been able to build our Accountable Care Program into the business of the Health Care Authority.

More important than the success of our individual programs, we've also taken a global look at our initiative through the development of a Healthier Washington sustainability framework that elevates value-based payment as the forerunning strategy for health systems transformation, supported by all of the other strategies, supports, and drivers to achieve sustained and lasting change. This framework can be applied to the holistic system of efforts, and will dictate how we think about what gets left behind when the grant period has ended. Instead of sustaining individual programs, we plan to sustain a community health system firmly rooted in the opportunity and incentives provided by value-based payment and its supports. Our partners and stakeholders across the state are working with one another and the state in different ways, and will continue to be a critical voice in this process.

THE ROAD AHEAD

As Healthier Washington turns toward the fourth and final year of the SIM grant, the focus shifts from investments and activities linked to implementation. The work now includes moves toward sustaining the transformations introduced into the health system, assessing the sustainability of our programs, models, and transformation supports and building them into state infrastructure, and understanding the impact of our efforts through evaluation.

Our budget for SIM in Year 4 is significantly smaller than previous years. This ramp-down is intentional, forcing us to be lean in our operations and find creative ways to sustain the initiatives that bring value. We will rely heavily on the voices of our partners and stakeholders, the internal subject matter experts at our state agencies, and the technical assistance knowledgebase offered to us by CMMI to ensure that we engage in smart spending practices and wise resource decisions.

Sustainability is key to our work in AY4, and while we are always thinking about the sustainability of our different programmatic efforts, we have developed a sustainability framework that conceptually addresses how the system itself will be sustained in transformation, allowing us to think less about what models and programs will be sustained and instead about what key system elements will be left behind. The key to this model lies in the distinction between the mechanisms and processes that are core to sustainability, and the supportive elements that foster the success of these core mechanisms. We consider value-based purchasing and payment to be a primary driver of health systems transformation sustainability, which supports and is supported by community partnerships and clinical-community linkages, clinical practice transformation, data and analytics, health information technology and information exchange, and person and family engagement. This framework allows our agencies and community partners to fully participate in the work necessary to sustain our transformation and achieve the Triple Aim.

SMARTER SPENDING: INNOVATIVE PAYMENT MODELS

In AY4 our value-based payment initiatives will continue to gain traction. The Accountable Care Program has already been built into the operations of the Health Care Authority (HCA), and SIM-funded staff will continue to provide strategic consultation to the program in order to foster increased enrollment, support contract renewals with the two participating provider networks, monitor and react to performance metric results, and take feedback from members and providers. All of these efforts will contribute to strengthening the program and solidifying it in the benefits portfolio for public employees and retirees in Washington State.

Our Payment Model 2 APM4 work is in a similar place of agency support, with no need for additional SIM contract funding in AY4. The Federally Qualified Health Centers that signed on to participate in the new payment methodology will submit the required data for performance measurement while working to find new and innovative ways to provide care to Washingtonians who seek primary care through these providers. The AY4 work for this part of Model 2 will be to ensure it remains viable within the HCA, with insight and consultation from the Office of Rural Health at the Department of Health.

The multi-payer demonstration portion of Payment Model 2 focuses on ensuring value-based arrangements for hospitals providing care in rural areas. Formerly known as the Critical Access Hospital work, it has been reframed to more broadly address the needs of patients in rural hospital districts, while providing the foundation for a global budgeting approach that includes all critical access hospitals in our state, and paving the way for a longer-term multi-payer strategy, including Medicare. The ultimate success of this work depends on Medicare participation, therefore the focus of the coming year is exploratory with an emphasis on long-term sustainability. We hope that our efforts can lead to agreement and participation with CMS, in order to determine a pathway for the longevity of this program.

Model 4, a model that seeks to support providers in value-based payment (VBP) arrangements by providing patient panel data, will test a maintenance-style arrangement between provider networks and the state. There was heavy lift in AY3 to launch the model, determine the security agreements necessary to exchange patient data, and support the networks in analysis. The AY4 work will build upon this foundation and support the continued delivery of necessary data.

BETTER CARE: PHYSICAL-BEHAVIORAL HEALTH INTEGRATION

One of our main priorities in AY4, which is a legislative mandate as well as a critical SIM strategy, is the integration of physical and behavioral health systems and supports. This supports Healthier Washington goal: “State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.” In the foundational legislation passed to support Healthier Washington in 2014, the state would move all regional service areas to an integrated managed care model by 2020. A two-county region went live in 2016, a three-county region in central Washington will make the transition in 2018, and vigorous effort in AY3 has paved the way for five additional regions, including all major population centers in Washington State, will offer integrated care by January 2019. Because these integration efforts involve participation from county governments, Accountable Communities of Health,

managed care organizations, and provider practices, a robust network of support is needed to ensure a successful transition. A large amount of both resources and effort will be directed toward this work in the coming year, in addition to preparing the three final regional service areas for integration in 2020.

BETTER HEALTH: POPULATION HEALTH MANAGEMENT THROUGH ACHS

Accountable Communities of Health (ACHs) remain one of the more innovative elements of Healthier Washington, and their evolution has allowed the state to focus less on their development as entities and more on how to support them in improving the health of the populations to which they are accountable. The ACHs have received a significant and empowering amount of funding through the Medicaid Transformation Demonstration Project (Demonstration), and SIM activities and connections are still necessary to support a whole population approach (Medicaid and non-Medicaid recipients, providers, and community partners) as well as support the ACHs' robust participation in evaluation activities.

Washington also plans to offer connections and strategic advice to community partners who hope to work with ACHs to partner in and continue transformation activities when SIM funding is no longer available. This may be a near-term sustainability strategy for those who need additional time to implement activities and demonstrate value, in order to find a permanent home or revenue stream within the market or community. These partners could be anyone, and this approach will be based on continuing conversations with ACHs and their community partners and providers. An example of this could be around how to leverage resources to provide continued clinical practice transformation support in service to ongoing community-based transformation beyond SIM. It is important to consider that the Medicaid Transformation Demonstration is not a grant, and is instead an incentive program that directs funding through the ACHs to community providers, both traditional and non-traditional, through the meeting of both process and outcome measures.

FOUNDATIONAL SUPPORTS

Healthier Washington has developed a sustainability framework that commits our state agencies and statewide entities to providing the core functions needed to support value-based payment and therefore health systems transformation efforts across the state. This includes our data, analytics, and health information technology capacity, practice transformation support and workforce planning capacity, our shared decision making guidance and patient decision aid certification, and our internal project management, program governance, communications, and stakeholder management activities.

For AIM in particular, the work will be focused on supporting agencies in carrying out payment model work, as well as continued innovation in data analytics and staff capacity for analysis. For shared decision making, the agency will follow legislative direction to create a sustainable resource stream for staff time and resources to fully embed the certification process into the HCA's clinical division, thus providing sustainability for our innovation in this area and demonstrating how other states can get decision aids certified and into contracts to support better care for patients. This and all of the supporting work will continue through AY4 in order to support the necessary programmatic activities that get us to sustainability. We are also planning to take full

advantage of the sustainability plan deliverables required by CMMI so we can develop a holistic sustainability deliverable that reconciles our different activities and analyzes options for scaling, sustaining, re-housing, or ramping down efforts in certain areas.

In AY4, Healthier Washington is aligning and integrating its multiple health IT and health information exchange activities into a single strategic roadmap and HIT operational plan. The health IT and health information exchange activities will be led by the State Health IT Coordinator and will be implemented in collaboration with ACHs, providers, payers, other state agencies, and community partners. The robust and widespread participation in the implementation of the health IT operational plan will help ensure that activities meet the needs of stakeholders, and are ultimately sustainable.

We at Healthier Washington are committed to the task of fulfilling our obligations under the SIM grant through dedicated work, smart spending and deep analysis. We are confident our efforts and those of our partners will move us toward a transformed health system with better outcomes for all Washingtonians.

Further detail and notable AY3 highlights

The information below details notable highlights of Award Year 3 by project. These details are not inclusive of all of the work that was completed, but serve as an overview of accomplishments, with a focus on the SIM Special Terms and Conditions.

ACCOUNTABLE COMMUNITIES OF HEALTH

- ACH regional health assessments and priorities were formalized through community data collection and data provided by the state.
- ACH infrastructure expanded to include financial oversight, clinical leadership, community engagement and representation, data coordination, and program management.
- ACH governance adjustments included additional workgroup formation and the development of new policies (e.g., conflict of interest, dispute resolution, and collaboration with tribes), and increased board education and guidance (e.g., sector expectations and tribal education).
- In several ACHs, pilot projects continued and an evaluation update is forthcoming to explore specific findings, progress, results and lessons learned.

THE PLAN FOR IMPROVING POPULATION HEALTH

- An actionable and focused work plan was created to assess the population health landscape and determine the best strategies for hard-wiring prevention activities into community-based transformation.
- Through the assessment activities, diabetes prevention and treatment emerged as a primary focus area, and well-child visits as the secondary focus area, as test cases for infusing prevention into health systems transformation.
- Appendix 6 presents a work plan for integrating new and enhanced diabetes prevention activities into the state health system.

PRACTICE TRANSFORMATION

- The Practice Transformation Support Hub, coordinated by Qualis Health, completed hiring of coach/connectors for each ACH region and was successful in enrolling more than 150 practices in coaching services.
- The Hub Resource Portal launched and has continued to be active. Portal v.2.0 launched October 31, 2017. From February 1 through October 23, 2017 analytics revealed:
    - 4,520 users visited (43.9 percent new and 56.1 percent returning)
    - 10,208 sessions were initiated
    - 68,260 unique page views
- Washington State worked with the Pediatric Transforming Clinical Practice Initiative (TCPi) and CMMI to craft a SIM-TCPi alignment plan, detailing the strategy to support practices and avoid duplication across practice transformation initiatives across the state.
- Qualis Health, along with subject matter expert sub-contractors, created several additional supportive resources and events for the provider community including:
    - A provider-centric outreach and engagement plan
    - A coaching package of assessment tools, action planning templates and assorted tools to address individualized needs of practices/agencies
    - An inventory of practice transformation and community-based resources in each ACH
    - An assessment of HIT issues for behavioral health agencies, as well as a pilot of technical assistance for behavioral health agencies to integrate interoperability tools into their clinic workflow

WORKFORCE PLANNING

- The Industry Sentinel Network initiative collected data and then published reports in July and August of 2017 on workforce trends in order to understand the gaps and surpluses between education and human resource needs. These findings can be accessed at www.wtb.wa.gov/healthsentinel/findings-facility.asp.
- The initiative plans to launch two more reports in AY3.
- Expansion of the data in AY3 now shows trends in demand by facility, profession, and role.

SHARED DECISION MAKING

- Training for providers in the Accountable Care Program was conducted to ensure understanding of the importance and use of patient decision aids (PDAs).
- Initial evaluation results of the Shared Decision Making training were positive and provide evidence of a promising start.
- The third PDA review was launched, focused on end-of-life care.

PAYMENT MODEL 1 / ADOPTION OF PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION

- We focused on continuing to ensure the success of the Southwest Washington early adopter region, including activities to move toward clinical integration, assess results of our efforts, and improve patient and provider experience.
- Preliminary reports of integration efforts in Southwest Washington showed statistically significant improvement in 10 of the 19 outcome measures, in comparison to non-integrated regions. Eight measures showed no significant difference and only one showed a decline. In the measure that showed a decline, the region was second best in the state.
- Six of Washington's regions—including its major population centers—have committed to adoption of fully integrated physical and behavioral health services under managed care by 2019. The three-county North Central region will transition January 1, 2018; the King, Pierce, Spokane, North Sound, and Greater Columbia regional service areas will follow in 2019.
- In order to mitigate issues about behavioral health data reporting, Washington State released a request for proposals in July 2017 for consultant guidance on SAMHSA block grant data reporting. The Western Interstate Commission for Higher Education (WICHE) Mental Health Program was announced as the Apparently Successful Bidder and the contract was executed in September 2017. Contract deliverables include consultant guidance on SAMHSA block grant data reporting requirements, analysis of gaps, and advisement on long-term solutions to maintaining submission compliance.
- To support the administrative integration of behavioral health into the HCA, agency integration teams developed and approved a charter, charted a project management strategy and plan, and began cataloging risks. Change enablement assessments were conducted and strategies were developed to support the people side of this transition. We established a collaborative working partnership between three agencies and the Governor's office to develop a governance structure and roles for each health agency.

PAYMENT MODEL 2 - ENCOUNTER TO VALUE

- After extensive internal and external work, Washington launched the fourth iteration of its alternative payment methodology (APM 4) with 16 federally qualified health centers (FQHCs). These clinics are now sending and receiving data for population health management and quality reporting, and the administrative functions of this work have largely been built into the HCA.
- Instead of focusing on a subset of the most financially stressed critical access hospitals (CAHs) in Washington, the CAH work broadened in scope to support all CAHs in a global budget approach to payment and service delivery. This change in scope also aligns with implementation of House Bill 1520, which grants the state authority to implement alternative payment methodologies for critical access hospitals participating in the Washington rural health access preservation pilot. With this, we are aligning and refocusing rural payment and delivery

reform efforts with a broader, more inclusive model. This year yielded valuable learnings and set continued work on a path for success.

PAYMENT MODEL 3 / ACCOUNTABLE CARE PROGRAM

- The results of the first year of the ACP program showed both networks within the program received full points for quality improvement on contract performance measures and qualified for the maximum shared savings and deficit mitigation.
- The team met with several public and private purchasers to educate them on the common measure set and the Healthier Washington approach to purchasing, including our Accountable Care Program (ACP). A variety of tools were created for these groups, including a value-based purchasing video, a Quality Improvement Score (QIS) video, a purchaser toolkit, and an Accountable Care Organization (ACO) calculator tool.
- We provided the ACP networks with technical assistance for existing counties as well as expansion to new counties.
- Premium differentials between the ACP and traditional plan offerings were modified so that the ACP was more affordable to employees in order to promote enrollment in value-based benefit offerings. Health literacy materials were developed in order to support consumer engagement and understanding. As of November 28, 2017, 20,780 employees have enrolled in UMP Plus, with two days left in the open enrollment period. This is an enrollment increase of 33.8 percent above November 30, 2016.

PAYMENT MODEL 4: GREATER WASHINGTON MULTI-PAYER

- Implementation of the rural and urban demonstrations of Payment Model 4, the data aggregation solution designed to empower providers in value-based purchasing arrangements by providing patient panel data.
- Two contractors testing this model successfully completed required security processes, including a security design review by the state Office of Cyber Security.
- Processes to pull and transmit data were established in collaboration with HCA's Enterprise Data Management division.

ANALYTICS, INTEROPERABILITY, AND MEASUREMENT (AIM)

- The AIM program has made significant strides in AY3 in building team capacity, beginning to leverage investments in analytical capabilities committed in AY1 and AY2, and promoting inter-agency partnerships with Department of Health (DOH), Department of Social and Health Services (DSHS) and behavioral health teams from across the agency by investing in cross agency capabilities.
- Work to update and maintain the Healthier Washington Data Dashboard continued, allowing ACHs and other entities to access population health measures in their region, as well as compare and view data trends over time.
- The state evaluation work continued to receive support through data extracts, most notably around Payment Model 3, the Accountable Care Program.

PERFORMANCE MEASUREMENT

- In AY3, the Performance Measures Coordinating Committee (PMCC) continued to evolve the Statewide Common Measure Set, a centralized set of curated measures for use in value-based contracts and performance reporting.
- Internal workgroups identified and approved 10 value-based measures for the 2018 contracts for physical and behavioral health integration.
- Substantial effort was made to align measures between Medicaid, the Accountable Care Program, and physical and behavioral health integration contracts, to ensure incentives are aligned and reporting is less burdensome for providers.

The Washington State Common Measure Set can be found on the Healthier Washington website, and is included in Appendix 8.

Looking ahead: Our vision for a Healthier Washington

By 2019, Washington's health care system will be one where:

- 90 percent of Washington residents and their communities will be healthier
- All people with physical and behavioral (mental health and substance use disorder) comorbidities will receive high quality care.
- Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

These milestones mirror our Triple Aim of better health, better care, and lower costs. In the SIM model, we have carefully selected metrics and measures so that we will know when we arrive. The state is relying on its evaluators and partners, as well as our own performance measures work, to chart our progress. While we discuss evaluation elsewhere in the document, it is worth mentioning that the evaluation team has as its central construct the impact of SIM on these three aims.

In Washington, we believe our investment areas and primary drivers have coalesced into a coordinated and integrated approach to health system transformation. They are no longer separate areas of investment, but instead a collection of levers that can be pulled to create impact on our global and interconnected efforts.

Our transformation work, guided by these priorities and strategies, will emphasize full-scale implementation of change and a roadmap to sustainability. In AY3 we introduced nine goals that were to form the foundation of our Healthier Washington activities. They are:

Goal 1	ACHs have capacity and mechanisms to be responsive to partnership opportunities and community priorities
Goal 2	Increase the number of providers, payers and purchasers engaged in Healthier Washington payment models
Goal 3	People and their families are engaged as active participants in their health and in health systems transformation efforts
Goal 4	Providers are supported in moving to team-based, integrated care
Goal 5	Providers are supported in moving to value-based arrangements
Goal 6	State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings
Goal 7	State, community and provider information systems support integrated, team-based care
Goal 8	Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation
Goal 9	Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures

Measuring progress against our nine Healthier Washington goals allows us to understand the health of our work in real-time. Our project management systems are

divided into deliverables (concrete instances of work that can be delivered), and objectives (measurable milestones made up of the required deliverables needed to achieve them). With both deliverables and objectives connected to and measured against these nine goals, we can have an accurate view of "goal health" for the year at any given time. Much development in our project management systems in Award Years 2 and 3 allowed for this tracking and measurement to take place. Using our goals as a guide, we have planned our AY4 initiatives to work in harmony, and as a system, toward a healthier Washington.

2. End State Vision

Our vision for a transformed health system that endures beyond the life of the SIM grant is one where our three foundational strategies of paying for value, whole-person care, and strong clinical-community linkages are embedded in the health system. This future also includes a climate of partnership, engagement, and mutual support between the state, communities, providers, and the market. While each component of Healthier Washington has a vision for how the work will endure, as can be seen in the table below, it is important to also consider the enterprise end-state vision and how each component will contribute to this whole.

At the heart of our vision for a transformed system is our value-based payment models and how appropriate incentives move us from volume to value, population health management, and innovative delivery system and person-centered care strategies. In this new reality, people have access to the right care at the right place at the right time, regardless of whether their need is physical or behavioral, if they live in a rural or urban community, or whether they use private insurance or Medicaid. People and their families experience increased health literacy, which allows them to make educated decisions about what benefits to choose, when to use care, and whether to obtain certain procedures. Providers at various stages of transforming their practices have tailored support and understand what it will take to enter into value-based contracts, hire appropriate staff, report on performance measures, and effectively manage their patient panels.

Accountable Communities of Health are a critical support mechanism for both people and the provider community, since they are a mechanism to convene the appropriate sectors to manage population health and risk-bearing entities. We expect them to keep their whole-population ethos at heart, working to meet requirements for the Medicaid Demonstration while also considering the needs of the populations in their region, regardless of payer or demographic. We are counting on the ACHs to infuse local sensibility, health equity, and a keen eye to the future of what a transformed system looks like in their particular locality, along with their more formal role under the Demonstration in transforming care for Medicaid recipients and incenting providers to move this work forward. ACHs have a central role in population health, practice transformation, the integration of physical and behavioral health, rural health innovations, person and family engagement, and identifying how health IT and information exchange can support service delivery transformation, so we expect a robust relationship between ACHs and Washington State for many years to come.

Our end state vision also includes transformed state agencies, namely HCA, DOH, DSHS, and the Governor's office, since Healthier Washington catalyzed many innovations that have already or will soon be built into the business of state government.

We intend to continue to build out this capacity so that ACHs can have the data and analytic support they need, DSHS staff and systems are incorporated so that behavioral health integration can be successful at the administrative level, rural health transformation work can continue, decision aids can be certified and incorporated into value-based contracts, and the benefits portfolio for public employees can include value-based options that incorporate risk and population health management. This work also requires state agencies to work together differently, since previously siloed responsibilities have become or are in the process of becoming integrated at the community level. It is critical that our future state maintains these evolved relationships.

We plan to use the final year of SIM to dig deeper into what exactly we will leave behind, with the knowledge that we will be left with the same strategies we started with at the beginning of SIM: a Healthier Washington includes a system that rewards value over volume, allows a person's physical and behavioral health to be managed together, and supports robust connections between the clinical delivery system and the rest of the community.

While our sustainability framework allows us to focus on the systems transformation aspects of this work, it is still paramount to consider the end-state goals for each program we started under SIM. In the table below, we have put together the individual end-state vision for each of these components, in order to illustrate the legacy we've been building toward and hope to achieve. The question each box answers is, what will the system look like in February 2019?

End State Vision: The programmatic view of a healthier Washington	
Accountable Communities of Health (ACHs)	ACHs are fully functional regional conveners in their respective communities, and are conducting their projects under the Medicaid Demonstration, while also keeping a whole-population perspective not limited to Medicaid beneficiaries. ACHs continue to partner closely with the state, as well as all partners who contribute to health, including social determinants. ACHs use data and analytics to both understand and manage the health of the people who live in their region.
Practice Transformation Support Hub	The provider community and ACHs have heightened awareness of the importance of clinical provider support in health systems transformation, especially in moving providers to value-based payment (VBP). Practice transformation resources, coaching, and technical assistance are available, and there is a roadmap and evidence supporting the types of assistance that works well. Because this support is robust and easily accessible, advances in readiness for VBP, integration, and improved linkages to community resources for providers will be apparent.
Workforce	The recommendations from the Community Health Worker Task Force and Industry Sentinel Network data provide a runway for meaningful workforce health policy that is focused on supporting providers in moving to VBP and integrated physical and behavioral health care. This foundation can be seen in how ACHs understand and use workforce related data in their community projects, as well as how engagement of community health workers is built into

End State Vision: The programmatic view of a healthier Washington	
	health programs. Their solutions allow for dynamic care teams and better methods for keeping communities healthy.
Shared Decision Making	Washington State will continue to review and certify patient decision aids in a variety of treatment areas, allowing for a robust library of high quality aids for providers to use in support of better decision-making for their patients. Purchasers will have the resources necessary to require the use of decision aids in their contracts with payers, and the state will continue to offer training and support to other states interested in pursuing this model. Certification activities will be built into the business of state government to empower patients and their families to seek information through positive interactions with providers in order to make the best, informed decisions for them, which take into account their personal preferences and values.
Payment Model 1 / Integration of Physical and Behavioral Health Services	As a result of integration activities, each Medicaid client will have a single entity responsible for their care. This will create a more holistic approach to care that reduces cost and redundancy, and has a profound impact on quality of life for people with physical and behavioral comorbidities. The health agencies that administer and pay for this care will be more efficient, and the environment will promote readiness for clinical integration.
Payment Model 2 / APM4 and Rural Hospital Multi-Payer	Under APM4, federally qualified health centers and rural health clinics are held accountable for increasing the value of care delivered and are financially rewarded for delivering high quality care. In turn, this allows for innovation in providing care in rural areas, so that patients can have the access they need and providers can have the flexibility they need to manage their whole population. Under the rural multi-payer demonstration, we will have reached agreements in principle on the model, and engaged in a mutually beneficial partnership with CMS. Through this work, rural and isolated areas will be able to better integrate and coordinate systems of care, and the financing model creates a unique value proposition for both payers and providers. Mitigating exposure where necessary, the transformed system will be able to create operational efficiencies while improving the quality of care delivered.
Payment Model 3 / Accountable Care Program	All active PEBB employees can proactively select a health plan and benefit from a robust health literacy campaign. PEBB members will make informed decisions about their health plans and enrollment in VBP options where providers are accountable for the cost and quality of care. We will start to bend the cost curve. Expansion of the ACP in existing and new counties takes place through the addition of more covered lives and new provider groups, which will signal to the market that it is time to move away from fee-for-service arrangements in favor of value-based options. We will continue to share our story with other purchasers to spread and scale VBP arrangements outside of state-financed health care.
Payment Model 4 / Multi-Payer	The Model 4 test will produce a knowledge base to help providers understand how to use data to manage the health of their populations. Multi-payer claims data will continue to be consolidated into a digestible, actionable format, facilitating population health management and VBP adoption. The lessons learned from this model will allow for continued engagement with other payers in order to support an all-payer data aggregation solution.
Analytics, Interoperability and Measurement (AIM)	An advanced analytic function within the AIM program is operating and sustainably funded in the agency model of data governance and decision support. A data warehouse with linkages to high-value external data sources has been built and is being used. This integrated data system is flexibly built to be modified over time to meet high-value use cases related to health system transformation, including the transition to VBP arrangements, whole-person care, and community engagement. The agency creates reports and dashboards for internal and external stakeholders that present a consistent, timely, accurate, and clear view of agency priorities and accomplishments. Partners and stakeholders are able to access Medicaid claims and encounter data to inform decision making, while protecting the privacy of beneficiaries and complying with

End State Vision: The programmatic view of a healthier Washington	
	federal and state laws. ACHs have access to detailed Medicaid information on patients' use of services, chronic conditions, and providers. This information is available in multiple formats and has consistent designations of key sub-populations.
Performance Measures	We will continue to leverage HCA's internal Quality Measures & Monitoring Improvement (QMMI) process to identify appropriate measures to tie to VBP in contracts, ensuring alignment with the Statewide Common Measure Set to reduce the burden on providers through the reporting of quality measures. Additionally, HCA will continue to use the oversight of the Performance Measures Coordinating Committee to evaluate the implementation of the Common Measure Set, ensuring alignment with state and national measurement priorities and requirements. The Washington State all-payer claims database allows for additional capacity and depth in price and quality reporting.
Health IT/Health Information Exchange	Through our integrated and aligned Health IT Operational Planning activities, HCA and partners (ACHs, providers, payers, state agencies) will collaboratively identify and support several data and health IT and information exchange activities needed to support service delivery and payment transformation. This collaborative, cross-sector approach will help ensure that we are responding to local needs and are aware of and seeking to leverage resources available across the state.
Communications	Healthier Washington is the conduit for carrying out the HCA's vision of "a healthier Washington." Healthier Washington is the brand for strategic breakthroughs in advancing delivery system and payment reform in Washington State. Healthier Washington implements strategies until such time that they are healthy enough to be incorporated into existing work streams by state agencies. Strategic communications and partnerships are essential components to achieve this vision and keep our key partners engaged.

3. Driver Diagram

The driver diagram is a logic model of our SIM initiative that includes measurable aims, primary drivers, and secondary drivers. The driver diagram identifies the aspects of the health system being targeted and why, how the proposed initiatives connect to one or more of our health transformation goals, and what populations will be impacted by the work.

The driver diagram has been a living document and has changed slightly from year to year to achieve greater specificity as Healthier Washington evolves. CMMI has shared this diagram as a model for other states.

Below are the revisions we've proposed to the Healthier Washington Driver Diagram for Award Year 4:

(1) In cell H4, we've annotated with an asterisk and brief comment the quality outcome targets that are specifically:

(a) in our measures for the overall SIM evaluation for which we have confirmed availability; and
(b) those not in the current data we believe to be available for SIM evaluation.

At the bottom of that cell, we have listed "Additional Measures" we plan to add to our SIM evaluation.

(2) In cell Q14 under "Metrics" we've added a few phrases in red font that are suggested for the Hub.

We are not suggesting any changes to the Payment Redesign portion of the driver diagram.

Please see Appendix 1 for an Excel document depiction.

4. Master Timeline for SIM Model

The following timeline provides a detailed reconciliation of AY3 components in order to lay the groundwork for AY4.

This master timeline captures:

- Completed activities/milestones in AY3 (achievements)
- AY3 milestones that have not completed along with a brief explanation of status, where applicable
- Targeted AY4 activities

Activities are grouped by the component/project area and objective. Objectives are prefixed with a reference (G1 through G9), to indicate the aligned Healthier Washington goal. Please use the below legend to interpret the color-coding of deliverables in the AY3/AY4 timeline:

Color	Meaning
	Complete
	On track / In Progress / Plan to complete by end of AY3
	Delayed / Plan to complete by end of AY3
	Delayed / Not on track to complete by end of AY3
	Removed from AY3 scope
	Reduction in scope
	AY4 Activity

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)											
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Accountable Communities of Health (ACH)	G1: By end of AY3 all ACHs will receive aligned information and various opportunities for support from DSHS, DOH, HCA, and HW consultants to inform regional priorities, strategies and overall ACH development.									1.1.1 AY3 Q1: Formative feedback to inform opportunities for ACHs and the state to better align initiatives
										1.1.2 AY3 Q1: HCA develops a feedback mechanism
										1.1.3 AY3 Q1-Q4: HCA reviews and elevates feedback
										1.1.4 AY3 Q1: Identify and communicate opportunities for the ACH within payment model and VBP spread/scale based on regional context
										1.1.5 AY3 Q1: Identify engagement opportunities between ACH leaders and key stakeholders, including WHA, associations, agency staff (e.g., PT Hub) **** Extended schedule - expected completion in Q4 AY3*
										1.1.6 AY3 Q1-Q4: By the end of AY3 efforts will be in place, related to changes internal to HCA for sustainability and transition to operations. One or more process measures will be implemented, supporting the move of DBHR into HCA by 2018
										1.3.1 AY3 Q1-Q4: Provide ACHs with access to technical expertise and consultation available through various DSHS Administrations.
										1.3.2 AY3 Q1-Q4: Provide guidance to help ACHs avoid duplication and/or complement services delivered by or through DSHS.
										1.3.3 AY3 Q1-Q4: Attend ACH Regional Meetings to establish relationship with ACHs and respond to requests for information and access.
										1.3.4 AY3 Q1-Q4: Empower cross-agency staff to attend ACH Regional Meetings.

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										1.3.5 AY3 Q1-Q4: As alignment and intersects of ACH and DSHS program and services emerge, link up DSHS program staff.
										1.3.6 AY3 Q2-Q3: Develop directory of key program staff at DSHS administrations.
										1.3.7 AY3 Q1-Q2: Present cross walk to ACH regions via development council or other and solicit input on DSHS topic areas. ****** Extended schedule - expected completion in Q4 AY3***
										1.3.8 AY3 Q1-Q2: 1st Qtr. DSHS Webinar
										1.3.9 AY3 Q2-Q3: 2nd Qtr. DSHS Webinar
										1.3.10 AY3 Q3-Q4: 3rd Qtr. DSHS Webinar
										1.3.11 AY3 Q1-Q4: Consideration of providing travel resources for DSHS attendance (beyond ACH Liaison) at ACH Convenings – Quarterly to support DSHS workshop component as part of ACH Convenings according to ACH interest and emerging needs.
										1.3.12 Q1-Q4: Facilitate further discussions with NoHLA, NAMI, Mental Health America, etc.
Accountable Communities of Health (ACH)	G1: By June 1, collaboratively establish roles and responsibilities of the ACH in integrated regions. ACHs serve as the primary local resource to engage the State in integration implementation activities									1.2.1 AY3 Q1-Q2: Coordinate detailed work plan development and deliverables with ACH workgroup
Accountable Communities of Health (ACH)	G1: By end of Q2 AY3, all ACHs have a decision-making process and organizational infrastructure that meets the state's expectations									1.4.1 AY3 Q1-Q2: Provide feedback and lessons learned based on evaluation.
										1.4.2 AY3 Q1-Q2: TA delivered according to need for adjustment or growth.
										1.4.3 AY3 Q1-Q2: Priorities updated to reflect ACH strategies to improve health outcomes.
										1.4.4 AY3 Q1: Guidance issued - Deliverables for CPAA/ACH TBD contract
										1.4.5 AY3 Q1-Q4: Technical assistance provided - Deliverables for CPAA/ACH TBD contract
										1.4.6 AY3 Q1-Q4: ACH decision-making and functional capacities developed (e.g., data, clinical, financial, executive, administrative, community)
										1.4.7 AY3 Q1: Project guidance provided to inform ACH adjustments, updates, etc.
										1.4.8 AY3 Q1-Q4: Project evaluation to incorporate effectiveness and utility of P4IPH tools and planning guide.
										1.4.9 AY3 Q1: Project work plans updated to reflect lessons learned, resources, etc. - Deliverables for ACH Sub-awardees contract
										1.4.10 AY3 Q1-Q2: ACH funding for operational projects - Deliverables for ACH Sub-awardees contract
										1.4.11 AY3 Q1-Q2: Seib engagement work - Deliverables for Seib PPA contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										1.4.12 AY3 Q1-Q2: Regional strategies updated to reflect engagement improvements and expanded representation.
										1.4.13 AY3 Q1: ACH leadership support provided upon ACH or HCA request and/or in conjunction with convening - Deliverables for CPAA contract
										1.4.14 AY3 Q1: Targeted or cohort technical assistance provided based on ACH-identified needs - Deliverables for EHF contract
										1.4.15 AY3 Q1: Plan for delivery developed, based on convenings and other appropriate targeted or cohort opportunities - Deliverables for EHF contract
										1.4.16 AY3 Q1: ACH convening to promote shared learning across regions, including leadership development - Deliverables for EHF contract
										1.4.17 AY3 Q2: ACH convening to promote shared learning across regions, including leadership development - Deliverables for EHF contract
										1.4.18 AY3 Q3: ACH convening to promote shared learning across regions, including leadership development - Deliverables for EHF contract
										1.4.19 AY3 Q1: Evaluation and feedback provided regarding ACH development, engagement and organizational infrastructure - Deliverables for Group Health Research Institute contract
										1.4.20 AY3 Q1-Q2: ACH Evaluation - Deliverables for Kaiser CCHE contract
										1.4.21 AY3 Q1-Q4: Formative feedback to inform lessons learned and contribute to project success/sustainability
										1.4.22 AY3 Q1-Q4: ACHs respond to feedback and implement adjustments
										1.4.23 AY3 Q1-Q4: Tribes consulted and surveyed to inform recommendations regarding mechanisms for ACH collaboration and HW engagement
										1.4.24 AY3 Q1-Q2: AIHC work - Deliverables for American Indian Health Com-mission contract
										1.4.25 AY3 Q1-Q4: Respond to recommendations, including guidance to ACHs as appropriate.
										1.4.26 AY3 Q1-Q4: ACH resources shared based on HCA approval (at least quarterly and/or in conjunction with convening's)
										1.4.27 AY3 Q1-Q4: TA website updated at least quarterly to reflect shared learnings and resources
										1.4.28 AY3 Q1: RHNIs and RHIPs updated to reflect any necessary adjustments or refinements
										1.4.29 AY3 Q1: Opportunities/guidelines identified for Practice Transformation connectors to support ACHs w/ linkages and awareness
										1.4.30 AY3 Q1-Q4: ACHs review data/resources and consider updates to RHNI and RHIP
										1.4.31 AY3 Q1: ACHs develop regional approach to coordinate with Practice Transformation connectors, including potential provider engagement strategies
Accountable Communities of Health (ACH)	G9: Ensure stakeholders, agency and finance									9.1.1 AY3 Q1: ACH convening / shared learning, including value proposition, regional sustainability planning (e.g., workshop re: Berry Dunn's work)

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	mechanisms are ready to implement sustainability plans in AY4.									9.1.2, .5, .8, .10 AY3 Q1-Q4: VBP and HW education opportunities for ACHs, including role of the ACH
										9.1.3 AY3 Q1-Q2: ACH convening / shared learning, including value proposition, regional sustainability planning, data/evaluation, etc.
										9.1.4, .7, .9 AY3 Q1-Q4: ACH and partner / association engagement opportunities
										9.1.6 AY3 Q1-Q3: ACH convening / shared learning, including value proposition, regional sustainability planning, data/evaluation, etc.
										9.1.11 AY3 Q1: Assess current-state of agency/HW "expectations" surrounding long-term ACH role (e.g., MCO contract language, VBP role, etc.)
										9.1.12 AY3 Q1-Q2: Map expected long-term ACH functions as they relate to operations and purchasing levers
										9.1.13 AY3 Q1-Q3: Work with ACHs to get feedback on the list of assumed/potential roles ****** Extended schedule - expected completion in Q4 AY3***
										9.1.14 AY3 Q1-Q4: Elevate potential funding considerations regarding assumed long-term ACH role
										9.1.15 AY3 Q1: ACH peer TA (e.g., CPAA) re: sustainability planning / shared resources, likely in conjunction with Berry Dunn's recommendations
										9.1.16 AY3 Q1-Q2: ACH peer TA (e.g., CPAA) re: sustainability planning / shared resources, likely in conjunction with Berry Dunn's recommendations
Accountable Communities of Health (ACH)	G1: Evaluation data collection provides evidence toward how ACHs add value to the regional work of ongoing health system transformation for the entire community.									1.1 AY4: ACHs actively participate in evaluation through survey/reporting
										1.2 AY4: ACHs participate in shared learning events and HW coordination opportunities
										1.3 AY4: ACHs design and implement Demonstration alignment strategy to support population health and ACH vision
										1.4 AY4: Demonstration opportunities identified to align with whole-population HW vision and reinforce broader ACH value
										1.5 AY4: Tangible opportunities identified to coordinate proactively with Tribal Affairs and/or Tribal Nations ahead of policy decisions and communications
										1.6 AY4: Resources and collaboration opportunities are provided to ACHs in a coordinated, timely and accessible manner
										1.7 AY4: Interagency and program levers identified and implementation plan developed
										1.8 AY4: Defined role for ACH as a partner in purchasing with a roadmap that includes specific activities
Accountable Communities of Health (ACH)	G9: Health equity tools/ guidelines/ best practice resources are delivered to each ACH.									2.1 AY4: Tangible opportunities identified to apply health equity resources to Healthier Washington
										2.2 AY4: Pilot program launched for an MCO to collect disaggregated data around race, ethnicity and language
Practice Transformation	G1: Health equity resources are									1.5.1 AY3 Q1-Q4: Engage clinical community to assess sustainability options for Hub components

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Support Hub (Hub)	available to, and utilized by, ACHs and state partners									1.5.2 AY3 Q1: ACHs develop regional approach to coordinate with Practice Transformation connectors, including potential provider engagement strategies
Practice Transformation Support Hub (Hub)	G4: By end of AY3, practices enrolled in Hub coaching services show progress towards advancement along continuum of integration									4.1.1 AY3 Q1-Q4: Practice Assessments will be conducted to measure movement along BH continuum
										4.1.2 AY3 Q1-Q4: Provider training conducted (spend down, payment/billing, contracts
										4.1.3 AY3 Q2-Q4: Client education conducted: These trainings will primarily be conducted in the form of "knowledge transfers" that will occur (depending on the topic) between the Providers and the BHO, MCOs, ASO, DSHS staff and HCA staff
Practice Transformation Support Hub (Hub)	G4: By the end of AY3, community-based resources are available through the Hub web portal and analytics reflect usage/access from within each ACH region.									4.2.1 AY3 Q1-Q4: The Hub will collaborate with the ACHs to conduct an inventory of community-based resources to share with practices to support whole-person care
										4.2.1.1 AY3 Q1-Q3: Step/Sub-Step 2: Convene a representative sample of providers/practices accessing Hub services to provide input to a sustainability plan. ****** Extended schedule - expected completion in Q4 AY3***
										4.2.1.2 AY3 Q3-Q4: Step/Sub-Step 3: DOH drafts proposed sustainability plan
										4.2.2 AY3 Q1-Q4: Deliverables for UW contract for web-based portal
										4.2.3 AY3 Q1-Q4: Deliverables for OTB contract for PM Support (Hub)
										4.2.4 AY3 Q1-Q4: Deliverables for Qualis contract for Coaching
										4.2.5 AY3 Q1-Q4: Deliverables for Qualis contract for Connectors
Practice Transformation Support Hub (Hub)	G5: By end of AY3, Hub coaches will provide skill and capacity building - toward VBP in a minimum of two regions									5.1.1 AY3 Q1-Q4: Disseminate just in time information to providers using the Hub web portal, stakeholders, mailing lists, etc. to help providers be successful as they prepare for and transition to new payment models
										5.1.2 AY3 Q1-Q4: Align FQHC/RHC APM 4 pilot sites with Hub resources
Practice Transformation Support Hub (Hub)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.17 AY3 Q1: Engage practice transformation consortium to identify provider support capacity in Washington State.
										9.1.18 AY3 Q1-Q2: Assess effectiveness and alignment of Hub services with provider needs. Identify value and demand for Hub services.
										9.1.19 AY3 Q1-Q3: Convene provider community (associations and others) with practice transformation community to establish priorities based on needs and capacity information. ****** Extended schedule - expected completion in Q4 AY3***
										9.1.20 AY3 Q1-Q4: Develop proposal for sustaining capacity for provider support to consider centers of best practices and centers of technical assistance.
										9.1.21 AY3 Q1-Q2: Identify DOH, HCA and DSHS activities that provide TA to the provider community (BH and Physical Health)
										9.1.22 AY3 Q1-Q3: Define a process to assess fit of Hub Services with DOH mission and organizational structure. ****** Extended schedule - expected completion in Q4 AY3***
										9.1.23 AY3 Q1-Q4: Develop recommendations for role of DOH in sustaining Hub services.

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
										9.1.24 AY3 Q1: Gather funding sources for existing provider supports. ****** Extended schedule - expected completion in Q4 AY3***
										9.1.25 AY3 Q1-Q4: Willingness of owners to share funding information.
										9.1.26 AY3 Q1-Q4: Availability of data to track demand for and effectiveness of Hub services.
										9.1.27 AY3 Q1-Q4: Need inventory of best practice sites and practice transformation.
Practice Transformation Support Hub (Hub)	G4: By end of Q4, practices enrolled in Hub coaching services show practice transformation advancement compared to previous/initial assessment.									1.1 AY4: Continue to assess enrolled and non-enrolled practices (upon request and with available resources).
										1.2 AY4: Continue coaching up to 125 enrolled practices through end Q4.
										1.3 AY4: Close out transition of practices and other sources of technical assistance and practice transformation support by Q4
										1.4 AY4: Report final summary status of practice transformation assessments and action plans for enrolled practices
										1.5 AY4: Provide final listing of active coaches, assignments and caseloads by ACH and practice type
Practice Transformation Support Hub (Hub)	G4: By end of Q2, a Hub sustainability/ transition assessment, strategy and process will be delivered for a decision on disposition.									2.1 AY4: Implement transition process including scaled down coaching and number of enrolled practices based on practice engagement and/or handoff to other resources
										2.2 AY4: Communicate and connect to ACHs, AIHC, and other to AY4 work plan and enrolled practices to AY4 work plan and connect to enrolled practices
Practice Transformation Support Hub (Hub)	G4: By Q4, respond to providers' practice transformation support needs, refining coaching interventions.									3.1 AY4: Provide final aggregate assessment data to relevant workgroups, evaluators, and leaders
										3.2 AY4: Deliver short-term TA to non-enrolled practices within available resources. • 2 Cohort Learning Series • 2 Webinars
Practice Transformation Support Hub (Hub)	G9: By Q4, options for practice transformation support are delivered to each ACH.									4.1 AY4: Communicate and connect relevant Practice Transformation information and resources to providers, ACHs, AIHC and others, through sustainable resource
Practice Transformation Support Hub (Hub)	G1: Provide direction to ACHs about Practice Transformation resources and assets available in their regions.									5.1 AY4: Monitor and adapt the SIM TCPi Alignment Plan through the PT Consortium
Shared Decision Making (SDM)	G3: By the end of AY3 we will increase the number and breadth of SDM									3.1.1 AY3 Q1-Q4: Provide training and outreach to providers to implement use of shared decision making and patient decision aids that address maternity care - Deliverables for Karen Merrikin contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	tools that have been certified.									
Shared Decision Making (SDM)	G3: By January 2018, offer up to 5 trainings on shared decision making, targeting providers engaged in HW activities									3.2.1 AY3 Q1-Q4: Collaborate with key stakeholders to co-sponsor, plan, convene, and promote trainings on shared decision making to providers engaged in Healthier Washington activities - Deliverables for Karen Merrikin contract
										3.2.2 AY3 Q1-Q4: Deliverables for Karen Merrikin contract
										3.2.3 AY3 Q1-Q4: Deliverables for TBD contract (GHRI/ Healthwise)
										3.2.4 AY3 Q1-Q3: Initiate, track, and finalize Washington Administrative Code (WAC) - Deliverables for Karen Merrikin contract
										3.2.5 AY3 Q1-Q4: Deliverables for TBD contract (Healthwise / GHRI)
										3.2.6 AY3 Q1-Q4: Develop process to integrate certified patient decision aids - Deliverables for Karen Merrikin contract ****** Re-scoped toward building a business model to integrate into HCA CQCT in AY4***
										3.2.7 AY3 Q1-Q4: Implement use of certified maternity PDAs - Deliverables for Karen Merrikin contract ****** Delivered within the scope of the Accountable Care Program***
										3.2.8 AY3 Q1-Q4: Implement outreach to maternity providers - Deliverables for Karen Merrikin contract ****** Removed from AY3 scope due to lack of staff capacity***
										3.2.9 AY3 Q1-Q4: Offer training and incentives for SDM - Deliverables for Karen Merrikin contract ****** Removed from AY3 scope due to lack of staff capacity; missed opportunity to engage providers in implementation of SDM***
										3.2.10 AY3 Q1: Activity 2: ACPs implementing use of certified maternity PDAs - Deliverables for Karen Merrikin contract
										3.2.11 AY3 Q1-Q4: Activity 3: Implement outreach activities to maternity providers - Deliverables for Karen Merrikin contract ****** Delivered within the scope of the Accountable Care Program***
										3.2.12 AY3 Q1-Q4: Activity 4: Engage with liability insurance community to offer training and incentives for SDM - Deliverables for Karen Merrikin contract
Shared Decision Making (SDM)	G3: By July 2017, certification of up to five decision aids that address joint replacement /spine care									3.3.1 AY3 Q1-Q2: Activity 1: Solicit submissions for aids that support joint replacement/spine care, convene review panel, and certify successful submissions as appropriate - Deliverables for Karen Merrikin, Expert review consultant TBD (OHSU/ UW/GHRI) contract
										3.3.2 AY3 Q2: Activity 2: Decision aids are certified and posted to Healthier Washington website
										3.3.3 AY3 Q1-Q4: Deliverables for TBD contract (OHSU/ UW/GHRI)
Shared Decision Making (SDM)	G3: By January 31, 2018 evaluate implementation of SDM and use of									3.4.1 AY3 Q1-Q4: Conduct an evaluation program to assess how ACPs are impacting patient engagement through implementation of shared decision making maternity pilots and use of PDAs - Deliverables for TBD contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	certified PDAs in at least 3 clinical sites									3.4.2 AY3 Q1-Q4: Activity 1: Evaluate the implementation of SDM and the use of certified decision aids into practice - Deliverables for UW contract
										3.4.3 AY3 Q4: Activity 2: Develop a written summary of findings of the evaluation of the ACP maternity SDM pilot - Deliverables for UW contract
Shared Decision Making (SDM)	G3: By January 31, 2019 100% of Managed Care Plans and at least 50% of commercial plans commit to supporting the integration of SDM strategies in provider practices.									3.5.1 AY3 Q1-Q4: Activity 1: Discussions with up to three payers to support integrating SDM into clinical process, including members and providers - Deliverables for Karen Merrikin contract ****** Re-scoped to AY4 to include as part of sustainability plan due to lack of staff capacity within AY3***
										3.5.2 AY3 Q1-Q4: Deliverables for University of Washington contract ****** This deliverable belongs under objective 3.4 above.***
Shared Decision Making (SDM)	G3: By January 31, 2018 co-convene at least two national meetings of stakeholders from SIM states implementing shared decision making									3.6.1 AY3 Q1-Q4: Activity 1: Collaborate with the National Quality Forum to co-coordinate the development of a multi-state shared decision making innovation network to collaborate with other states implementing shared decision making - Deliverables for Karen Merrikin contract ****** Descoped: National Quality Forum development not funded***
Shared Decision Making (SDM)	G3: By January 2019, up to 3 FQHC sites have implemented shared decision making into their clinical workflow, including the use of maternity patient decision aids									3.7.1 AY3 Q1-Q4: Provide onsite and virtual hands on training and coaching to practices to build systems within their practices that incorporate shared decision making and use of certified decision aids - Deliverables for Karen Merrikin, consultant TBD (Healthwise/ GHRI) contract
Shared Decision Making (SDM)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.28 AY3 Q1: Host developer roundtable discussion to discuss options for future processes ****** Developers already engaged in roadmap planning process; separate deliverable not required***
										9.1.29 AY3 Q1-Q3: Share draft cost plan with stakeholders for feedback ****** Developers already engaged in roadmap planning process; separate deliverable not required***
										9.1.30 AY3 Q1: Revisit financial model and track actual staffing costs for certification model ****** Delayed due to lack of staff capacity - expected completion in Q4 AY3***
										9.1.31 AY3 Q1-Q2: Develop draft cost plan for PDA certification submissions ****** Re-scoped to AY4 to include as part of sustainability plan due to lack of staff capacity within AY3; see 1.1.1 below***
										9.1.32 AY3 Q1-Q4: Implement application costs into submission process ****** Re-scoped to AY4 to include as part of sustainability plan due to lack of staff capacity within AY3; see 1.5 below***

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Shared Decision Making (SDM)	G3: By Q3, build a business case to transition SDM and certification into HCA (CQCT).									1.1 AY4: Develop financial model for sustaining process to review and certify patient decision aids
										1.1.1 AY4: Develop draft cost plan for PDA certification submissions
										1.2 AY4: Develop staffing model for implementing SDM/certification of PDAs within CQCT
										1.3 AY4: Develop plan to implement certification process/SDM project within CQCT
										1.4 AY4: Pilot internal business model for certification process/SDM
										1.5 AY4: Implement application costs into submission process
Shared Decision Making (SDM)	G3: By end of AY4, develop a roadmap for implementing SDM and certified Patient Decision Aids into practice across Washington.									2.1 AY4: Develop a sustainable online training model for training clinical providers in SDM
										2.2 AY4: Convene thought leaders to design draft roadmap for sustaining and spreading SDM
										2.3 AY4: Convene SDM stakeholders, including providers, plans, patients, developers, etc., to develop a roadmap for sustaining and spreading SDM in Washington and promoting the use of certified PDAs
										2.4 AY4: Finalize implementation plan for sustaining and spreading SDM and promoting the use of certified PDAs across Washington
Shared Decision Making (SDM)	G3: By the end of AY4, measurable increase in SDM requirements into state-based contracts.									3.1 AY4: Meet with Medicaid program leadership to discuss proposal for supporting SDM in state-based contracts
										3.2 AY4: Convene all MCOs to discuss / get commitment for supporting SDM in contracts
										3.3 AY4: Draft SDM contract language based on outcome of meeting and submit to Medicaid leadership for input / approval
										3.4 AY4: Submit draft SDM contract language to MCOs for negotiation / approval
										3.5 AY4: Enter into final SDM contract language with MCOs for 2019
										3.6 AY4: Build plan for future SDM contracting requirement, with input from MCOs
										3.7 AY4: Repeat process for PEBB contracts; since final language needs to be complete in Q2, follow up in 2019 may be needed
Payment Model 1 (PM1)	G4: By end of AY3, practices enrolled in Hub coaching services show progress towards advancement along continuum of integration									4.1.4 AY3 Q1-Q4: Step/Sub-Step 1: Establish a TA contract with North Central Region (Grant/Chelan/Douglas counties) for project management and provider TA (Note: This is also an activity in goal 500)
										4.1.5 AY3 Q1: Step/Sub-Step 2: Meet with BH providers to understand TA needs
										4.1.6 AY3 Q1: Step/Sub-Step 3: Engage the Hub to ensure TA is available and meeting the needs of providers and consider if additional TA contracts need to be established outside of county TA and Hub
										4.1.7 AY3 Q2-Q4: Step/Sub-Step 4: Engage selected MCOs in NC region to ensure significant TA is provided directly to the BH providers on billing protocols, in advance of go-live
Payment Model 1 (PM1)	G6: By Q1 2018, HCA executes Payment Model 1									6.1.1 AY3 Q1-Q4: Deliverables for Mid-Adopter Regions contract
										6.1.2 AY3 Q2-Q3: Deliverables for Mercer / TBD contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	implementation plan for Mid Adopter Region(s), transitioning 60K Medicaid lives to integrated financing									6.1.3 AY3 Q2-Q3: Deliverables for Milliman contract
										6.1.4 AY3 Q3-Q4: Deliverables for North Central Region contract
										6.1.5 AY3 Q3-Q4: Deliverables for Pierce County contract
										6.1.6 AY3 Q1: Contract/obtain TA on how data can be collected to satisfy necessary reporting requirements ****** Extended schedule - expected completion in Q4 AY3***
										6.1.7 AY3 Q1-Q4: As an interim strategy, any data that can be submitted via the DSHS BHDS is submitted ****** HCA Leadership strategy reconsidered / moved to longer-term focus***
										6.1.8 AY3 Q1-Q4: Develop a recommendation and obtain DSHS and HCA leadership approval on an alternate method for obtaining necessary non-encounter BH data
										6.1.9 AY3 Q1-Q4: Develop and execute a work plan to implement the strategy identified in Activity 3. ****** Delivery window extended due to complexity; expected completion in AY4***
										6.1.10 AY3 Q1: Begin to obtain data via new method from MCOs/BH-ASO in SW region. ****** Delivery window extended due to complexity; expected completion in AY4***
										6.1.11 AY3 Q3-Q4: Conduct a readiness review to ensure that data can be collected in the NC region beginning on January 1, 2018. ****** Delivery window extended due to complexity; expected completion in AY4***
										6.1.12 AY3 Q1-Q4: ProviderOne system changes are developed and tested
										6.1.13 AY3 Q1-Q4: Data architecture and reporting systems are developed and tested
										6.1.14 AY3 Q1-Q4: Encounter and non-encounter data is shared between state agencies, MCOs, providers, and others ****** Delivery window extended due to complexity; expected completion in AY4***
										6.1.15 AY3 Q1-Q4: Data sharing will meet the needs/requirements of MCOs, multiple agencies, providers, and others ****** Deliverable is encompassed in item immediately above***
										6.1.16 AY3 Q1-Q4: Establish an implementation team in the North Central region comprised of County officials and Accountable Community of Health representatives.
										6.1.17 AY3 Q1-Q4: Establish a community advisory body that will engage with HCA and implementation team on the design of integrated managed care in the NC region.
										6.1.18 AY3 Q1-Q4: Establish Tribal engagement details
										6.1.19 AY3 Q1-Q4: Establish Tribal consultation process
										6.1.20 AY3 Q1-Q4: Establish a TA Contract with the North Central Region to support project management activity at the local level and TA for providers as they transition to managed care.
										6.1.21 AY3 Q1: Determine number of Health Plans to participate
										6.1.22 AY3 Q1: Determine if county will act as BH-ASO or if HCA procures

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										6.1.23 AY3 Q1: Determine Carve outs (population & benefits)
										6.1.24 AY3 Q1: Determine implications of fully integrated foster care plan going live in 2018
										6.1.25 AY3 Q1: Build in addressing impacts of new Federal Medicaid regulations
										6.1.26 AY3 Q1: Determine AI/AN carve-outs
										6.1.27 AY3 Q1-Q4: Submit change requests if necessary and conduct work to transition enrollees from any MCOs that will no longer provide coverage to a new integrated MCO plan effective 1/2018.
										6.1.28 AY3 Q1: Determine bed allocation
										6.1.29 AY3 Q1: Develop & release RFP
										6.1.30 AY3 Q1: Procure an organization to act as a Behavioral Health Administrative Service Organization (BH-ASO) in the North Central Region
										6.1.31 AY3 Q1: Draft and finalize fully integrated MCO contracts and BH-ASO contract
										6.1.32 AY3 Q1: Set an integrated Medicaid per-member-per-month rate for fully integrated managed care plans.
										6.1.33 AY3 Q2: Determine distribution of non-Medicaid funds between MCOs and BH-ASO and any other entities
										6.1.34 AY3 Q2-Q3: Conduct readiness review to verify that MCOs and BH-ASO are prepared for go-live
										6.1.35 AY3 Q2: Network Adequacy established
										6.1.36 AY3 Q1-Q4: Provider training conducted (spend down, payment/billing, contracts
										6.1.37 AY3 Q2-Q4: Client education conducted
										6.1.38 AY3 Q3-Q4: DSHS/HCA Agency staff training conducted
										6.1.39 AY3 Q2-Q4: Facilitate "knowledge transfer" to educate MCOs on BH programs and services
										6.1.40 AY3 Q1-Q4: MACSC plan ready
										6.1.41 AY3 Q3-Q4: Eastern State infrastructure ready
										6.1.42 AY3 Q2-Q4: Send client notifications per CMS requirements, informing clients of transition from BHO coverage to integrated MCO coverage
										6.1.43 AY3 Q4: Facilitate the sharing of continuity of care client information between the BHO and the integrated MCOs and BH-ASO. Includes establishing data sharing agreements between parties
										6.1.44 AY3 Q2-Q4: Process client transfers/ enrollments in P1
										6.1.45 AY3 Q2-Q4: Complete releases and transfer agreements with clients
										6.1.46 AY3 Q2-Q4: Plan developed; books closed
										6.1.47 AY3 Q1: E&T services confirmed
										6.1.48 AY3 Q2-Q4: Establish an Early Warning System Steering Committee and identify early warning system indicators for tracking on 1/1/2018

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										6.1.49 AY3 Q1-Q4: Integrated financing contracts in SW and for NC include language that incentivizes the use of value-based purchasing payment methods with providers and also incentivizes plans to work with providers to move to more integrated clinical models.
										6.1.50 AY3 Q1-Q4: Data & reporting systems in production
										6.1.51 AY3 Q1-Q4: PRISM System access, reports modified
										6.1.52 AY3 Q1-Q4: ProviderOne system changes in production
										6.1.53 AY3 Q4: Stakeholder access modified as needed ****** Deliverable is encompassed in items immediately above***
										6.1.54 AY3 Q4: ITA, BH, Unavailable Bed reports available
										6.1.55 AY3 Q2-Q4: Establish monitoring group for 1/1/2018 implementation and set up daily calls to triage transition issues
										6.1.56 AY3 Q4: Activate support processes for MCO, Provider Reps, Eastern State, Eligibility
										6.1.57 AY3 Q4: Confirm information systems functioning correctly (data integrity and functionality)
										6.1.58 AY3 Q4: Leverage support process to identify and implement systemic improvements
										6.1.59 AY3 Q1-Q4: Participate in local working groups focused on integration of physical and BH services and financial integration models.
										6.1.60 AY3 Q1-Q4: Proactively engage ACH's to educate about integrated care, answer questions, and dispel myths.
										6.1.61 AY3 Q1-Q4: Develop and execute a communications plan to educate stakeholders statewide about integrated care and financing.
										6.1.62 AY3 Q2-Q3: Obtain a binding letter of intent from at least one regional service area to pursue integrated financing in 2019.
										6.1.63 AY3 Q1-Q4: Good quality measures of the integration of care and whole person wellbeing have been identified and implemented
Payment Model 1 (PM1)	G6: Create a pathway to clinical integration of BH/PH									6.2.1 AY3 Q1-Q4: Deliverables for TBD contract ****** Provided to Hub for Qualis work to continue recruitment, enrollment and retention of practices***
										6.2.2 AY3 Q1-Q4: Deliverables for TBD / Cambria contract
Payment Model 1 (PM1)	G6: By Q3, two regions have submitted Binding Letters of Intent for late Mid-Adopter integrated financing									6.3.1 AY3 Q1-Q3: Proactively engage & educate stakeholders about integrated financing & incentives for Mid-Adopters
										6.3.2 AY3 Q1-Q2: Step/Sub-Step 1: Obtain feedback from ACH's regarding how they believe they should play a role in both the development of integrated managed care in their region, and also the post "go-live" role (Committees they will manage, etc.)
										6.3.3 AY3 Q4: Step/Sub-Step 2: Issue guidance regarding the ACH role in an integrated region, both the design of integrated financing and the options for post-implementation roles
										6.3.4 AY3 Q1-Q4: Step/Sub-Step 1: Include ACH representative in NC implementation team
										6.3.5 AY3 Q1-Q4: Step/Sub-Step 3: Accomplish Goal 1050 and provide clarity on ACH role in integrated care models and financing ****** Deliverable is encompassed in above items***

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Payment Model 1 (PM1)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.33 AY3 Q1-Q4: Conduct Change Management activities to mobilize commitment to integrated financing
										9.1.34 AY3 Q1: Collaboratively establish ACHs roles and responsibilities in integrated regions
										9.1.35 AY3 Q1: Co-develop Mid-Adopter Region(s) integrated financing model design with county, region, payer, and tribal inputs
										9.1.36 AY3 Q1: Establish working groups and community stakeholdering committees to participate in implementation efforts in Mid Adopter region(s)
										9.1.37 AY3 Q1: Include ACH rep in NC implementation team
										9.1.38 AY3 Q1: Proactively engage & educate stakeholders about integrated financing & incentives to solicit Mid-Adopter BLOI
										9.1.46 AY3 Q1-Q3: Prepare stakeholders for transition to integrated financing (agency staff, clients, providers, MCOs, MACSC plan)
										9.1.49 AY3 Q1-Q3: Solicit Binding Letters of Intent for late Mid-Adopter integrated care
										9.1.50 AY3 Q1-Q3: Confirm network readiness to implement integrated financing
										9.1.57 AY3 Q1-Q4: Implement Early Warning Systems & Processes
										9.1.58 AY3 Q1-Q4: Activate Integration Stabilization systems and processes
										9.1.59 AY3 Q1: Develop viable BHA/HCA data integration solution to enable long-term (2020 and beyond) non-encounter BH data submission and reporting for services covered under all GFS and Medicaid funding ****** Delivery window extended due to complexity; expected completion in AY4***
										9.1.60 AY3 Q1: Develop BHO termination process
										9.1.61 AY3 Q1-Q3: Implement plan for BHO Transfers to integrated care coverage
										9.1.63 AY3 Q1-Q4: Complete BHO termination process
										9.1.64 AY3 Q1: BH Providers in Mid-Adopter region(s) receive coaching/TA to successfully contract with MCOs
										9.1.65 AY3 Q1: ACH supports for integrated care defined and implementation planning underway
										9.1.66 AY3 Q1: Engage HUB to ensure TA is available/meeting the needs of providers
										9.1.68 AY3 Q1-Q2: Implement ACH supports for integrated financing and care
										9.1.73 AY3 Q1-Q4: Complete Mid-Adopter procurements (minimum of 2 MCOs and BH-ASO if needed)
										9.1.75 AY3 Q1-Q4: Implement payment integration incentives for VBP
										9.1.76 AY3 Q1-Q4: Provide BH providers TA on billing protocols in Mid-Adopter Region(s)
										9.1.77 AY3 Q1: Implement BHDS (v2.0) to enable Early Adopter region, MCOs, BHOs and providers to submit all required behavioral

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										health data and reporting for all non-encounter BH data for services covered under all GFS and Medicaid funding ****** HCA Leadership strategy reconsidered / moved to longer-term focus***
										9.1.78 AY3 Q1: Develop viable plan to enable Mid-Adopter region(s), MCOs, BHOs and providers to submit all required behavioral health data and reporting for all non-encounter BH data for services covered under all GFS and Medicaid funding ****** Extended schedule – expected completion in Q4 AY3***
										9.1.79 AY3 Q1: ProviderOne system changes defined
										9.1.83 AY3 Q1-Q3: Implement Mid-Adopter BH data submission and reporting plan for all non-encounter data for services covered under all GFS and Medicaid funding ****** Delivery window extended due to complexity; expected completion in AY4***
										9.1.84 AY3 Q1-Q3: ProviderOne system changes developed
										9.1.85 AY3 Q1-Q4: ProviderOne system changes tested and implemented
Payment Model 1 (PM1)	G6: Plan and implement integrated care in at least 2 more regions by January 1, 2019.									1.1 AY4: Collaboratively develop the integrated care model design in each Mid-Adopter region, including defining parameters of transition year sub-contractual relationships.
										1.2 AY4: Complete procurement for integrated care plans
										1.3 AY4: Complete procurement for BH-ASO
										1.4 AY4: Complete rate setting for integrated care rates
										1.5 AY4: Determine distribution of non-Medicaid funds between MCOs and BH-ASO and any other entities
										1.6 AY4: Conduct readiness review to verify that MCOs are prepared for 1/1/19 go-live
										1.7 AY4: Conduct readiness review to verify that the BH-ASO is prepared for 1/1/19 go-live
										1.8 AY4: Conduct "knowledge transfer" to educate MCOs on BH programs and services
										1.9 AY4: Host a Learning Collaborative for MCOs and BHOs to facilitate shared learning in advance of 2019 transition
										1.10 AY4: Send client notifications per CMS requirements, informing clients of transition from BHO coverage to integrated MCO coverage
										1.11 AY4: Clients transferred to new integrated care plans
										1.12 AY4: Establish an Early Warning System Committee in each Mid-Adopter integrated care region
										1.13 AY4: Successful execution and transition of Medicaid beneficiaries in Mid-Adopter integrated care regions
										1.14 AY4: Distribute SIM TA dollars through interagency agreements to regions that submit binding letters of intent to become Mid-Adopters
Payment Model 1 (PM1)	G9: Build HW / SIM work into other agency efforts that fit into priority areas.									2.1 AY4: Transition NC and SW operations to MPOI Staff, prep for transition of 2019 regions to Medicaid operations staff

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Payment Model 1 (PM1)	G9: By Q4, align agency business processes to support health systems transformation.									3.1 AY4: BHI: Facilitate interagency coordination and execute Transition Plan
										3.2 AY4: BHI: Monitor project performance metrics and provide ongoing reporting
										3.3 AY4: BHI: Develop organizational maturity recommendations and performance-tuning approach
										3.4 AY4: BHI: Plan, facilitate, and drive Systems Integration to support communication and collaboration between inter-agency staff
										3.5 AY4: BHI: Implement change management plans and provide transformation support/facilitation
										3.6 AY4: BHI: Maintain project management infrastructure
										3.7 AY4: BHI: Monitor progress and support any mitigation efforts needed to ensure effective results
										3.8 AY4: BHI: Provide Inter-Agency Executive Oversight support for Behavioral Health Integration
Payment Model 2 (PM2)	G1: By June 1, collaboratively establish roles and responsibilities of the ACH in integrated regions. ACHs serve as the primary local resource to engage the State in integration implementation activities									1.2.2 AY3 Q1-Q4: Align with and help inform ACH role in PM2 - Need to draw distinction for rural providers/client needs ****** Reduced scope due to Medicaid Transformation Demonstration and to align with broader VBP efforts.***
Payment Model 2 (PM2)	G2: 25% of commercial payments are VBP									2.1.1 AY3 Q1-Q4: Deliverables for TBD contract for Rate development / Provider 1 changes
Payment Model 2 (PM2)	G2: 30% of state financed payments are VBP									2.2.1 AY3 Q1-Q4: Deliverables for WSHA contract for support for CAH engagement ****** Refocusing effort to a Rural Multi-Payer Demonstration***
										2.2.2 AY3 Q1: Agreement in principle with CMS on the final APM 4 model.
										2.2.3 AY3 Q1: Identified pilot sites and signed memorandum of understanding
										2.2.4 AY3 Q1-Q2: Implementation preparation of APM 4.
										2.2.5 AY3 Q1-Q2: Implementation of APM4 in Pilot site, in alignment with BH / PH incentivized payments
										2.2.6 AY3 Q2-Q4: Statewide planning and spread of FQHC/RHC APM4
										2.2.7 AY3 Q1-Q2: Feedback mechanism developed on appropriateness of measures - efficacy at the pilot sites
										2.2.8 AY3 Q1-Q2: Finalization of the proposed model
										2.2.9 AY3 Q1-Q3: Agreement in principle with CMS on the final model. ****** Re-scoped; In AY3, HCA plans to deliver final products to CMMI and plans to host discussions to support early agreements. A final waiver will be sought in AY4. See AY4 deliverable 2.1 below.***

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										2.2.10 AY3 Q1-Q3: Agreement in principle with leadership (HCA, DOH, DSHS) and external stakeholders on the final model. ****** Same as 2.2.9 above***
										2.2.11 AY3 Q3: Identified pilot sites and signed memorandum of understanding ****** Re-scoped; final agreement to be based off of approved model. See AY4 deliverable 2.2 below.***
										2.2.12 AY3 Q1-Q4: Align FQHC/RHC APM 4 pilot sites with Hub resources
Payment Model 2 (PM2)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.86 AY3 Q1: Implementation readiness/best practice development
										9.1.87 AY3 Q1-Q2: Implementation readiness/best practice development
										9.1.88 AY3 Q1-Q3: Implementation readiness/best practice development
										9.1.89 AY3 Q1-Q4: Implementation readiness/best practice development
										9.1.90 AY3 Q1: Process development - engagement with finance and operations
										9.1.91 AY3 Q1-Q2: Process development - engagement with finance and operations
										9.1.92 AY3 Q1-Q3: Process development - engagement with finance and operations
										9.1.93 AY3 Q1-Q4: Process development - engagement with finance and operations
Payment Model 2 (PM2)	G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.									1.1 AY4: APM4 - Recruit four additional FQHCs for APM4
										1.2 AY4: APM4 - Review and implement solutions for small providers and support their participation in APM4
										1.3 AY4: APM4 - At least one (1) RHC added to APM4 by January 31, 2019
										1.4 AY4: APM4 - Identify and implement modifications for APM4 sustainability
										1.5 AY4: APM4 - Compile and review lessons learned for spread and scale
										1.6 AY4: APM4 - Review implications of expended services and determine if there will be specific carve outs for APM4 going forward in the future
Payment Model 2 (PM2)	G2: Executed agreement with providers and payers (1 commercial and 1 MCO) for implementation of a rural multi-payer demonstration by January 1, 2019.									2.1 AY4: Rural Multi-Payer - Agreed upon waiver for rural multi-payer model by December 31, 2018
										2.2 AY4: Rural Multi-Payer - Commitment to pilot model from providers by December 31, 2018
										2.3 AY4: Rural Multi-Payer - Commitment to pilot model from at least one commercial payer by December 31, 2018
										2.4 AY4: Rural Multi-Payer – Pending anticipated 2019 legislation, attain early implementation of model on January 1, 2019
										2.5 AY4: Rural Multi-Payer - Alignment and implementation plan for the HW initiatives

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
										2.6 AY4: Rural Multi-Payer – External stakeholder engagements to promote advocacy
										2.7 AY4: Rural Multi-Payer - Agreement with CMS that the model qualifies for an advanced APM under MACRA
Payment Model 3 (PM3)	G2: 30% of state financed payments are VBP									2.2.13 AY3 Q1-Q4: Deliverables for TBD contract - SDM TA for Model 3 expansion & Multi-payer alignment ****** This item was re-planned as technical assistance offer to ACP networks for Model 3 expansion***
										2.2.14 AY3 Q1-Q4: Deliverables for TBD contract - Metrics TA for Model 3 expansion & Multi-payer alignment ****** This item was re-planned as technical assistance offer to ACP networks in support of offering assistance to providers in existing ACP counties***
										2.2.15 AY3 Q1-Q4: Deliverables for contract TBD contract for Data Aggregation TA - Data aggregation TA for Model 3 expansion & Multi-payer alignment ****** De-scoped - this item (and associated funds) was re-planned to AIM in the support of access to PEBB data***
										2.2.16 AY3 Q1-Q4: Deliverables for TBD contract - Care Transformation TA for Model 3 expansion & Multi-payer alignment ****** This item was re-planned as technical assistance offer to ACP networks in support of offering assistance to providers in existing ACP counties***
										2.2.17 AY3 Q1-Q4: Financial and quality thresholds established in MCO contracts to align with purchasing strategy
										2.2.18 AY3 Q1-Q4: ACP expansion for 2018
										2.2.19 AY3 Q1-Q4: Public purchaser outreach & education
										2.2.20 AY3 Q1-Q4: Create incentive (e.g. SDM funding) for providers to join ACP networks
										2.2.21 AY3 Q1-Q4: BHPH financial and quality thresholds established for AY4 ****** This item was de-scoped from PM3, as it doesn't apply to this payment model***
										2.2.22 AY3 Q1-Q4: Private purchaser outreach and education - Washington Roundtable ****** Governor met with the Washington Roundtable and discussed health issues. Washington Roundtable did not prioritize this work.***
										2.2.23 AY3 Q1-Q4: Engaging brokers
										2.2.24 AY3 Q1-Q4: Engage additional payers in PM4 ****** Removed from AY3 scope; included in Payment Model 4 plan.***
										2.2.25 AY3 Q1-Q4: Conduct focus groups with purchasers
Payment Model 3 (PM3)	G2: HW efforts are aligned with Federal VBP initiatives (QPP/MACRA, CPC+), to include Alignment of MACRA with state-based activities - # of									2.3.1 AY3 Q1-Q4: Work with CMS on requirements under MACRA/QPP to accept customized state-based model - Deliverables for Brad Finnegan, Cambria Solutions contract
										2.3.2 AY3 Q1-Q4: Work with CMS on QPP requirements to be payer-agnostic and to include community health workers as QPs - Deliverables for Brad Finnegan, Cambria Solutions contract
										2.3.3 AY3 Q1-Q4: Provide tools and resources to increase knowledge of population health based VBP - Deliverables for Brad Finnegan, Cambria Solutions contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	providers in advance payment model									2.3.4 AY3 Q1-Q4: Work with CMS on requirements under MACRA/QPP to accept customized state-based model
										2.3.5 AY3 Q1-Q4: Work with CMS on QPP requirements to be payer-agnostic and to include community health workers as QPs
										2.3.6 AY3 Q1-Q4: Commercial payers are adopting integration
										2.3.7 AY3 Q1-Q4: By the end of AY3 we will measure the number of commercial payer outreach activities (APCD)
										2.3.8 AY3 Q3: Activity 2: Rule finalized.
Payment Model 3 (PM3)	G2: Cost growth below national average									2.4.1 AY3 Q1-Q4: Connect participating providers to the resources from the Practice Transformation Hub
										2.4.2 AY3 Q2-Q4: Create incentive program to engage providers not participating in risk-based contracts
Payment Model 3 (PM3)	G2: Spread and scale Care Transformation strategies through other purchasers									2.5.1 AY3 Q1-Q2: Deliverables for TBD contract - Spread & Scale to Purchasers
										2.5.2 AY3 Q1-Q4: Work with Boeing to help them implement Bree care transformation standards ****** Unable to engage with Boeing due to their ACO priorities; no plans to continue in AY4 but will coordinate as appropriate***
Payment Model 3 (PM3)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.94 AY3 Q1: Federal engagement - multi-payer alignment, state-based alignment with Medicare and Medicaid ****** Awaiting final rule on MACRA Advanced Alternative Payment Model application and approval process.***
										9.1.95 AY3 Q1: Executive leadership of employers and other purchasers
										9.1.97 AY3 Q1: Payers - engage QHPs
										9.1.101 AY3 Q1-Q3: Providers - TA for 4 foundational elements (care transf., measures, risk, data)
										9.1.105 AY3 Q1-Q4: Federal engagement - update on P4V progress and identify potential support to spread and scale VBP to other environments ****** Conducted provider survey to understand barriers to adopt VBP. Will leverage survey results to identify needed supports to spread and scale VBP***
										9.1.106 AY3 Q1-Q4: Broker engagement
										9.1.107 AY3 Q1-Q4: Providers - model 3 expansion; TA ****** UW pursuing expansion for AY4, PSHVN not expanding geographically***
										9.1.108 AY3 Q1-Q4: Payers - Model 4 expansion ****** Removed from AY3 Scope due to delays in providing data to providers.***
										9.1.109 AY3 Q1-Q4: Ownership/Agency process merge: P4V team in cooperation with other HW and agency teams ****** Will develop sustainability plan in AY4***
Payment Model 3 (PM3)	G2: 40% of commercially-financed health care payments are in VBP									1.1 AY4: Purchaser Support - Engage employer groups to promote VBP)
										1.2 AY4: MACRA support - Get payment models certified as APMs

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
	arrangements as defined by the HCP-LAN APM Framework									1.3 AY4: Engage HBE and QHPs in VBP and other transformation activities (i.e. equity, adequacy, evidence-based standards)
Payment Model 3 (PM3)	G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.									2.1 AY4: Implement bundles in ACPs
										2.2 AY4: Decision to extend/re-procure ACP contract(s)
										2.3 AY4: Launch workgroup to explore how to align all state-financed plans (i.e. fully insured) with VBP strategies
										2.4 AY4: Include ACH participation as a requirement for participation in all HW payment models
										2.5 AY4: Develop and implement spread and scale sustainability plan
Payment Model 3 (PM3)	G2: Increase the number of covered lives involved in HW payment models by X%									3.1 AY4: Engage health plans in HW payment models (example: offer TA funds to a payer and provider partner from MCOs to disaggregate a subset of common measures by race/ethnicity as part of C&E HILN)
										3.2 AY4: Launch promotional tour to share results from ACP and TJR COE programs
Payment Model 3 (PM3)	G2: Two additional counties in ACP for 2019 plan year (as of January 1, 2019)									4.1 AY4: Expand ACP into two new counties for plan year 2019
Payment Model 3 (PM3)	G3: Align health literacy messages and strategies across HW and agency programs									5.1 AY4: Increase enrollment/State employee health literacy (health plan selection, key benefits terms (e.g. deductible), use of the provider search, VBP, obtaining high quality care, importance of a PCP and participating in open enrollment)
Payment Model 3 (PM3)	G9: Build HW / SIM work into other agency efforts that fit into priority areas.									6.1 AY4: Hold purchaser conference
										6.2 AY4: Develop ACP Sustainability Plan
										6.3 AY4: Develop VBP Sustainability Plan
Payment Model 3 (PM3)	G9: By Q4, align agency business processes to support health systems transformation.									7.1 AY4: Add Demonstration alignment measures to HW payment models and other state-financed health care contracts
Payment Model 4, Multi-Payer Strategy	G2: Improved quality clinical quality through multi-payer alignment									2.6.1 AY3 Q1-Q4: Payment Model 4 - Contractors submit quality reports - scores on Diabetes, Hypertension, Preventative and Screening, Depression, High Cholesterol, Maternity, Patient Experience, Well-Child, and Prescription Management measures in model 4 - - Model 2 FQHC/RHC APM 4 - Deliverables for Northwest Physicians Network contract ****** Providers contractors are planning on submitting data in Q4. Potential delays due to delays in providing claims data.***
										2.6.2 AY3 Q1-Q4: Deliverables for Regence contract
										2.6.3 AY3 Q1-Q4: for Summit Pacific contract
										2.6.4 AY3 Q1-Q4: Deliverables for Cambria Solutions contract
Payment Model 4, Multi-Payer Strategy	G2: Measure progress through PM4 contract									2.7.1 AY3 Q1-Q4: Assess semi-annual progress report from PM4 contractor
										2.8.1 AY3 Q1-Q4: Assess annual progress report from PM4 contractor

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Payment Model 4, Multi-Payer Strategy	G2: Measuring payer and provider participation									2.8.2 AY3 Q1-Q4: Work with PM4 contractor to implement core HW value-based and patient-centered behaviors
										2.8.3 AY3 Q1-Q4: Engage additional payers and providers in PM4 ****** Removed from AY3 scope – de-scoped due to lack of data flow from HCA***
										2.8.4 AY3 Q1-Q4: Assess PM4 contractor's performance on quality measures
										2.8.5 AY3 Q2-Q4: Step/Sub-Step 1: Assess semi-annual progress report from PM4 contractor
										2.8.6 AY3 Q4: Step/Sub-Step 2: Assess annual progress report from PM4 contractor
										2.8.7 AY3 Q1-Q4: Step/Sub-Step 3: Work with PM4 contractor to implement core HW value-based and patient-centered behaviors
										2.8.8 AY3 Q2-Q4: Step/Sub-Step 4: Engage additional payers and providers in PM4 ****** Removed from AY3 scope; same as 2.8.3 above***
										2.8.9 AY3 Q1-Q4: Step/Sub-Step 5: Assess PM4 contractor's performance on quality measures
										2.8.10 AY3 Q2-Q4: Develop and implement an assessment tool
										2.8.11 AY3 Q4: Conduct end-of-year assessment of provider-readiness
Payment Model 4, Multi-Payer Strategy	G2: 40% of commercially-financed health care payments are in VBP arrangements as defined by the HCP-LAN APM Framework									1.1 AY4: Explore incentives for ACHs to increase VBP in non-Medicaid payment models
Payment Model 4, Multi-Payer Strategy	G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.									2.1 AY4: Explore episodes of care and/or bundled payments in Medicaid, building on Model 4 infrastructure
										2.2 AY4: Facilitate full contracts with each Model 4 Contractor and at least one additional MCO
										2.3 AY4: Facilitate incorporation of one or both Model 4 partners in one or both ACP networks
										2.4 AY4: Explore incorporation of Model 4 partners into other HW payment models and state-financed programs (i.e. DEMO, APM4, multi-payer)
										2.5 AY4: Supply UMP claims data to NPN for Model 4
Analytics, Interoperability, Measurement (AIM)	G7: By April 1, implement BHDS (v2.0) to enable Early Adopter region, MCOs, BHOs and providers to submit all required behavioral health data and reporting for all non-encounter BH data for services									7.1.1 AY3 Q1-Q4: BH Data Consolidation Project - Phase 1 (implement v2.0) of tool 4/1/2017
										7.1.2 AY3 Q1-Q4: Deliverables for Centralized 'EHR' contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
	covered under all GFS and Medicaid funding.									
Analytics, Interoperability, Measurement (AIM)	G7: By end of Q1, develop viable integration solution to enable long-term (2020 and beyond) non-encounter BH data submission and reporting for services covered under all GFS and Medicaid funding.									7.2.1 AY3 Q1: Communicate, collaborate, and coordinate, and detailed work plan development and deliverables with AIM workgroup
Analytics, Interoperability, Measurement (AIM)	G8: Provide data, analytics and reporting support to Payment Models.									8.1.1 AY3 Q1-Q3: AIM Model 1 Support - Deliverables for OTB Solutions contract
										8.1.2 AY3 Q1-Q3: AIM Model 2 Support - Deliverables for OTB Solutions contract
										8.1.3 AY3 Q1-Q3: AIM Model 3 Support - Deliverables for OTB Solutions contract
										8.1.4 AY3 Q1-Q3: AIM Model 4 Support - Deliverables for OTB Solutions contract
Analytics, Interoperability, Measurement (AIM)	G8: By end of Award Year 3, AIM will have acquired all data sources needed for support of HW.									8.4.1 AY3 Q1-Q4: Data Use Agreements (TBD)
										8.4.2 AY3 Q1-Q4: Data Integration efforts (TBD)
										8.4.3 AY3 Q1-Q4: Deliverables for Berry-Dunn / TBD contract **** De-scoped – deliverable submitted to Healthier Washington at the end of AY2 provided a foundation for the Healthier Washington sustainability framework. Because this framework has been woven into sustainability planning work by the team it was determined that a continuation of the contract was not necessary.*
										8.4.4 AY3 Q1-Q4: Deliverables for Desautel-Hege contract
										8.4.5 AY3 Q1-Q4: Deliverables for OTB Solutions Group contract
										8.4.6 AY3 Q1-Q4: Deliverables for University of Washington/ DHS contract **** Expected completion in Q4 AY3*
Analytics, Interoperability, Measurement (AIM)	G8: By June 1, 2017 have in place a Data & Analytics sandbox for HW AIM personnel to support HW.									8.5.1 AY3 Q2-Q4: Master Data Management Tool Release 2 (Provider Domain) 5/1/2017
										8.5.2 AY3 Q2-Q4: Master Data Management Tool Release 3 (Reference Data Mgmt) 8/1/2017
										8.5.3 AY3 Q2-Q4: Data & Analytics Innovation Sandbox - Development 2/1/2017-03/31/2017 **** Expected completion in Q4 AY3*
										8.5.4 AY3 Q2-Q4: Data & Analytics Innovation Sandbox - Implementation 4/1/2017-06/01/2017 **** Expected completion in Q4 AY3*
										8.5.5 AY3 Q1-Q4: Deliverables for AIM Analytic Sandbox contract
										8.5.6 AY3 Q1-Q2: Deliverables for Tableau contract
										8.5.7 AY3 Q1-Q2: Deliverables for BRFSS contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
										8.5.8 AY3 Q1-Q2: Deliverables for TBD for Data Acquisition contract
										8.5.9 AY3 Q1-Q2: Deliverables for Truven contract ****** De-scoped: Contract moved to EDMA/Corina McCleary***
Analytics, Interoperability, Measurement (AIM)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.110 AY3 Q1-Q4: Bi-weekly meetings with ACH/AIM liaisons on data, analytics and reporting needs
										9.1.111 AY3 Q1-Q4: Quarterly release of HW Data Dashboards, tailored to ACH's evolving data & measurement needs
										9.1.112 AY3 Q1-Q4: Start planning for AIM's support of ACH's under Medicaid 1115 Waiver
										9.1.113 AY3 Q1-Q4: Bi-weekly HW AIM Steering meetings focused on integrating AIM related data & analytics work into operational work of HCA, DOH, DSHS
										9.1.114 AY3 Q1-Q4: Participate in implementation of HCA's Enterprise Data Management Office (EDMA), including policies, processes and other controls related to agency data, analytics and reporting
				*						9.1.115 AY3 Q1-Q4: Work with multiple programs across HCA that have an analytic and/or data function to collaborate on projects that span programs, to share technical assistance when needed, to ensure customers experience a seamless interaction with HCA, and to align investments in data and analytic infrastructure.
										9.1.116 AY3 Q1-Q4: As we develop data sources to support value based purchasing, innovative payment model design, and behavioral and physical health integration, we will need to ensure that data sources have long-term technical, legal, and analytic support and integration with existing data systems. We will also want to ensure that the development of measure and reporting systems are consistent and integrated with other efforts throughout Healthier Washington.
										9.1.117 AY3 Q1-Q4: There are several other data initiatives underway in the state. One is an All Payers Claim Database and another is a Clinical Data Repository. Both these data bases have the potential to be complimentary and value added sources of information on purchasers, system performance, and collaboration. AIM will continue to align, keep open communication, and identify and pursue opportunities for support and leveraging of resources and investments. ****** De-scoped: No deliverable components***
Analytics, Interoperability, Measurement (AIM)	G8: HCA/ Analytics, Interoperability and Measurement (AIM) and ETS /HIT section support use systems, data, measurement and analysis tools to support and sustain SIM priorities.									1.1 AY4: Acquire and integrate data needed to support SIM deliverables and operationalize subsequent transmissions (e.g., Medicare, PEBB, EDIE, other high value data sources identified)
										1.2 AY4: Create and deliver data products for VBP payment models including deliverables for PM2, PM3 and PM4
										1.3 AY4: Provide data needed for SIM evaluation deliverables including UW, CCHE, RTI & RDA
										1.4 AY4: Expand HW AIM team Data/Analytics capacity through Data/Analytics training
										1.5 AY4: Provide AIM Project Management/Lean Projects support through OTB Solutions contract
										1.6 AY4: Build HW AIM team capacity through the purchase of SAS (x7) and STATA (x4) Licenses

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	Objective / Milestone	AY3				AY4				Deliverable(s) with quarterly due dates
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Performance Measurement and Reporting (PMR)	G8: ACHs have ready access to evidence based strategies linked to health issues identified by Dashboard									8.2.1 AY3 Q1-Q4: Deliverables for Washington Health Alliance contract
										8.2.2 AY3 Q1-Q4: Provide web-based tools linking health issues to recommended strategies; provide related TA - Deliverables for Providence Core contract
Performance Measurement and Reporting (PMR)	G8: By AY3, the State Common Measure Set has evolved to include additional measures that address population health									8.3.1 AY3 Q1-Q4: Solicit input from key stakeholders and present recommendations to PMCC for consideration at Q3 committee meeting - Deliverables for Washington Health Alliance contract
Performance Measurement and Reporting (PMR)	G8: Review and update the Statewide Common Measure Set as needed and publish updated version by January 2018.									8.6.1 AY3 Q1-Q4: Activity 1: Convene the PMCC quarterly to review and approve new measure topics for the Statewide Common Measure Set drawing from the current "parking lot of measures"; review recommendations from ad hoc measure selection workgroups; submit recommendations to HCA for annual updates to the current "starter" set of common measures - Deliverables for Washington Health Alliance contract
										8.6.2 AY3 Q2-Q4: Activity 2: Convene ad hoc workgroup annually to explore evidence and feasibility for adding new measures that address measure topics identified by the PMCC - Deliverables for Washington Health Alliance contract
										8.6.3 AY3 Q1-Q4: Activity 3: Convene one ad hoc workgroup of data/results suppliers to evaluate annual implementation of reporting from the measure set and recommend changes to the process and/or replacement or retirement of currently approved measures to the PMCC for 2018 - Deliverables for Washington Health Alliance contract
Performance Measurement and Reporting (PMR)	G8: By January 31, 2018 develop and implement a communication campaign to promote and spread the ongoing use of the common measure set through the enhanced Community Check Up web portal by purchasers, payers, providers, ACHs, and consumers to promote the uptake of users.									8.7.1 AY3 Q1-Q4: Develop, launch, and implement an ongoing communication campaign, including materials, videos, talking points, and web content, to educate purchasers, payers, providers, and communities about the purpose of the common measure set and the new attributes of the Community Check Up and to promote the uptake of users.
										8.7.2 AY3 Q1-Q4: Activity 1: Develop, launch, and implement an ongoing communication campaign, including materials, videos, talking points, and web content, to educate purchasers, payers, providers, and communities about the purpose of the common measure set and the new attributes of the Community Check Up and to promote the uptake of users - Deliverables for Washington Health Alliance contract
Performance Measurement and Reporting (PMR)	G8: By December 31, 2017, produce a publicly available web-based and written report of cost and quality measures based on results produced from the Statewide Common Measure Set.									8.8.1 AY3 Q1-Q4: Using a web-based platform to capture appropriate data sources, publicly report results using an online platform, as well as a written report for the Statewide Common Measure Set on an annual basis - Deliverables for Washington Health Alliance, Office of Financial Management contract
										8.8.2 AY3 Q1-Q4: Activity 1: Using a web-based platform to capture appropriate data sources, publicly report results using an online platform, as well as a written report for the Statewide Common Measure Set on an annual basis - Deliverables for Washington Health Alliance, Office of Financial Management contract

SIM Component/Project Implementation Gantt Chart (Award Years 3 and 4)										
Component/ Project Area	**Objective / Milestone**	**AY3**				**AY4**				**Deliverable(s) with quarterly due dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Performance Measurement and Reporting (PMR)	G9: Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.									9.1.118 AY3 Q1: PMCC/Alliance develop strategies for engaging payers and purchasers in uptake of common measures
										9.1.119 AY3 Q1-Q2: Implementation of strategies to align common measures across payers and other key stakeholder groups
										9.1.120 AY3 Q1-Q3: Convene PMCC evaluation workgroup to evaluate appropriateness of current measure set
										9.1.121 AY3 Q1-Q3: Finalize measures for 2018 measure set and need for ongoing PMCC involvement
										9.1.122 AY3 Q1: Contract in place and contractor begins building out APCD.
										9.1.123 AY3 Q1-Q2: Coordinate reporting of common measures with OFM
										9.1.124 AY3 Q1-Q3: Identify measures for 2018 state contracts to tie to payments
										9.1.125 AY3 Q1-Q4: Finalize approvals for 2018 contracts
Performance Measurement and Reporting (PMR)	G1: By end of AY4, ACHs understand how the information in the Community Check Up can support their consumer and provider engagement efforts.									1.1 AY4: Promote the use of the Statewide Common Measure Set and data provided on the Community Check Up to support HW activities, including the use of the provider level data and consumer engagement messaging to support the work of the Accountable Communities of Health
Performance Measurement and Reporting (PMR)	G8: By end of AY4, PMCC / Statewide Common Measure Set management is built into QMMI process.									2.1 AY4: Convene the PMCC quarterly to develop a plan for the ongoing implementation and evaluation of the Statewide Common Measure Set, including the role and process for PMCC to provide oversight
										2.2 AY4: Develop a process with QMMI to provide recommendations and communication to the PMCC
										2.3 AY4: Publicly report results for the Statewide Common Measure Set, using a web-based platform
										2.4 AY4: Deliver pricing and quality data for the Washington State Common Measure Set on Health Care Quality and Cost
										2.5 AY4: Updates of the Washington State Common Measures Set for Health Care Quality and Cost Performance Outcomes Website
										2.6 AY4: Develop WA-APCD Analytic Enclave to Provide Access to Healthier Washington State Partners and the Accountable Communities of Health

B. General SIM Policy and Operational Areas

1. SIM Governance

a. Management Structure and b. Decision Making Authority

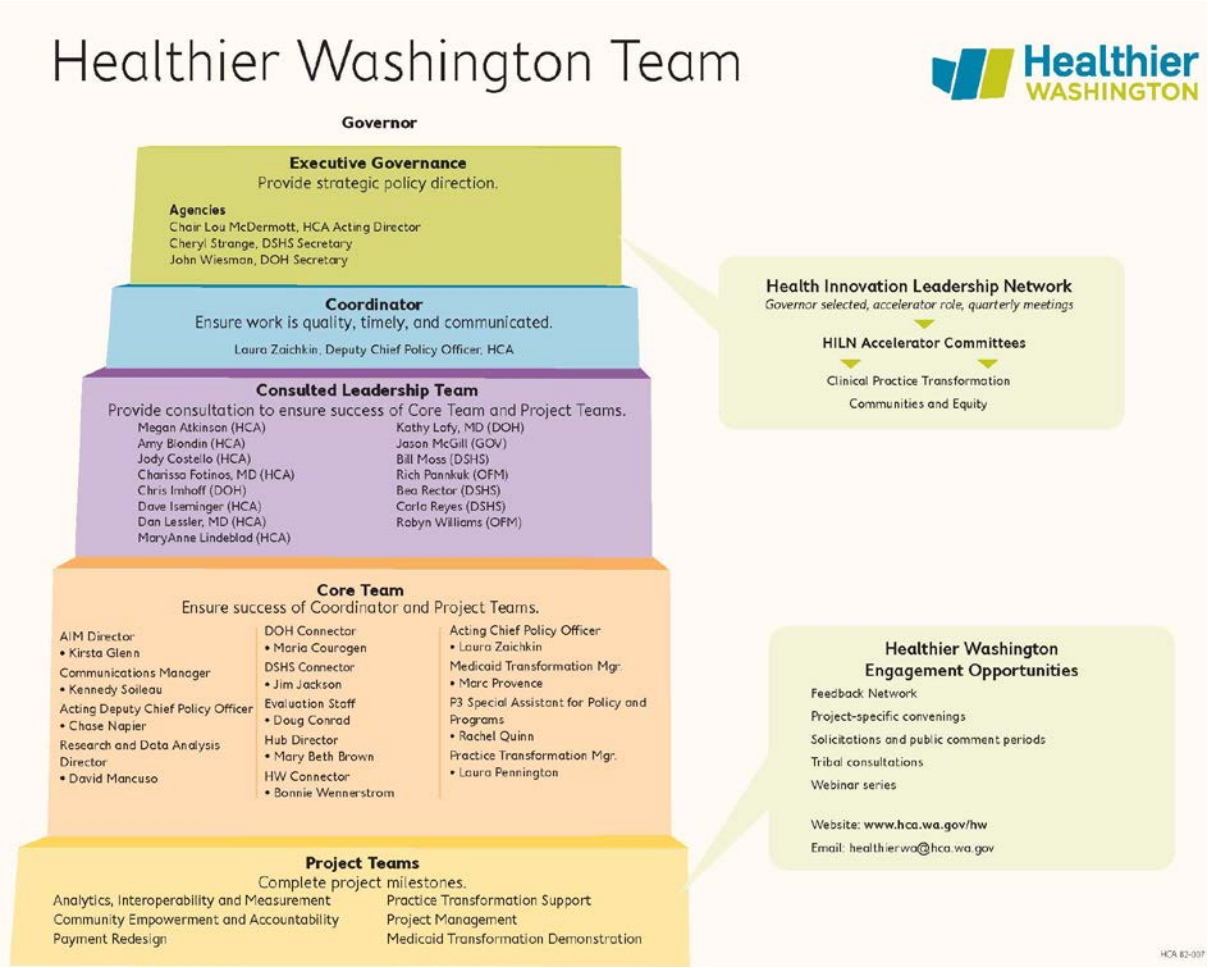
Those ultimately accountable for the Healthier Washington SIM grant include Washington State Governor Jay Inslee, and our Healthier Washington Executive Governance Council: Lou McDermott, HCA ACTING Director and acting Healthier Washington executive sponsor, John Wiesman, DOH Secretary of Health, and Cheryl Strange, DSHS Secretary. SIM program sponsorship is provided by the Healthier Washington Coordinator, Laura Zaichkin, HCA Deputy Chief Policy Officer.

In Healthier Washington governance, decision-making is both vertical and horizontal. Each member of the SIM team provides a functional role within grant work, as well as an organizational role within their respective agency. Representatives from DSHS, DOH, and OFM are members of the team and valued for both their subject-matter expertise and their ability to link and confer with their home agencies.

Team leads are encouraged to maximize their decision-making authority. Each level of program governance has a specific role and accountability, as follows:

- Executive Governance, comprised of members of the Governor's cabinet, provides strategic policy direction and ensures the overall success of the program.
- The Healthier Washington Coordinator ensures work is quality, timely, and communicated. As the program sponsor, the Coordinator is a critical resource for team leads for decision making and strategy. Sponsors are leaders and subject matter experts who are available to consult and advise on all decision types. Of paramount importance is the sponsor's ability to present an escalated or cross-agency program issue to the Consulted Leadership Team or Executive Governance. The Healthier Washington Coordinator is a key program sponsor who informs decision recommendations and suggests strategies.
- In a sponsoring and advising role, the Consulted Leadership Team, comprised of leaders and subject matter experts across the agencies, provides weekly consultation to ensure the success of the Core Team and project teams.
- The Core Team is the functional and operational coordinating body for the program. The team meets monthly and on an ad-hoc basis to review status, address hot topics, resolve issues, and ensure the forward momentum of Healthier Washington.
- Healthier Washington has a number of project teams, comprised of team leaders, program managers and staff, working collaboratively to manage the initiatives under the Healthier Washington umbrella. The program managers are responsible for identifying decisions that need to be made as well as helping to prepare the requisite data required to make a final and firm decision. The project management group is also responsible for documenting and tracking all project-related decisions.

Figure: The Healthier Washington Governance Structure (See Appendix 3)



As directed by state law, the HCA will continue its leadership role and executive sponsorship of Healthier Washington. Gov. Jay Inslee directs the Healthier Washington initiative and has been closely involved in ensuring alignment of the initiative with other state innovation initiatives. The governor has directed alignment of agency initiatives and performance measures in support of health and wellness, and emphasized the importance of health system reform at the state and community levels.

Similar to Healthier Washington's multi-sector approach to innovation and the achievement of the Triple Aim, the initiative is led, managed and implemented by engaging the talents and resources of multiple state agencies in addition to HCA, namely, the Department of Health (DOH), the Department of Social and Health Services (DSHS), and the Office of Financial Management (OFM).

In addition to building upon the strengths of multiple state agencies, Healthier Washington relies upon strong private sector support and adoption of the initiative. Some of this exists within the contractual arrangements between the state and private entities, while some is voluntary. For example, Healthier Washington's partnership with the Washington Health Alliance includes funded deliverables around quality and price

measurement, but it also has contributed in-kind resources and subject matter expertise around value-based models and purchaser engagement.

c. Leveraging Regulatory Authority

Washington has the authority in place to implement Healthier Washington. The state has taken full advantage of expanding Medicaid enrollment and has embarked on robust planning for the full launch of the Medicaid Demonstration.

In 2014, to implement the Innovation Plan, the governor requested two landmark pieces of legislation, which passed with bipartisan support. House Bill 2572 adopted key recommendations from the Innovation Plan, including Accountable Communities of Health, the Practice Transformation Support Hub, developing and reporting on the common measure set, and directing the state to increase value-based purchasing for Medicaid and public employees. Senate Bill 6312 set the path for the phased approach to fully integrated managed care by 2020.

E2SHB 2572 – "Better Health Care Purchasing"
• Creates legislative oversight • Establishes and funds first two Accountable Communities of Health • Establishes statewide performance measures committee • Creates practice transformation support hub • Establishes all payer claims database and creates a safe harbor • Directs HCA to increase value-based contracting for Medicaid and public employees

2SSB 6312 – "Treating the Whole Person"
• Medicaid purchasing for physical, mental health and chemical dependency services must be fully integrated by 2020 • Creates behavioral health organizations by 2016 to integrate chemical dependency and mental health services administration • Medicaid purchasing will be aligned in regional service areas by 2016 • Incentives for early-adopters of full integration • Incentives for outcome-based performance • Reciprocal contracting arrangements required for co-located services

This built upon Washington's history of legislation that supported and continues to support innovation.

- **Shared decision making.** In 2007, the state passed the Blue Ribbon Commission bill that promoted a shared decision-making pilot within the state. Additionally, it provided that if a patient signs an agreement to use a "certified decision aid" as part of the informed consent process, there is a presumption that the patient has given his or her informed consent. Consequently, in 2012, the state passed legislation that grants HCA's chief medical officer the authority to certify patient decision aids.

- **State Health Information Exchange (HIE).** In April 2009, the Washington State Legislature passed Substitute Senate Bill 5501 designed to accelerate the secure electronic exchange of high-value health information within the state. SSB 5501

directed the HCA to designate a private sector organization to lead implementation. In October 2009, the HCA designated OneHealthPort to serve as the lead HIE organization. The Clinical Data Repository now has more than 1 million records.

- **All Payer Claims Database (APCD)**. In 2015, the Washington State Legislature passed Chapter 246, Laws of 2015 (Engrossed Substitute Senate Bill 5084), which directs the Office of Financial Management (OFM) to establish a statewide all payer health care claims database (WA-APCD) to support transparent public reporting of health care information. The Medicaid program, the Public Employees Benefits Program, all health insurance carriers operating in the state, all third-party administrators paying claims on behalf of health plans in the state, and the state Labor and Industries program will be required to submit medical, pharmacy, and dental claims to the Washington-APCD. This year, OFM worked closely with Oregon Health Sciences University (OHSU) to establish the environment and expects reporting from the Washington-APCD will begin in early 2018.

- **Telehealth**. The 2015 legislative session passed Senate Bill 5175, which broadens the scope of telemedicine to enable its use in urban and underserved areas in addition to rural areas. It also enables payment for both the originating and the distant site in a telemedicine transaction beginning in 2017. This will encourage more extensive use of this growing technological toolkit to serve individuals and enhance provider capacity and resources. This has been codified in the Revised Code of Washington and Washington Administrative Code, and has been implemented in HCA's Apple Health contracts with managed care organizations (MCOs) as an option for providers in the delivery of services. As implementation is still early, it is not yet clear what the outcomes are on cost and access.

- **Critical Access Hospital Support.** During the 2017 session, the Washington State Legislature passed a bill allowing alternative payment methodologies for critical access hospitals (CAHs) participating in the Washington Rural Health Access Preservation Pilot. The legislation authorizes the HCA to develop this alternative service and payment system, and requires the medical assistance payments to CAHs be established at a level sufficient to sustain essential services to the community. Substitute House Bill 1520 provides foundational support for the broadened scope of the CAH work of Payment Model 2, moving toward a multi-payer solution to transform rural care delivery.

- **Medicaid Transformation Demonstration Authority and Alignment.** See additional detail on the Medicaid Transformation Demonstration and its alignment with SIM later in this document.

d. Stakeholder Engagement. A key component of Healthier Washington is broad engagement of interested citizens to promote bi-directional dialogue and feedback, align with stakeholders performing this work already to accelerate and amplify their effort, and encourage the momentum and sustainability of the initiative. The opportunity to engage in the initiative is open to all and allows for various levels of engagement: From listening, observing, and learning to actions taken as leaders and champions to promote change. While some partners, such as members of the initiative's Health Innovation Leadership Network, are expected to work as change agents and lead the charge in this work, there are many ways for interested stakeholders to engage. Contributors to Healthier Washington may be participants in Healthier Washington payment model tests or serve as partner communities; sharers and learners may take part in public comment opportunities and project-specific convenings; and interested stakeholders may simply observe the efforts by accessing the web meetings and resources in order to stay informed about work in the field. Additional specificity on the highlights of our stakeholder work and the engagement of specific groups is detailed in this section.

AY3 HIGHLIGHTS INCLUDE:

- The Healthier Washington Symposium and Purchaser Conference provided an essential forum to gather key partners and motivate them toward commitment. In the room were representatives from payers, purchasers, provider groups, and other key partners in the marketplace that are essential to moving this work forward and sustaining it outside of SIM.
- Healthier Washington utilized Salesforce, our stakeholder management software system, to manage our relationships with contacts and organizations vital to our work. Teams used this resource to house ACH meeting notes, as well as obtain vital contact information for convenings and conferences.
- Healthier Washington conducted qualitative research on two key stakeholder groups: Purchasers and payers, and developed plans for better engagement of these groups in AY4. The research questions focused on the level of awareness about health care transformation in general among these groups, and the effectiveness of Healthier Washington communications tools in particular.

Findings from this research include:

- Feelings of mistrust throughout the delivery system as health care costs keep rising and services decrease.
- Purchasers conveyed wariness of both payers and providers, with one respondent suggesting "insurance companies are the only winners here," while others complained that medical billing is a "black box" offering little clarity or transparency on allowable costs.
- Payers observed that only the state has shown an interest in a value-based purchasing model, not commercial clients.

Healthier Washington is assessing a number of options for reaching out to these target groups anew, possibly providing them with additional tools to understand their roles and their ability to be proactive in health systems transformation. The annual purchaser

conference and symposium are a key mechanism for Healthier Washington and will serve as a springboard to more engagement.

- The Healthier Washington story bank grew and the resource was enhanced for team members and engaged stakeholders through talking points, handouts, PowerPoint slides, and other materials. The resource enables staff and stakeholders to describe how the efforts of Healthier Washington affect all Washingtonians.
- Individual teams continued to proactively reach out to the unique stakeholder groups that are essential to the success of individual programs. These unique groups include housing, philanthropy, education, social service providers, high-level health system decision-makers through our Health Innovation Leadership Network, and others. As explained in the Payment Model 1 stakeholder engagement illustration below, this approach has been particularly valuable in the work to integrate physical and behavioral health where community-based members help inform outreach campaigns and play a key role in vital committees.

STAKEHOLDER ENGAGEMENT ILLUSTRATION: PAYMENT MODEL 1

By their very nature, the interdependent elements of the Healthier Washington initiative necessitate community, health system, and marketplace engagement. As such, Healthier Washington partners go beyond payers, providers, purchasers, public health, policymakers, consumers, and tribes, and reach into communities and those that impact the social determinants of health such as housing, education, philanthropy, and social service providers. Healthier Washington's multi-sector approach is reflected in the workgroups and advisory bodies that have been formed under the initiative. The state has undertaken significant work to engage payers, providers and other community stakeholders, especially in relation to the transition to integrated physical and behavioral health under Payment Model 1.

The most acutely impacted stakeholders in this transition are behavioral health providers, particularly those providers that exclusively serve the Medicaid population and have historically contracted exclusively with the behavioral health organization (BHO), the county, or the state on a fee-for-service basis, and have never contracted with a managed care plan. The transition from contracting with the county or state to contracting with the Medicaid managed care organization requires significant change management and technical assistance for these providers. For example, some providers do not have a full time billing staff person, billing software, an advanced system for accounting and tracking claims payment and denials, or a regular process to check new clients' eligibility for Medicare and other programs. Additionally, there is a significant communications and stakeholder engagement campaign that occurs with providers and community members simply to explain: Why this transition is occurring, what the transition means for them, when it is happening, how to get support, how to be an active partner in the process, and why this transition will ultimately benefit clients and providers.

In preparing for the upcoming wave of mid-adopters of integrated services, the state set up an implementation team of stakeholders including county staff, the behavioral health organization administrator, and the director of the ACH, as those individuals will serve

as our primary partners in the development and implementation of the payment model. We hold weekly calls with those individuals and bi-weekly multi-hour meetings to design the program and plan for implementation and transition. We also allotted $200,000 in technical assistance to the counties, which enables them to hire a local project manager and consultants who work directly in the community with providers and other stakeholders. This implementation team serves as the main liaison to the broader community, including an alliance of the impacted behavioral health providers. In Southwest Washington, there were 15 behavioral health providers who were significantly impacted by this change and formed the Behavioral Health Alliance. The Alliance engaged heavily with the implementation team and ACH, which in turn engaged heavily with the state during program design and the initial procurement of MCOs to administer integrated services.

Additionally, the state also engages with the MCOs to ensure they will be able to establish the necessary behavioral health provider network and deliver services, and to ensure they modified their own internal organization to prepare for the delivery of behavioral health services. These activities include the hiring of a behavioral health medical director, changes to their quality improvement program, implementation of level-of-care guidelines, etc.). Once the integrated managed care plans are selected through competitive procurement, HCA establishes a knowledge transfer process called to educate the selected MCOs on every detail of the local behavioral health payment and delivery system. This process is essentially a learning collaborative, in which the HCA organizes participants from DSHS, the counties, the ACH, the existing RSN, and the provider community to educate one another on the behavioral health delivery system and payment structure. The HCA also conducts extensive on-site readiness review with the selected plans to ensure they are prepared for the coverage effective date.

The HCA also works with the ACH in each region to establish an Early Warning System Steering Committee that includes representatives from the provider community, the MCOs, the county, law enforcement, and consumers, to track 11 metrics related to whole person care implementation, which were designed to rapidly identify any issues that must be addressed. This Early Warning System continues until the first year of implementation is complete. Lastly, after the go-live date, the HCA holds daily calls with providers, MCOs, the ACH, and the implementation team to rapidly address implementation problems in real time. After the first several months of implementation these move to weekly and eventually monthly calls. Lastly, as the HCA continues to transition additional regions into the payment model, payers, providers and other stakeholders are encouraged to learn from Southwest Washington and to begin preparations for their own regional transition. HCA staff also travel across the state to meet with providers in each region and answer questions about the transition and provide education about integrated managed care, as they consider in their own region when to make the change. This engagement work is of critical importance, so that both providers and payers are working in partnership with the state to ensure a successful transition to integrated payments for physical and behavioral health services.

Key partner groups and activities include:

TRIBES (GOVERNMENT TO GOVERNMENT)
State, county and tribal governments will continue to have a key role as conveners, regulators, purchasers and policymakers. Healthier Washington has contracted with the American Indian Health Commission (AIHC) through AY3 to ensure Washington's 29 tribes are engaged effectively in Healthier Washington. The AIHC has done considerable work to date on convening tribes and ACHs, providing assessment and education services to both tribal governments and the state.

Every ACH is required to adopt the ACH tribal collaboration policy and communication procedure, which include the following elements:

- An expectation of respectful collaboration and communication
- A committee of ACH staff and participants and designees of tribes, Indian Health Service (IHS) facilities, and urban Indian health programs (UIHPs) to determine whether any ACH actions being contemplated, including the development of policies, programs, or agreements will have an impact on American Indians/Alaska Natives, tribes, IHS facilities, or UIHPs
- Delivery of written information to tribes, IHS facilities, and UIHPs concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other ACH participants for participant or other meetings

An ACH may adopt a different policy/procedure if the ACH and every tribe, IHS facility, and UIHP agree to it.

COUNTIES (GOVERNMENT TO GOVERNMENT)
Engagement at the county level has been of particular importance. Counties have a traditional role in the organization and delivery of behavioral health services to local populations. Payment Model 1, with its emphasis on integration of physical and behavioral health services, creates an opportunity to think regionally and consider how other elements of the system can complement the achievement of whole-person health. Counties are responsible for signaling to the state their readiness to transition to integrated physical and behavioral health care. The case study of engagement with early adopter stakeholders that begins on page 47 provides a detailed view of how HCA interacts with counties.

PURCHASERS
Purchasers and payers alike play a key role in Healthier Washington as both directly and indirectly influence payment and delivery of services. Active engagement and participation of both stakeholders is necessary in order to achieve Healthier Washington's paying for value goal: drive 80 percent of state-financed health and 50 percent of commercial health care to value-based payments (VBP) by 2019.

HCA hosted its annual Purchaser Conference in concert with the annual Healthier Washington Symposium in October 2017. HCA made considerable outreach to the statewide purchaser community, leveraging partnerships to extend invitations to small,

medium and large employers in Washington. More than 150 people attended the purchaser-focused event, themed "A Commitment to Value," and purchasers shared their experience and results from various VBP efforts.

HCA is wielding its purchasing power to engage payers in transformation strategies. The three commercial plans contracted to serve the state employee health benefits program have agreed to report on metrics tied to the state's Common Measure Set. The measure set has broad reach, so reporting on all measures is not required. Every year through the HCA Clinical Quality Measurement & Monitoring process, appropriate measures are selected for reporting to HCA through the state employee contracts.

PAYERS

Washington has five managed care organizations (MCOs) that are contracted to provide behavioral health and physical health services on a phased basis. Two of the five MCOs currently have contracts that reflect integrated physical and behavioral health services. Stakeholder engagement with the MCOs and behavioral health organizations (BHOs) continues to be central to the organization, financing and delivery of integrated behavioral and physical health services under Model Test 1. BHOs are engaged on at least a monthly basis, through BHO administrator meetings and through other opportunities regarding integration at a financial and delivery-level. MCOs have participated as key stakeholders in the development of the "early adopter" and "mid-adopter" approach to integrated managed care. The MCOs not only have incorporated behavioral health providers in their networks, but have reached out to the providers of crisis services in order to more fully coordinate services. As active participants in the ACHs, often as members of governing boards, the MCOs are actively engaged and attentive to community health concerns, as well as opportunities that extend beyond their managed care agreements with the state.

Additional efforts to engage with commercial payers include HCA's presence at the Washington Roundtable to ensure we are in alignment and understand the thinking of payers as they seek to understand the marketplace and move toward value-based plan offerings. HCA also has spent time and effort engaging with insurance brokers in order to understand their perspective, which is critical since they are often the sole intermediary between a purchaser and payer.

We also are seeking to engage more fully with CMS to explore support for Medicare participation, since this population is widespread in all areas of the state and is expected to grow substantially in the coming years.

PROVIDERS

One of the learnings achieved through our Healthier Washington stakeholder engagement activities was the need to extend our expectations beyond payers to partner more closely with the provider community. We have acted upon these signals and put several elements in place, including contracts with provider networks through Models 3 and 4, as well as a 1 percent withhold in Medicaid contracts. In both working closely with provider networks and building accountability into contracts, we have been better able to move the state toward value-based arrangements and steer providers to beneficial supports.

Healthier Washington's focused support for providers comes from the Practice Transformation Support Hub. The Hub's role is to extend regional health connectors into each region, supporting providers directly in their transformation to value-based care. The Hub also offers web resources, practice coaching and facilitation, trainings, networking events and learning collaboratives to help support and maintain linkages with providers. A practice transformation consortium was formed in early 2017 with internal and external partners who will help leverage short- and long-term service delivery components. In AY4, engagement will be focused on continued provider support in moving to VBP arrangements, as well as the sustainability of meaningful practice transformation in Washington State.

Practice Transformation Support Hub successes in provider engagement include:

- The Hub coach/connectors embedded in each ACH focused efforts in AY3 on outreach and engagement of primary care and behavioral health agencies transitioning to value-based arrangements and whole-person care.
- The Hub exceeded its enrollment goal of 150 provider organizations in the third quarter of AY3 while also bringing customized training and technical assistance to affinity groups of providers.
- Contractor Qualis Health delivered care coordination training to new care coordinators hired by rural health clinics affiliated with the Northwest Rural Healthcare Network.
- In partnership with the UW AIMS Center, the Hub coordinated group trainings for a cohort of tribal clinics as well as two groups of behavioral health agencies and one group of primary care providers on behavioral health integration.
- The Hub partnered with the Washington Council on Behavioral Health to deliver a VBP Academy in conjunction with National Council on Behavioral Health expert faculty.
- The Hub undertook additional work, building a toolkit for behavioral health agencies facing health information technology transitions to integrated care, and for those seeking to implement EDIE/PreManage in their workflow to access information about patients shared with other providers.

Additional provider engagement from other Healthier Washington programs include:

- **Accountable Communities of Health:** Many types of providers sit at ACH tables, allowing for robust conversation on provider engagement and support. These conversations have led to ACH projects that are provider-focused, allowing for incentive dollars to flow to providers who are engaging in transformation work. While much of this work lies within the Medicaid Demonstration, SIM provided a foundation of engaging with these providers that translates to their continued support and success.

- **Shared Decision Making:** Washington has made great progress in certifying patient decision aids in 2017. Because providers are the champions of this work, we have offered training to support understanding and adoption of decision aids in clinical practice. We also continue to leverage the efforts of organizations who

are working to implement shared decision making into practice, such as Group Health Research Institute, and learning from their experience. Key stakeholders have also included payers, purchasers, state legislators, IPDAS, developers, academics, AHRQ, and The Gordon and Betty Moore Foundation.

- **Payment Model Test 1:** Providers of mental health and substance use disorder services, as well as primary care providers, have been working closely with HCA and community representatives in the development and execution of the fully-integrated managed care model. Our current efforts are focused on the success of the North Central mid-adopter region, and have several workgroups in place to support providers through various aspects of the integration process.

- **Value-Based Payment Model Test 2:** Because the success of Model 2 depends on the acceptance of new payment arrangements by community clinics and rural hospitals, establishing and maintaining effective working relationships with those providers is essential. In AY3, Healthier Washington secured contracts with 16 FQHCs to launch APM4, and we will continue to work closely with those providers to ensure success. We have also partnered on model design and evaluation with representative associations, including the Washington State Hospital Association, Washington Association of Community and Migrant Health Centers, and the Rural Health Clinic Association of Washington.

- **Value-Based Payment Model Tests 3 and 4:** The introduction in 2016 of value-based payment under Model 3 is the result of successful recruitment and negotiation with two accountable care provider systems, the Puget Sound High Value Network and the University of Washington Accountable Care Network. AY3 efforts led to positive results for the first year in provider networks and PEBB member engagement. AY4 efforts will be focused on continuing to support providers in accountable arrangements, as well as engaging eligible public employees in choosing value-based plans.

- **Health Information Technology:** The state's clinical data repository, Link4Health, went live in 2017 and currently has a number of providers and health systems engaged in submitting Consolidated Clinical Document Architecture (CCDA) records. There are 74 providers and systems, made up of a combination of small groups and systems like UW Medicine and MultiCare, actively submitting to the production database. In October 2017 there were about 25 more submitters in the user acceptance testing (UAT) environment. There are also 64 approved time-based extensions that have been granted to providers, due to vendor issues, changing EMRs, and mergers.

  Major Clinical Data Repository milestones include:

  - University of Washington now submitting from Epic
  - 1.1 million CCDs in the system
  - Percent of current MCO enrolled lives in the system with a clinical record established is equal to about 16 percent and steadily growing.

Provider feedback is critical to the success of this work, and bi-directional communication is undertaken to ensure the system is working. They recently announced a milestone: The one millionth record to enter the data repository. Uptake of the CDR has been slow but steady, and the team responsible continues to look for opportunities to engage providers. See our HIT plan in Appendix 4 for more details on how and why we plan to engage stakeholders in AY4.

- **Common Measure Set:** The Statewide Common Measure Set is a core element of Healthier Washington and provides the foundation for accountability and measuring performance across all areas of Washington. Provider engagement is key to the work of the Performance Measures Coordinating Committee (PMCC), since measure alignment is critical to reducing provider fatigue. The committee will continue to convene quarterly through 2018 to consider recommendations for evolving the measure set and supporting providers in population health management and successful VBP arrangements. Beyond the SIM grant, we will continue to ensure quality measure alignment through the Quality Monitoring and Measurement Improvement process, in partnership with key stakeholders. Through this process the measures will be reviewed for alignment with agency and state priorities, and key initiatives.

COMMUNITY

Our community engagement strategy is largely carried out by our Accountable Communities of Health. ACHs follow a cascading engagement strategy that balances the need for a nimble decision-making structure with meaningful multi-sector engagement of community leaders. In AY3, this strategy was applied to broaden relationships with providers and other community assets who contribute to whole-person health.

Notably:

- ACHs partnered with HCA and Empire Health Foundation to hold two convenings, one that included more than 100 participants representing our largest ACH stakeholder meeting to date. The format of each convening relied more heavily on ACH-led sessions to highlight the work on the ground and allow ACHs and their partners to learn from one-another. We facilitated breakout sessions as well to promote all voices.
- Regional ACH engagement significantly expanded over the course of AY3. ACHs evolved their governance structures to fill missing sector seats and ensure balanced representation. Cascading engagement strategies also evolved to include tribal outreach and engagement, consumer engagement (e.g., consumer councils), the formation of workgroups based on priority areas, and broader communication and feedback mechanisms through social media, "office hours," and a more robust web presence. ACHs also actively solicited public comment and input on project areas to be pursued in the future.

CONSUMERS

The principles of transparent engagement, continuous learning, and collaboration will continue through established workgroups and communication outlets, such as the Healthier Washington website and quarterly webinars.

As part of their cascading engagement strategies, ACHs are expected to engage consumers within their communities. Health is local and the identification of local issues and corresponding solutions requires authentic local engagement. ACH membership includes consumers and consumer advocates.

Under Model 3, patient engagement is foundational. Both networks under the Accountable Care Program are at financial risk for timely access and patient experience, as a number of CG-CAHPS measures are included in the quality improvement model (which determines the network's savings or deficits).

At the same time, HCA has worked to encourage healthy behaviors of state employees through educational tools like the SmartHealth employee wellness program. For example, state employees received a lower annual deductible if they completed the wellness assessment and follow up activities that they self-report on the SmartHealth web portal. Follow up activities included completing an advance directive to align with strategies implemented on the supply side. HCA will continue to develop and promote additional consumer tools as consumer engagement has been the number one priority with public employees for 2017.

Healthier Washington also engages consumers through the Health Innovation Leadership Network detailed below, which includes the work of Accelerator Committees, notably the Communities and Equity Accelerator Committee. In AY4, Healthier Washington will continue to engage consumers through the lens of health equity, to ensure equal participation in the benefits of achieving the Triple Aim.

Health Innovation Leadership Network. HILN is the formal mechanism for sustainability through strategic partnerships and a key to adoption and spread of value-based payment. Healthier Washington continued to move this group to commitment and action in AY3, which allows us to focus on obtaining this commitment in AY4.

In AY3:

- We continued to engage our HILN members in strategic planning for health systems transformation and further advanced an "action agenda" (Appendix 7) to outline activities for the HILN in this award year.
- Our HILN leaders led the Healthier Washington Symposium in October 2017. This event reached 350 health and health care leaders across the state.
- Our Clinical Engagement Accelerator Committee remained highly engaged in developing strategies to enlist more providers in state programs and goals.
- Our Communities and Equity Accelerator Committee made strides in equity solutions that can be used to inform the work of AY4.

Reports of accelerator committee activities can be found on our website.

2. Health Care Delivery System Transformation Plan

a. Service Delivery Model(s) and Payment Model(s)

As described in earlier sections of this document, Washington State has developed a sustainability framework that is focused on value-based purchasing (VBP) and payment as the key driver to health systems transformation, with our other initiatives acting as critical support functions to aid in achieving lasting change. It is this framework that has shaped our strategy and work plans for Award Year 4, prioritizing investment in work that is critical and building work into agency business as environments allow. Throughout our planning we approach Healthier Washington as a system that is more than a collection of initiatives knowing that none of these initiatives alone will create the sweeping change that CMMI has asked us to deliver under SIM. The next section, weaves the work of our programs to support VBP arrangements and ensure critical infrastructure is in place for sustainability.

Accountable Communities of Health

While the ACHs are not a service delivery model, they are a key part of our transformation and innovation model.

Healthier Washington recognized and leveraged pockets of innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared health goals, including representation from groups addressing social determinants of health. Nine regional ACHs are now thriving in Washington, operating as independent self-governing entities. Through these diverse multi-sector partnerships, ACHs are an integral part of achieving the Triple Aim and an equitable health system that is responsive to regional needs. Specifically, ACHs are:

- Bringing together diverse public and private community partners to identify and work on shared regional health goals by engaging the optimal mix of contributors on each ACH.
- Identifying opportunities for the ACH and community partners to understand and bridge health and quality of life issues.
- Partnering with the state to inform the development of other Healthier Washington investments (including the Medicaid Transformation Demonstration), recognizing ACHs are the connection to communities and the local conduit to achieve true systems change.

While ACHs have flexibility to tailor projects based on regional needs, the expectation under the SIM test is that ACHs employ a "Triple Aim" strategy that links communities to health care delivery systems, public health, and supports that contribute to the health of the individual, in addition to better care and lower cost. Strategic elements from the Plan for Improving Population Health initiative (P4IPH) have been integrated into the statewide ACH strategy in order to promote meaningful population health management.

ACHs are key partners in many Healthier Washington initiatives. Below are a few examples:

- With clear alignment between ACH regions and the regional service areas for Medicaid purchasing, ACHs are a local partner in payment model redesign. Specifically the ACHs are functioning as a partner in the move to integrated care as Washington moves away from traditional fee-for-service and drives toward paying for value that focuses on the health of the community and individual. One example under Payment Model 1 is what we call an "early warning system" that provides an on-the-ground perspective of the transition to whole-person care. This includes alerts regarding regional and local health and community system or access issues and corresponding recommendations.
- In addition to value-based payment, ACHs will play a key role as part of clinical practice transformation to promote clinical-community linkages and physical and behavioral health integration. Statewide practice transformation support entities now have a strong relationship with each ACH.
- The Analytics, Interoperability, and Measurement effort will provide measurement and population health data to drive decision making. We have been and will continue to rely upon the ACHs to identify local requirements and inform statewide priorities. The evaluation requires short-term and long-term measures, along with a Triple Aim lens based on the representation that exists within the ACH and the desire to link communities and delivery systems.

Accountable Communities of Health	
AY4 strategies	In AY4, we will support ACHs through evaluation and ongoing peer learning. The focus for AY4 is solidifying ACH value propositions and leveraging the Medicaid Transformation Demonstration to reinforce the ACH vision and whole population approach. ACHs will be funded under SIM to engage in Healthier Washington learning events, peer learning and coordination, and the ongoing CCHE evaluation. The ACH award amount per region will keep the whole-population vision alive, and provide ACHs dedicated support through SIM to engage in non-Medicaid Demonstration specific work. We will continue to emphasize the alignment of the Medicaid Demonstration and goals of SIM, recognizing both are tools to move ACHs and the state toward VBP and whole-person health. Medicaid Transformation Demonstration is the expected primary funding source over the next several years. ACHs also have other funding streams, including support from philanthropy, state grant programs, MCOs, and significant in-kind support. We will not fund a distinct technical assistance lead under SIM, but the peer learning and convening functions will be sustained by Healthier Washington staff.
Key deliverables or major work	• ACHs will design and implement a strategy to support population health and reinforce the ACH vision, in alignment with the Medicaid Transformation Demonstration. This will be SIM work, focused on the whole population of an ACH region.

Accountable Communities of Health	
efforts for AY4 include:	• Center for Community Health and Evaluation will continue evaluation reports and an annual ACH member survey. • HCA staff will partner with ACHs and the Communities and Equity Accelerator Committee to identify and implement resources to support Healthier Washington's health equity effort. • HCA staff will assess ACH functions and state policy and program levers to support the whole population health vision post-SIM.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	In order to promote cohesive transformation across the delivery system, we have emphasized the importance of aligning with existing initiatives and identifying specific strategies to leverage other work to reinforce the whole population mission of the ACHs and Healthier Washington. This is the most effective use of SIM resources, especially in light of the many priorities of our community partners and the state as a whole. Another example of alignment is coordination across Payment Model 1 and ACHs, clarifying engagement strategies, communication with community partners, and the role of the ACHs, MCOs and counties related to transformation and integration specifically. There may also be an opportunity to perform targeted outreach and alignment to connect participating partners within the Accountable Care Program with the ACHs. These opportunities will be explored further in AY4.
Have there been any changes in approach for AY4?	A notable change to our approach in AY4 is the reliance on Healthier Washington staff, evaluation partners, and ACHs themselves to support peer learning and technical assistance. Part of sustainability planning is a ramp-down in AY3 of dedicated technical assistance and convening support. This isn't to de-emphasize the need, in fact, ACHs continue to emphasize the importance. The Healthier Washington team will take on an increased coordination and convening function, and ACHs will rely more heavily on their own capacity and resources for subject matter expertise.
What is the approach to stakeholder engagement in AY4?	The ACH engagement strategy is an evolving one. It has changed from a more centralized liaison approach to one that relies on the broader team, including value-based purchasing leads, integrated managed care leads, our ACH lead from DSHS, and other subject-matter experts across agencies depending on subject matter, to share in the engagement process. We are currently evaluating the pros and cons of this shift and we may see a move in AY4 to establish more continuity between particular ACHs and points of contact within Healthier Washington. Otherwise, our broader communication and convening strategies remain and seem effective.
Who are the participating providers and organizations?	ACHs have continued to convene a broad array of both traditional and non-traditional health system and community partners, including payers, providers, social services, business partners, housing, corrections, education, and others, depending on the priorities of individual regions. This approach is central to the ACH model and will continue through AY4 and beyond.

The Practice Transformation Support Hub

The key aims of the Healthier Washington clinical practice transformation strategy are to support primary and behavioral health providers to:

- Participate in an integrated system of care that addresses the needs of the whole person
- Respond to value-based payment models
- Link to community resources for their patients

The Hub continued to develop and strengthen its programs and services in AY3:

- Practice coaching, facilitation and training program – led by Qualis Health
- Regional health connectors, a Health Extension Network – led by Qualis Health
- Web-based resource portal - led by University of Washington Primary Care Innovation Lab

In 2017 we fully deployed nine regional health connectors. They have been transformational in their new roles:

- Serving as ambassadors from the community to the providers (and vice versa)
- Amplifying the provider voice and acting as an advocate for providers in their communities
- Tracking and creating inventories of local resources
- Referring and connecting providers to resources
- Tracking provider requests and needs
- Sharing successes and gaps in resources with ACHs and the larger community.

The Practice Transformation Support Hub	
AY4 Strategies	In order to promote alignment across the delivery system, we will continue to align practice transformation resources through the Practice Transformation Consortium. Hub coaching will support payment models that apply to the enrolled practices. Hub coaching and resources will be shared and aligned with ACH objectives and goals through the connector. Hub coaching will incorporate measures from Medicaid contracts, MACRA/MIPS, and the Demonstration toolkit. Hub coaching will align with the VBP Roadmap and the Health Information Technology strategic plan.
Key deliverables or major work efforts for AY4 include:	• Aggregated assessment data for enrolled practices. • Coaching to 125 enrolled practices. • Alignment of practice transformation supports through the Practice Transformation Consortium. • Transition practices to other sources of technical assistance and practice transformation support by the year's fourth quarter.
How has the plan been modified for AY4 to focus on	Hub coaches will provide coaching support to 125 enrolled practices through 2018 with a reduced coaching staff. Throughout AY4, the

The Practice Transformation Support Hub	
program alignment across the delivery system?	coaches will report to Healthier Washington and DOH, and to relevant ACHs and provider associations, on the progress and needs of enrolled practices so that final transition to other support in the fourth quarter will be seamless and well planned. Practice transformation support will begin to transition from a state-based service to one that is supported by statewide entities. In AY4, we will work through SIM to transition clinical practice transformation supports to other sources of technical assistance or other sources of funding. The VBP Academy Phase II, for instance, will seek funding through the SAMHSA Mental Health Block Grants from DSHS' Department of Behavioral Health and Recovery, possibly in partnership with a TCPi initiative. The resource portal will not use SIM funding to launch version 3.0 and will identify other resources to support sustainability. The Hub team will continue assessing progress among practices and aggregating assessment data to close out AY4.
Have there been any changes in approach for AY4?	We always envisioned that by the end of SIM, clinical practice transformation support would be identified as a community asset and funded as such. The state will facilitate the process to connect resources and funding to providers and their representative organizations and connect them to the best source of provider support. This transition away from state ownership will begin in early AY4, with much of the work occurring in the first two quarters. This shifts the focus to the sustainability of practice transformation capacity, both among the workforce of coaches and in the agencies and clinics that have participated in Hub activities. The Hub will not add additional practices or build new functionality in the resource portal, but rather will be communicating the value of the Hub infrastructure that has been built with SIM resources, positioning the Hub as a community asset that stakeholders will want to support.
What is the approach to stakeholder engagement in AY4?	Our practice transformation efforts were put in place to support providers in the transition to VBP, with an emphasis on primary care and behavioral health providers. As such, provider engagement will continue to be a focus, as well as engaging regional communities around ACH tables. The Hub will continue to convene tribal partners, rural stakeholders through the state office of Rural Health and WSHA, and support providers engaged in Healthier Washington payment models 2 through 4. The goal of stakeholder engagement in AY4 is to create a runway for the sustainability of practice transformation supports to the provider community. This will be accomplished through demonstration of value, strategic planning, and the engagement of the ACHs to leverage financing through the Medicaid Transformation Demonstration.
What do you need from other SIM investment areas to carry out this work?	This work is dependent upon coordination and information sharing from the Model 1 team, the AIM team and the HIT strategic plan. The Hub requires guidance for productive engagement at the ACHs on behalf of providers.
Your target population?	Small to medium providers delivering behavioral health and primary care, including substance use disorder providers.

Shared Decision Making

Shared Decision Making (SDM) has been a key component of our practice transformation support endeavors. Our success in AY3 in getting several patient decision aids (PDAs) certified has energized our plans for AY4.

In AY3, the Accountable Care Network began to implement SDM into the workflow at three of their clinical practices, using maternity and joint/spine patient decision aids. Between each of the three sites, 130 clinical providers received training in SDM 101. The training was extended to additional providers not participating in the ACP and offered in an online learning format by Healthwise. An additional 125 orthopedic specialists received SDM training, followed by a pilot on using SDM with total joint replacement and spinal fusion patients. In the second and third quarters we reviewed patient decision aids in total hip and total knee replacement, as well as spinal fusion, working with experts from Dartmouth Institute. In the third quarter we launched our third round of certification of patient decision aids that address end of life care.

We also contracted with a member of the International Patient Decision Aid Standards (IPDAS) Collaboration to develop a training for the review panelists and will use the content to develop an online learning module for future review panels.

In summary:

- Healthier Washington trained more than 300 clinical providers in shared decision making;
- Healthier Washington certified four orthopedic patient decision aids;
- Healthier Washington launched its third round of certification of patient decision aids, focusing on end-of-life care.

Our certification of orthopedic patient decision aids was projected to be completed by end of August 2017. Due to delays in our contracting process with our expert reviewers, the process to review and certify these PDAs took longer than expected. Going forward we will set specific deadlines for experts to respond in order to participate.

Shared Decision Making	
Key strategies for AY4	In AY4, we will build a business plan for integrating SDM and certification of patient decision aids into the Clinical Quality and Care Transformation (CQCT) division within HCA to sustain the work beyond SIM. This includes engaging key partners across the state to develop a roadmap to support and continue to move this work forward, because HCA cannot do it alone. This requires buy-in from key partners, including providers, patients, health plans and professional liability insurers to ensure requirements for SDM and use of certified PDAs are included in contracts and incentivized for providers to incorporate SDM into practice. This work supports recent updates to the NCQA accreditation guidelines to support population health management that includes health insurers providing practices with certified PDAs. Also in AY4 as we continue to expand the number of certified aids, we plan on providing open access to training for providers using an online module that has been tested through our Accountable Care Program. In order to ensure successful widespread implementation of SDM into practice across Washington, we need to ensure providers understand what good SDM is and receive training to do it and receive incentives to do it well, either through contractual VBP agreements with payers, or through tools (PDAs) provided for their use. This is a bit of a shift away from providing direct technical assistance to support SDM implementation. Nevertheless we continue to monitor the activities within the Accountable Care Program network sites and Federally Qualified Health Centers that have been implemented in previous funding years to continue to understand best practices and share those learnings with our national and state partners. There is quite of bit of research that demonstrates the value of using PDAs in conjunction with SDM. This includes increasing patients' knowledge, engagement, and satisfaction to initial studies that look at outcomes. In Washington we have legislation that supports the certification process, as well as recent NCQA Health Plan accreditation guidelines that supports the use of certified patient decision aids. As the only certifying body of PDAs, as well as legislation to back it up, the business case will include charging for certification. All of this presents a viable business case for continuing SDM as part of our agency work. At the end of AY4 it is our goal to have a business plan in place, which has been pilot tested, as well as language in our 2019 public employee health benefits and Medicaid contracts that supports the use of SDM and certified PDAs.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	In order to promote alignment across the delivery system, we are engaging different providers, payers, producers of PDAs, and patients to support use of SDM and PDAs, incentivize quality and value, a better experience for the patient, and reduce variation of services, which can ultimately reduce costs We are bringing in the patient voice to help us work with producers of PDAs to continue to inform the incorporation of health literacy requirements We are working collaboratively with health plans to identify what we mean by "support the use of SDM and the use of certified PDAs" in contracts. This could be anything from providing the tools to providers to paying providers to do SDM.

Shared Decision Making	
Have there been any changes in approach for AY4?	• Shifting away from providing direct technical assistance to a few practices as we learned best practices, to spreading and scaling the use of SDM so we can universally promote the use of certified aids to align with recent NCQA accreditation guidelines • Building and testing our sustainability model to charge developers for review and certification of PDAs
What is the approach to stakeholder engagement in AY4?	We began working with a group of stakeholders in 2015 and are reconvening these same stakeholders, along with new partners. Those critical new partners include the patient voice and the professional liability insurer. We are also having distinct separate conversations with health plans about appropriate contractual language, although they will also be critical to discussions to develop the roadmap.
What is needed from other SIM investment areas to carry out this work?	• Input and collaboration from payers to identify language for 2019 contracts. This work will engage all of the Medicaid and PEBB payers, because it is our intention to put language in the 2019 state contracts requiring SDM and the use of PDAs • Collaboration and input from practices engaged in implementation of SDM and use of certified PDAs through payment models 2 and 3 SDM pilots • Results from SDM pilot evaluation learnings • Support from the Hub to help promote online training to providers
Your target population?	Clinical providers, payers, purchasers, patients, and producers of PDAs
Percent of beneficiaries impacted?	Goal is to impact all public employee and Medicaid beneficiaries
Participating providers / organizations?	Currently, three Accountable Care Networks (NW Hospital, MultiCare, Evergreen) and two FQHCs
Participating payers?	Currently PEBB ACP and bundled care contracts (UMP/Regence, Kaiser Northwest, and Premera), and will include requirements in all MCO contracts and all PEBB contracts in 2019.

Paying for Value: Our Payment Models

Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019. Paying for value is key to achieving the Triple Aim and ensuring systems contribute to the health of the whole person. Meeting this goal will require shifting reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes as measured by the Statewide Common Measure Set.

Washington State will use its position in the marketplace to drive transformation. While we have goals around health expenditure trends, which will be measured as part of our state evaluation, we are focused on our levers as a purchaser and convener, working to transform the system through our four innovative payment models.

Payment Model Test 1

Our work to integrate physical and behavioral health for Medicaid managed care clients across the state has been a complex and rewarding effort. This model supports long-standing feedback from communities and providers around the importance of behavioral health and physical health operating in tandem, as well as the clear and necessary benefits of care coordination. While the model is legislatively mandated,

recent preliminary data (described in more detail below) shows positive initial results and affirms beliefs held by our communities and legislators that serving the whole person leads to better health outcomes and increased cost savings. The Payment Model Test 1 work also illustrates particularly well how alignment across the Healthier Washington investment areas can lead to transformation and sustainability. Alignment opportunities included:

- Partnering with the ACHs in integrated managed care regions and assisting in collaboratively establishing roles/responsibilities of the ACH in those regions.
- Starting Jan. 1, 2018, integrated financing contracts in Southwest Washington will include language that incentivizes the use of VBP methods with providers and incentivizes plans to work with providers to move to more integrated clinical models.
- Throughout AY3, bi-weekly check-in calls with Southwest Washington helped ensure success with integrated care models and the Hub technical assistance.
- Assisted in implementing a marketing and communications plan to address concerns regarding integration and inform and encourage other regions to become mid-adopters.
- Collaboratively developed the North Central model design by determining the number of health plans to participate (based on the results of the MCO procurement), establishing an advisory council at the ACH, and participated/continued to participate in local workgroups, such as the IT/EHR, rate setting, consumer engagement, and early warning system workgroups.
- Addressed impacts of new federal Medicaid regulations and new state legislation.
- Participated in the assessment of the five BHAs in North Central ACH, conducted by Qualis Health and Outlook Associates, regarding each BHA's billing capacity and identifying needed technical assistance.

In AY3, efforts were undertaken to evaluate the Southwest Washington region on several measures, to demonstrate the effect of integration compared to non-integrated regions. We are proud to report that the Southwest region is performing better than non-integrated regions in 10 of 19 measures, including percent homeless, percent arrested, follow-up after emergency department visit for alcohol or drug dependence after both seven and 30 days, and antidepressant medication management. The Southwest region is performing as well as non-integrated regions in eight measures. A report offers details on these preliminary results.

In AY4, we will implement integrated financing for Medicaid services in the North Central region, as well as five new regions that have provided their commitment to become mid-adopters of the model by 2019. By the end of the SIM grant period, up to 72 percent of Medicaid beneficiaries will have access to whole-person care. By 2020, Medicaid beneficiaries in every service area in Washington will be served by managed care systems providing an integrated set of physical and behavioral health services.

Healthier Washington partnered with DSHS in AY3 to develop a Learning Collaborative, which will be repeated in AY4. The Learning Collaborative plays a critical role in

implementation of the 2019 mid-adopter regions by establishing a statewide, standardized learning process for the transition of vital information. This will reduce duplication and provide an avenue for the establishment of regional workgroups that focus on local nuances and regionally-specific topics.

The Learning Collaborative sessions will cover a variety of topics that use the learning and experience of the BHOs and MCOs and provide an avenue to identify action steps necessary for transition planning and the successful implementation of integrated care. The following are topic areas to be covered during the Learning Collaborative sessions:

- Core principles of a recovery-oriented system of care
- Provider network/capacity building/provider engagement
- Community partnership
- Services and financing
- MCO/BHO collaboration
- Understanding monitoring requirements

The leadership shown by the counties and the ACH in Southwest Washington has also set the stage for longer-term sustainability of the integrated financing model. Their investment of time, talent and local resources in convening partners and confirming a commitment to the success of the model not only helps assure continuation of services to their own residents, but sets an example that the other regions can follow.

Model 1 / Physical and Behavioral Health Integration	
AY4 strategies	In October 2017, HCA received signed binding letters of intent from 24 counties, comprising five regional service areas, committing to pursuing payment model 1, effective January 1, 2019. These counties represent the most populous in the state, and by January 2019, 29 of 39 counties will have transitioned to this model, including the regions that implemented in 2016 and 2018. Inclusion of these additional regions will create a total of 1,570,029 Medicaid beneficiaries in whole person care. HCA will continue working on implementation in these five regional service areas, while preparing to bring the 10 remaining counties into model 1 by January 2020. In January 2020, 100 percent of Medicaid beneficiaries will receive services through an integrated managed care plan, including dual-eligibles or other fee-for-service populations who will receive behavioral health through a "behavioral health services only" managed care product. The integration of agency and administrative functions will continue in AY4, and SIM staff and contractors will move further toward the integration of the DSHS Behavioral Health Administration into the Health Care Authority. There are three main work streams involved in agency integration: Project management, change management, and systems integration management. State agencies and contractors will work closely together on this work so that the administration of integrated physical and behavioral health care can also be mirrored at the administrative level.
Key deliverables or major work efforts for AY4 include:	• Release a procurement to select the integrated managed care plans for the rest of the state, including the five "mid-adopter" regions implementing in 2019 and the 2020 regions.

Model 1 / Physical and Behavioral Health Integration	
	• Release a procurement for a behavioral health administrative service organization (BH-ASO) that will operate the crisis system and other non-Medicaid services in mid-adopter regions. • Set rates and funding allocations for integrated managed care for 2019 regions. • Achieve HCA/DSHS agency integration. • Successfully transition BH benefits to the MCO/BH-ASO contracts in five mid-adopter regions by January 2019.
Have there been any changes in approach for AY4?	We achieved more mid-adopters than expected, which is a significant achievement that will require a more strategic balance of existing resources. Healthier Washington and the Medicaid program are actively looking at various strategies and methods for ensuring adequate staffing for the work ahead, relying heavily on non-SIM operational resources. Other aspects of ensuring the focus can be on integrating new regions includes: Transition planning of duties for the Southwest and North Central regions into standard operation, documenting the implementation steps necessary for successful transition, documenting and acting upon lessons learned, and participating in discussions with DSHS on how to best staff our work within the future landscape.
What is the approach to stakeholder engagement in AY4?	The stakeholder management strategy for Model 1 remains largely the same. The achievement of having 24 additional counties sign on as mid-adopters is beyond what was originally anticipated and demonstrates that our stakeholder engagement strategy has been effective in moving us toward our goals. Heavy lifting to coordinate integrated care will continue by state staff, providers, ACHs, and counties as this work moves forward.
What is needed from other SIM investment areas to carry out this work?	This work is dependent upon continued engagement at the community level via the ACHs and through the counties and existing behavioral health organizations and their networked providers. Additionally, the Hub continues to support the model by providing technical assistance related to clinical integration, which dovetails with the transition to an integrated financing model. The Hub has also provided critical technical assistance and support related to provider billing transitions, which will be necessary in the mid-adopter regions.
Your target population	All Medicaid beneficiaries in mid-adopter regions (24 counties).
Percent of beneficiaries impacted?	72 percent
Participating payers?	Five

Payment Model Test 2

Model Test 2 aims to move federally qualified health centers (FQHCs), rural health clinics (RHCs) and critical access hospitals to a value-based payment system that allows them the flexibility to achieve better health, better care, and lower costs for the populations they serve.

FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS: ALTERNATIVE PAYMENT METHODOLOGY (APM) 4

On July 1, 2017, 16 clinics began using a new alternative payment methodology for Medicaid managed care enrollees that provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentivizes for improved health care outcomes while meeting federal requirements.

FQHCs and RHCs are essential providers of care to Washington's Medicaid population. These clinics qualify for cost-based reimbursement from Medicare and Medicaid for the delivery of comprehensive health care services, typically to an underserved area or population. These primary care providers offer some of the most innovative and integrated delivery models in the state, yet their reimbursement structure stifles further care delivery innovation.

Current reimbursement for clinics is defined by face-to-face, encounter-based payments. This structure results in a system that creates an incentive to deliver care based on volume over value. While statutory and regulatory requirements help to ensure access is maintained, these regulatory requirements make changes to payment especially difficult.

APM 4 moves these providers to a value-based purchasing (VBP) system, giving them the flexibility to expand on innovative and integrated delivery models, and accelerate the effectiveness of VBP initiatives on both a state and federal level. While ensuring federal reimbursement requirements are met, APM4 attempts to shift from the paradigm of encounter-based requirements by moving the clinics to a per-member-per-month (PMPM) rate, which will be prospectively adjusted based on quality performance.

The goal of APM4 is to allow clinics to improve access to care by focusing on improvement against specific quality measures, and allowing clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 is also intended to incentivize alternatives to face-to-face visits and allow clinics to offer more convenient access to primary care services.

WASHINGTON RURAL MULTI-PAYER DEMONSTRATION

Starting in 2015, Healthier Washington's Payment Model 2 worked collaboratively with the Washington Rural Health Access Preservation (WRHAP) group, the Washington State Hospital Association (WSHA), and partnering state agencies to explore new models of payment and delivery that help to build sustainability and support some of Washington's smallest rural providers in the transition to value-based payment.

Supported by WSHA, the WRHAP group successfully worked with Washington's legislature on the passage of SHB1520. This legislation helps to sustain WRHAP members and ensure they are able to provide essential health services to their community, and supports their transformation to value-based payment. Inspired by this investment, Healthier Washington's long-term vision, and input from CMS, HCA has moved to expand this early engagement with the WRHAP group to be inclusive of additional rural providers. In parallel HCA is working to make the best use of available resources provided under this timely legislation.

The Washington Rural Multi-Payer Demonstration seeks to move rural providers into a budgeted payment methodology that encapsulates primary care and hospital related services and is inclusive of multiple payers.

There are four key goals of the Washington Rural Multi-Payer Demonstration:

1. Value-based payment reform – This demonstration focuses on patient-centered solutions that will reward rural providers for the value of care delivered, not for the volume of care delivered, and will incentivize rural providers to improve outcomes for patients and populations.
2. Sustainable solutions for maintaining and increasing access – This demonstration will address the unique challenges of rural health delivery, and will help to maintain and increase access to essential health services. These solutions will allow for rural providers to be successful under value-based purchasing arrangements.
3. Delivery system transformation – This demonstration will incent delivery system integration and will seek to redefine primary care for rural populations. This will include aligned payment systems, cross-cutting incentive structures and regulatory flexibility.
4. Patient engagement – This demonstration will deliver the right care, at the right place, at the right time, and will ensure that each patient is engaged with the local health care delivery.

The Washington Rural Multi-Payer Demonstration model will require a Medicare waiver and targets principled agreement with CMS, targeted for the conclusion of SIM.

Payment Model 2	
AY4 strategies	FQHC/RHC APM4: We plan to use AY4 to sustainably transition APM4 fully into agency business, an activity that has already begun. The majority of the work will focus on promotion of APM4 with stakeholders in order to spread and scale the model, and the implementation of a data sustainability plan to ensure data supports can continue beyond SIM. Rural Multi-Payer: We evolved this part of the model in AY3 to shift from a narrower approach that focused on smaller rural hospitals to an approach that focuses on a broader model that is inclusive of all rural providers and

Payment Model 2	
	one that embraces a multi-payer, globally budgeted approach. This is in response to the broader vision embraced by Healthier Washington and CMMI. Our initial starting point was with a subset of critical access hospitals that expanded over time. Reflecting on the overall goal of health system transformation, newly aligned vision will meet broader payer and provider needs. Next year's work will involve advancing the model with payers, providers, the Washington State Legislature, and other stakeholders. Work will also be undertaken to align the model with the Medicaid Demonstration and other supportive initiatives at the state and federal levels. We will seek comment from providers and payers to pilot the model, and seek agreement with CMS on Medicare participation.
Key deliverables or major work efforts for AY4 include:	FQHC/RHC APM4: • Fully integrate APM4 into agency business; • Recruit four additional FQHCs for APM4 • Recruit at least one RHC to APM4 These goals reflect the large endorsement in 2017 for participation. We are confident that those who were able to participate have moved forward already. Expansion reflects capacity considerations of providers, and resolution of outstanding issues such as change in scope. Rural Multi-Payer: • Develop complete model proposal with figures and proposed rates, engage payers and providers in review, and seek letters of intent from payers and providers. Deliver complete proposal to CMMI for review. • Negotiate terms and finalize model for approval with CMS, finalize details and negotiate final terms and rates. • Establish legislative direction for continued model development and implementation. • Identify alignment strategy with Medicaid Demonstration • Work with providers and payers to set up data relationships, identify and contract with auditing entity, establish administrative infrastructure for implementation.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	FQCH/RHC APM4: • More emphasis on the Medicaid Demonstration, and continue to align with Healthier Washington initiatives and projects, and promote APM4 participation with stakeholders that are impacted across initiatives, e.g. opioid project for ACHs need to work with FQHCs and RHCs if they are going to be successful; and • Greater alignment and engagement with MCOs. Rural Multi-Payer: • Alignment with the Medicaid Demonstration and MCOs requirements as an integral part of the model; • Where possible align with current VBP initiatives to leverage networks and current implementation; and • Incent coordination across multiple payers.

Payment Model 2	
Have there been any changes in approach for AY4?	FQHC/RHC APM4: No changes to report. Rural Multi-Payer: • Shift from a narrower approach focused on smaller stressed providers to a broader approach that seeks VBP transformation for all interested rural providers.
What is the approach to stakeholder engagement in AY4?	FQHC/RHC APM4: • Promote APM4 in supporting materials, through publically available forums and directly engage with providers. • Cultivate provider champions to promote APM4 adoption. Rural Multi-Payer: • Will be shifted to include all rural providers.
What is needed from other SIM investment areas to carry out this work?	FQHC/RHC APM4: • Continued staff support in development and implementation of the communications strategy. Rural Multi-Payer: • AIM – Data support (principally Medicare data support); and • Support Hub – Practice transformation support.
Your target population?	FQHC/RHC APM4: Medicaid recipients Rural Multi-Payer: Medicaid, Medicare and commercial payer beneficiaries
Participating providers / organizations?	FQHC/RHC APM4: 16 FQHCs

Paying for Value: Payment Model Test 3

Payment Model 3 is focused on both the Accountable Care Program (ACP) for public employees in Washington State, as well as targeted efforts to engage payers and purchasers and support the market in the move to value-based purchasing and payment. To date the state has taken a "first mover" approach in moving to value-based contracting, which has largely been accomplished through our Medicaid 1 percent withhold and ACP for public employees and retirees.

Work in AY3 was focused on expanding the ACP program into additional counties and encouraging additional PEBB members to switch to value-based benefit plans. Legislation was passed in early 2017 adding Washington State public school employees into the health care purchasing jurisdiction of the HCA, introducing additional members and their families into the pool of those who can benefit from the ACP program and its continued plans for expansion. Because this model has largely been built into agency business, no dedicated SIM contract funds will be allocated to Payment Model 3. Model 3 staff will work closely with the HCA's employee benefits division to ensure the spread and scale of this model.

To further scale and spread the accountable care option, this model test will be expanded statewide in 2018 via the following strategies:

- Facilitating discussions between the two ACP networks and provider groups from other payment models. To date, one network partner has been in discussions with a Model 4 provider partner. Healthier Washington will also explore aligning the ACP programs with our Apple Health MCO partners.

- Healthier Washington has provided funds for technical assistance to each network in order to better facilitate onboarding new provider groups as the networks attempt to expand their reach into additional counties and fortify their presence in current counties. Upon request, we assist ACP network partners in their recruitment efforts by providing customized data reports on potential provider partners (e.g., number of state employees attributed to the provider practice, utilization data, etc.).

- Continued engagement of senior purchaser leaders through the Washington Health Alliance Purchaser Affinity Group. The Washington Health Alliance will expand its current purchaser group, the Purchaser Affinity Group (PAG) to include C-suite leaders and other large self-insured purchasers who are not currently members of the group. Current PAG membership includes benefit managers from Starbucks, King County, Boeing, and unions. To be held four times a year, the meetings will be a 'call to action' and a mechanism to engage and educate benefit decision makers at organizations.

- Healthier Washington has also been working closely with Boeing, the Pacific Business Group on Health, and its purchaser members to share our experiences and brainstorm ways to spread and scale ACO ideas with other large purchasers in the Seattle area.

- Continued targeted presentations to purchaser groups and 1:1 meetings with public and private purchasers. Over the last year, Healthier Washington staff and HCA Executive leaders met with benefit staff at REI and Costco. Now that Year 1 financial results are available, Healthier Washington staff will produce webinars, continue to proactively select presentations and arrange individual meetings with public and private purchasers to further educate and spread the model test and accountable care tools.

- HCA hosted a statewide purchaser conference on value-based purchasing, with over 150 in attendance, to increase awareness and share actionable steps for purchasers to use to implement value-based contracting strategies. Multiple purchasers shared their stories and experience developing and implementing VBP contracts, including HCA, Boeing, and Walmart.

Payment Model 3	
AY4 strategies	• Work with University of Washington Accountable Care Network to expand into new counties for 2019. Puget Sound High Value Network has made the business decision not to expand geographically and will focus on new and existing members in their current counties of operation. • Support health literacy among PEBB members. • Implement bundles in ACP networks. • Provide PEBB support for decision to extend or re-procure ACP networks. • Share results of Center Of Excellence program and ACP networks with purchasers/providers/payers including the Health Benefits Exchange.
Key deliverables or major work efforts for AY4 include:	• Work with communications team to create educational tools for members to promote health literacy. • Add bundles to the existing ACP contracts as an amendment in 2019 and/or a new ACO procurement, which would begin January 1, 2020. • Contract to extend or RFP to re-procure ACP networks, a strategic Healthier Washington leadership decision to be made in spring or summer 2018. • Meetings and webinars with purchasers/providers/payers (including Health Benefit Exchange). • Meetings with UW ACN on geographic expansion efforts and submit data to them as needed.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	• Focus on health literacy. We need educated beneficiaries to increase enrollment in value-based purchasing products.
Have there been any changes in approach for AY4?	• No SIM funds will go directly towards payment model 3, but staff will support sustainability of VBP, ACP, and promote health literacy within the scope of the PEBB budget.
What is the approach to stakeholder engagement in AY4?	• Movement from the concept of VBP to having specific results to share with external audiences.
What is needed from other SIM investment areas to carry out this work?	• Obtaining data for analyses within the ACP networks requires resources for dedicated contractor support. We need AIM to have a public employee data set to do in-house analyses so we can support this program in an affordable manner.

Payment Model Test 4

Healthier Washington Payment Model Test 4: Greater Washington Multi-Payer seeks to accelerate the adoption of value-based purchasing by increasing providers' access to patient data across multiple payers and health systems. The resulting multi-payer product will have the capacity to coordinate care, share risk, and engage a large population comprising commercial, Medicaid, public employee, and Medicare beneficiaries. Claims and clinical data integration and aggregation will provide a unified view of patient care and timely feedback to providers, regardless of payer, facilitating improved care coordination and population health management.

Payment Model 4 (Data Aggregation Solutions)	
AY4 strategies	• Transmit in full, claims data for all covered lives from Uniform Medical Plan (UMP) Classic and UMP Consumer Directed Health Plan (CDHP) and Apple Health Medicaid, attributed to Model 4 contracted physician networks. • Facilitate the expansion of Model 4 to additional providers and/or payers if contractor(s) are willing and able. • Explore incorporating both contractors into the ACP network(s) o Either provider group (Northwest Physicians Network or Summit Pacific Medical Center) could join one or both of the ACP networks, which would expand the ACP model to additional providers. The Model 4 multi-payer infrastructure could potentially serve as a bridge to expanding the ACP model to additional payers. • Given the success of HCA's total joint replacement center of excellence, Model 4 provides a unique opportunity to investigate the possibility of using Apple Health claims data to build out an episode-of-care approach within the managed care space. • Develop a sustainability plan for this model with our contractors.
Key deliverables or major work efforts for AY4 include:	• Annual work plan • Semi-annual progress report • Report on quality measures *(The Contractor(s) will report their performance on clinical quality measures (based on the ACP measure set) to HCA. The report will be presented in a numerator/denominator style format. The measures will comprise clinical data from the multi-payer data involved in Model 4.)* • Participate in qualitative evaluation with UW evaluation team • Develop sustainability plan
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	• We are coordinating with HCA's Clinical Quality and Care Transformation (CQCT) division to connect the Model 4 contractors to the shared decision making training being offered. • We have already connected the contractors to the Hub and will continue to seek opportunities to align Model 4 with other Healthier Washington transformation efforts. • We have aligned quality measures in the contracts with those from the ACP and MCO contracts. • We have narrowed the focus for AY4 to focus on robust implementation of the model and assurance that data is flowing between the involved managed care organizations and UMP plans. • We have a prioritized strategic focus on a plan for long-term sustainability.
Have there been any changes in approach for AY4?	• We must reduce our focus on expansion and instead hone in on implementation, evaluation and sustainability of the current state. • We are exploring additional uses for the internal infrastructure we are developing for this model for use in bundled episodes-of-care in Apple Health Medicaid. • Given a smaller contract budget, we will likely limit the expectations placed on the contractors to expand the model to additional (commercial) payers. We will still encourage and support any efforts for expansion, but it is unlikely to be tied to a contract deliverable.

Payment Model 4 (Data Aggregation Solutions)	
What is the approach to stakeholder engagement in AY4?	We have shifted away from targeting stakeholders for expansion and narrowed our focus to supporting our contractors to ensure a successful implementation and robust AY4 demonstration of the utility of this model
What is needed from other SIM investment areas to carry out this work?	• Will need continued subject matter expert (SME) support from the AIM team and project management support • Will need continued SME support from the rest of the VBP team • Will need continued SME support from other investment areas such as the Hub and SDM
Participating providers / organizations?	• Northwest Physicians Network • Summit Pacific Medical Center

Analytics Interoperability and Measurement (AIM)

Our AIM strategy includes continuing to build and strengthen our data governance, analytics, health IT coordination, and internal capacity. AY4 will be a look to the future in terms of how we support the varying data needs of our initiatives and programs that are being built into agency business.

AIM	
AY4 strategies	In AY4, AIM focuses on the transition to sustainability for an integrated data and analytic function within HCA to support ongoing health systems transformation. All AIM SIM investments in AY4 are either for time limited projects like the state evaluation, capacity building for the AIM team, or have an ongoing funding source identified. With the implementation of the Medicaid Transformation Demonstration, some analytic functions that were initially funded under SIM have now been transitioned to serve Demonstration functions and be fully funded under the Demonstration. The HCA has also absorbed some data and analytic infrastructure investments that were initiated through the SIM grant. This vision of eventual agency incorporation has been supported through HCA strategic planning efforts, and the agency has now absorbed work to house PEBB data, to build an enterprise data warehouse, and to create a sustainable plan for Medicare data storage. In AY4, SIM funding is focused on completing the state and federal evaluation of the SIM grant, providing for acquisition and use of data sources that directly support payment model innovation and integrated managed care, and developing analytic capacity that can leverage the data and analytic infrastructure being created through other SIM investments and ongoing agency funding.
Key deliverables or major work efforts for AY4 include:	• Investments in critical data acquisition that meet immediate deliverables and build towards incorporation into a broader agency data infrastructure strategy. • Targeted payment model support that will be integrated into the build of enterprise data warehouse with its advanced analytic tools. • Project management support to align and integrate program specific data governance processes with growing agency data governance capability.

AIM	
	• Investment in training for AIM staff to adapt general skills to a unique HCA analytic environment. Investment in analytic tool licenses to transition to enterprise data warehouse analytic environment in 2019. • Purchase and distribution of PEBB data product to be supplied to both state and federal independent evaluators of the SIM grant for Payment Model 3.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	In order to promote alignment across the delivery system, data and analytic investments in AY4 are directly tied to specific needs identified in related program areas.
Have there been any changes in approach for AY4?	A notable change to our approach in AY4 is the acceleration of efforts to identify potential sustainable funding sources and to adjust AIM investments to meet requirements of those funding sources. This effort has led the AY4 AIM investments under SIM to focus more tightly on data and analytic elements directly tied to supporting other SIM investment areas. A focus of AY4 deployment will be the integration or development of functionality into the underlying data and analytic infrastructure of HCA.
What is the approach to stakeholder engagement in AY4?	The AIM work is supportive of multiple projects and processes within Healthier Washington. Therefore, the engagement strategy is focused on customer service and a drive to provide our working partners with the data and analytic support needed for success. Stakeholder engagement includes close relationships with ACHs in order to be responsive to their regional data needs, evaluation contractors to ensure they have the data necessary to carry out their work, and with providers in Healthier Washington payment models.
What is needed from other SIM investment areas to carry out this work?	This work is dependent upon close alignment and communication with AY4 SIM investments to ensure that AIM data and analytic support meet critical functionality and information needs and have an integrated sustainability plan beyond the SIM grant. This alignment includes the development of an Early Warning System, encounter to value payment model support, scalable support that highly leverages other available resources for the rural payer model, and sustainability support for payment models 3 and 4. The sustainability plan for AIM will require close alignment and integration into the growing decision support function within the agency.

Communications

The Healthier Washington communications strategy is focused on clear and concise messaging, event convening, and strategic planning to foster engagement in health systems transformation.

Communications (Healthier Washington)	
Update to project / initiative strategies for AY4	In AY4, we will continue and build upon our current engagement efforts, including convening meetings, workgroups, accelerator committees, and event presence, to enable Healthier Washington visibility and sustainability beyond the SIM grant.
Key deliverables or major work efforts for AY4 include	• Continue building and promoting our Voices of a Healthier Washington story bank • Build a framework to ensure Healthier Washington (as a brand identity) thrives beyond the duration of the SIM grant • Continue to update and add to our existing library of fact sheets, FAQs, webinar presentations, and infographics • Identify and ensure a presence at stakeholder and community events and meetings to disseminate information, identify champions, and advance the goals of Healthier Washington • Conduct a campaign to segment our current Feedback Network (2,600 people), in order to better target communications

b. Quality Measure Alignment

In January 2015, the legislative directive to build aligned Medicaid and public-private measures of health system performance was announced. The passage of E2SHB 2572 required the development of a statewide core measure set, the Common Measure Set, to inform health care purchasing. With the adoption of a "starter" set of 52 measures across the domains of prevention, chronic illness, and acute care, the Performance Measures Coordinating Committee (PMCC) has continued to convene and evolve the measure set as state priorities change and mature.

Payers and providers are equally committed to reducing the administrative burden of overlapping measure requirements and are active participants on the Performance Measures Coordinating Committee. All commercial payers have voluntarily committed to participating in public reporting of the common measure set. Additionally, the state invested in a campaign that targets purchasers to promote the adoption of the measure set. These efforts have resulted in a measure set that can be effectively used by multiple payers, clinicians, hospitals, purchasers, and communities for health improvement, quality improvement, provider payment system design, benefit design, and administrative simplification efforts, as appropriate.

Looking forward, the committee recognizes the need to turn attention towards maintenance and monitoring of the current measure set. There is a commitment to align with national measure sets where possible, though there is also recognition of the need to develop measures that address high priority areas, especially where they do not currently exist.

- In October 2017, the PMCC reviewed and recommended for public comment the following measures to include in the 2018 Common Measure Set:

    1. Percentage of women who receive first trimester prenatal care

2. Percent of youth who report using tobacco products, marijuana, alcohol or other drugs during the past 30 days
3. Obesity:
    - Measure A: Age-adjusted percent of youth self-reporting a body mass index (BMI) of >30 (calculated based on self-reported height and weight)
    - Measure B: Age-adjusted percent of adults 18 years and older self-reporting a body mass index (BMI) of >30 (calculated based on self-reported height and weight)
4. Opioid Prescribing:
    - Measure A: Among new opioid patients, percent who then transition to chronic opioids in the next quarter.
    - Measure B: Percent of patients at high doses among patients prescribed chronic opioids.
    - Measure C: New opioid patients' days supply of first opioid prescription
5. Patient Experience: Measure: How well providers use information to coordinate care
    - Industry standard measure based on CG-CAHPS patient experience measure
    - Collected as part of a survey distributed and measured by the Washington Health Alliance

The common measure set will be used to regularly assess and report performance at the community, health plan, clinical practice, and/or hospital level. Results will be publicly reported in an unblinded manner when numerators and denominators are sufficient to produce results that are statistically valid.

Note: the current set of SIM metrics can be found in Appendix 2: Core Progress Metrics and Accountability Targets. It contains the metrics table from the quarterly progress report due November 30, 2017.

Performance Measure Alignment	
AY4 strategies	In AY4, we will build upon previous work to leverage the Performance Measures Coordinating Committee to evolve the Statewide Common Measure Set. Without an oversight committee, who is perceived as non-biased to external partners, we run the risk of identifying "one off" measures for contracts that do not align, which would move us away from our commitment to standardization and place undue burden on the practice community. In AY4 we plan to work with the PMCC to move towards a maintenance mode for the committee. This way, the common measure set can still be monitored, and the committee can help us test out newer and more innovative strategies as we move into the future of measurement. Washington will report the Statewide Common Measure Set, and we will promote the use of it more broadly to consumers and ACHs.

Performance Measure Alignment	
Key deliverables or major work efforts for AY4 include:	• Work with PMCC to develop a roadmap for the future of measurement in Washington and the role of PMCC in implementation • Work with ACHs to promote the use of the Community Check-Up to inform project development and promote information to consumers and employers • Work with the Clinical Quality Care Transformation (CQCT) division within HCA to align PMCC functions with internal agency processes.
How has the plan been modified for AY4 to focus on program alignment across the delivery system?	• Working more broadly with ACHs to promote the use of the Community Check-Up report • Working with employers to promote use of quality measurement in contracting with payers
Have there been any changes in approach for AY4?	• Shifting away from continuing to add measures to Common Measure Set to more of a focus on monitoring how we are implementing the measures in our contracts and the impact of those measures • Looking towards the future of measurement and continually developing new strategies for informing policy
What is the approach to stakeholder engagement in AY4?	The members of the PMCC are part of a governor-appointed committee who represent a variety of jurisdictions and interests. We will however be reaching more strategically to the ACHs.
What is needed from other SIM investment areas to carry out this work?	• Coordination with ACHs • Coordination with payment model teams to ensure alignment of measures that drive value.

All-Payer Claims Database

The completion of the WA-APCD infrastructure in 2017 allows for the purchase of price and quality reporting through this mandatory state resource, based on the Washington State Common Measure Set described above. It is important to note that we are continuing to resource the Washington Health Alliance to provide additional detail into quality measure reporting by payer and by ACH, levels that the WA-APCD does not drill down to. The WA-APCD will provide additional reporting to include price information.

The Office of Financial Management (OFM) is required in Chapter 43.371.060 RCW to contract with the WA-APCD lead organization for reporting on quality and pricing data for the Washington State Common Measure Set. In AY4, the contractor will build on the previous development work of a state-mandated all-payer claims database that will be used to improve health care transparency. The goals of this transparency are:

- Assist patients, providers, and hospitals to make informed choices about care
- Enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices
- Enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time
- Promote competition based on quality and cost

Although a voluntary APCD has existed in the state for a number of years, in 2014 the Legislature enacted law establishing the WA-APCD with mandatory reporting. Through this contract, OFM will expand the reporting infrastructure for pricing, cost, and quality data to support transparency of the Statewide Common Measure Set beyond AY4.

All-Payer Claims Database (APCD)	
AY4 strategies:	Work with OFM to provide reports on the common measure set for ACHs, and determine use-cases and ongoing viability for this resource

Key deliverables or major work efforts for AY4 include:	• Deliver pricing and quality data for the Washington State Common Measure Set on Health Care Quality and Cost
	  o Expand Reportable Common Measure Set Measures for Medicare
	  o Add Common Measure Set Measures Adopted by the PMCC
	  o Enhance Reporting of Performance Results to Physician Organizations, Hospitals, and Other Providers
	• Updates of the Washington State Common Measures Set for Health Care Quality and Cost Performance Outcomes Website
	  o Provide three refreshes of the Common Measure Set using an additional three months of quality-approved data
	• Develop WA-APCD Analytic Enclave to Provide Access to Healthier Washington State Partners and the Accountable Communities of Health

How has the plan been modified for AY4 to focus on program alignment across the delivery system?	Provide access to APCD data sets for specific ACHs who have the analytic capacity
Have there been any changes in approach for AY4?	• In AY4, we will largely transfer public reporting requirements for the statewide common measures from the voluntary APCD to the state-mandated APCD. The Washington State Legislature passed a budget proviso requiring this shift in focus. • The state-mandated WA-APCD results are only available online and do not include hard copy reports as in the past. This will require communication and expectations management.
What is needed from other SIM investment areas to carry out this work?	• Coordination with ACHs • Coordination with AIM team to access Medicare data if available

c. Plan for Improving Population Health (P4IPH)

In AY3, The Healthier Washington Plan for Improving Population Health (P4IPH) became an actionable, focused work plan designed to identify and implement specific system and policy changes to integrate prevention activities into the ongoing operation of the health and health care system. HCA, DOH, and DSHS implemented a structured process to identify initial priority focus areas for P4IPH. The process resulted in the

selection of one primary focus area, diabetes prevention and treatment, along with one secondary area: well-child visits. Also in AY3, the Population Health Planning Guide, developed late in AY2, became a permanent fixture on the DOH public-facing website. The Guide is a resource for any program or entity to follow in their implementation of a population health-focused effort.

Our partner in this population health work for AY3 was Kaiser's Center for Community Health and Evaluation (CCHE). CCHE helped to guide the development of the population health work plan, create an inventory of existing initiatives, and coordinate a needs assessment, all focused on the primary focus area of diabetes.

Dedicated efforts to create a focused roadmap for population health in Washington State are longstanding, with the pre-work for P4IPH coming from the 2014 Prevention Framework. As a reminder of the origins of this work, the objectives of the Prevention Framework are:

- **Objective One:** By December 31, 2018, Washington State will increase the proportion of the population who receives evidence-based clinical and community preventive services that lead to a reduction in preventable health conditions.

- **Objective Two:** By December 31, 2018, Washington State will increase the proportion of the population with better physical and behavioral health outcomes by engaging individuals, families, and communities in a responsive system that supports social and health needs.

- **Objective Three**: By December 31, 2018, Washington State will increase the number of communities with improved social and physical environments that encourage healthy behaviors, promote health and health equity.

- **Objective Four:** By December 31, 2018, Washington State will increase the number of integrated efforts between public health, the health care delivery system and systems that influence social determinants of health to lower costs, improve health, improve the experience of care and contribute to the evidence base.

In AY4, P4IPH activity will be focused on enhancing linkages between statewide initiatives and programs and the ACHs. In each region there are many areas of overlap between these existing statewide programs and the activities of the ACHs, both in terms of strategic goals and populations targeted. This shows potential for many productive collaboration opportunities, and P4IPH will work to inform both ACHs and the statewide initiatives about each other and help to identify and promote these collaboration opportunities. We will add information on these initiatives to the Population Health Planning Guide website to make it more accessible to the ACHs.

d. Health Information Technology (HIT)

Healthier Washington has worked to align and integrate its multiple health information technology and health information exchange activities into a single HIT Operational Plan that includes deliverables and work streams from SIM, the Medicaid Demonstration, and additional HCA HIT/HIE projects. The Health IT Operational Plan identifies the tasks to be implemented by quarter for the remainder of 2017 and 2018, and will be updated annually through 2020. Implementation of the Health IT Operational Plan will be coordinated by the Health IT Coordinator at HCA, and tasks in the plan will be led by subject matter experts from multiple organizations. Implementation will occur in collaboration with ACHs, providers, payers, other state agencies, and other stakeholders. The robust and widespread participation in the implementation of the health IT Operational Plan will help ensure that activities meet the needs of stakeholders in a meaningful and sustainable way.

See Appendix 4 for detailed HIT operational roadmap for 2018-2020.

e. Workforce Capacity and the Industry Sentinel Network

The Healthier Washington strategies of value-based payment, integrated care, and clinical-community linkages all require a foundation of workforce capacity strategies to ensure effectiveness and successful transformation outcomes. Our workforce capacity has largely been supported by ongoing work at our state health agencies, with specific and targeted SIM investments to support community health worker recommendations and industry health workforce data trends. In AY4, the sustainability of this work resides with the Medicaid Transformation Demonstration, since foundational elements of Initiative 1 require regional projects to have a workforce component. Practice transformation also includes workforce, and alignment with the work of the Practice Transformation Hub will be essential to ensuring that this continues to be woven into the work we do.

In AY4 we seek to sustain our industry sentinel work, align with the Practice Transformation Support Hub and Medicaid Demonstration requirements, and engage with Accountable Communities of Health to ensure we are providing the right guidance, data, and support.

Workforce Capacity	
AY4 strategies	In AY4, we will complete and publish the final AY3 Health Workforce Sentinel Network report. We will continue to identify opportunities for sustainability and integration, including with the Medicaid Demonstration Initiative 1 and the Practice Transformation Support Hub.
Key deliverables or major work efforts for AY4 include:	Identify sustainability opportunities for Health Workforce Sentinel Network data collection and reporting.
How has the plan been modified for AY4 to focus on	In order to promote alignment across the delivery system, we are aligning Health Workforce Sentinel Network planning and sustainability strategy with Demonstration Initiative 1 activities.

Workforce Capacity	
program alignment across the delivery system?	
Have there been any changes in approach for AY4?	A notable change to our approach in AY4 is to transition planning and sustainability strategy to Initiative 1 of the Demonstration. The Sentinel Network promises to provide real-time workforce planning data to allow ongoing planning and evaluation of workforce activities and needs.
What is the approach to stakeholder engagement in AY4?	We will enhance our focus on connection with ACHs through evolving Medicaid Initiative 1 structure and plans.
Participating providers / organizations:	Participating data collection network providers include behavioral health organizations, hospitals, long-term care facilities, physician groups and practices, federally qualified health centers, rural health clinics, and hospitals.

3. SIM Alignment with State and Federal Initiatives

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 Medicaid waiver, known in Washington State as the Medicaid Transformation Demonstration Project. The resulting five-year contract authorizes up to $1.5 billion in federal investments to promote innovative, sustainable and systemic changes that improve the health of Washingtonians receiving Medicaid services.

While SIM and the Medicaid Demonstration are separate initiatives, the Demonstration was specifically designed to accelerate the foundational elements that SIM created to transform the health system in Washington State. The goals, strategies, and outcomes are intentionally the same. In the table below, we will discuss alignment and relationships with other federal initiatives. The Demonstration is the largest and most important of these, and a foundational part of the SIM sustainability strategy.

The Demonstration funding is dependent on the federal government matching funds to two sources made available by the state (neither of which obligates the expenditure of state general funds):

- Intergovernmental Transfers (IGT)
- Designated State Health Programs (DSHP)

The Demonstration's goals over the next five years are to:

- Integrate physical and behavioral health, to create a system of whole-person care
- Convert 90 percent of Medicaid provider payments to reward value-based payment strategies
- Improve health equity so all, even the most vulnerable Medicaid beneficiaries, can benefit
- Increase and improve services that support our aging population

The Demonstration is divided into three, interdependent initiatives:

- Initiative 1: Transformation through Accountable Communities of Health (ACH)
- Initiative 2: Long-term Services and Supports (LTSS) for the aging population
- Initiative 3: Foundational Community Support Services (FCS) through supportive housing and supported employment

Under Initiative 1, ACHs will work with community partners on four to eight regionally critical projects that will improve population health and transform the way health care is provided. An independent assessor will review regional project plan applications, and make recommendations to support project approval. The state worked with its independent assessor to develop a project plan review tool.

- Project funding will be triggered by the achievement of community health milestones, which are laid out in the project plans. Funds will be disbursed through a neutral financial executor.
- As mentioned in the section on stakeholder engagement, the state will continue to engage and coordinate with tribal governments to assess Demonstration impacts and opportunities.

Long-term Services and Supports includes services to assist unpaid caregivers. These supports include training, education, specialized medical equipment, and assistance. It also provides a personal care benefit for anyone who does not have a caregiver.

Foundational Community Support Services assists Medicaid clients with complex needs with finding and maintaining stable housing and employment.

At the end of five years, an independent party will conduct an evaluation to verify that the initiatives are sustainable. It is also important to note that funding under the Demonstration is based on achievement of milestones, therefore money does not come until it is earned.

Additional information and resources are available on our website: www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation.

Other Federal Initiatives:

- CMMI Health Care Innovation Awards
- Health Care Innovation Awards
- Health Care Innovation Awards Round Two
- Community-based Care Transitions Program
- Bundled Payments for Care Improvement (BPCI) Models 2 and 3
- Transforming Clinical Practice Initiative (TCPi)
- Medicare Care Choices Model
- Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient-Centered Medical Homes
- Meaningful Use and HITECH
- Initiatives from related agencies such as CDC, ONC, SAMHSA, HRSA and AHRQ

Alignment / Approach re: SIM / Federal Initiatives	
Accountable Health Communities	While Washington State is not participating in the Accountable Health Communities model, there is alignment with the underlying values of the model through several state initiatives. According to CMS, the AHC initiative was put in place "based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs." This same evidence has created the basis for many of our projects and initiatives, including the Medicaid Transformation Demonstration, Accountable Communities of Health, and the Plan for Improving Population Health.
Transforming Clinical Practices Initiative (TCPi)	Washington State is fortunate to have been granted several TCPi awards, including funding for a large pediatric TCPi initiative. In order to ensure alignment between these efforts and the Healthier Washington Practice Transformation Support Hub, we worked in partnership with SIM staff at CMMI and TCPi staff in Washington State and at CMS to create a Practice Transformation Alignment Plan that was completed in early 2017. Through this work, Washington State developed a Practice Transformation Consortium to implement the plan and coordinate these crucial alignment activities, in order to reduce redundancy and duplication of services.
Health Homes	The Washington Health Homes Demonstration leverages Medicaid health homes, established under Section 2703 of the Affordable Care Act, to integrate care for full-benefit Medicare-Medicaid beneficiaries. Washington has targeted the demonstration to high-cost, high-risk Medicare-Medicaid enrollees based on the principle that focusing intensive care coordination on those with the greatest need provides the greatest potential for improved health outcomes and cost savings. HCA is geographically expanding the Medicaid health home initiative to better more timely care for patients with complex care needs. There is also specific alignment between this program and our Healthier Washington Payment Models 1 and 2: Recognizing the connection between behavioral health challenges on physical health, Health Homes are a required component of PM1's Integrated Managed Care Contracts. This administrative alignment creates a mechanism and opportunities for MCOs to identify more clients that could benefit from Health Homes, as they have access to information pertaining to both physical health and behavioral health. In Integrated Regions, MCOs must have offer Health Home services to eligible clients and have a sufficient network to provide these services. The Health Homes program focuses on care coordination at different levels of risk. The incentives structures of the Health Homes program and the APM4 track of Model 2 are aligned around the Triple Aim and value-based purchasing. APM4 participants are financially incentivized to work with MCOs in the management of the health of the population that they serve. Central to provider success under APM4 is care coordination, both within their organization and with external providers. Structurally, these value-

Alignment / Approach re: SIM / Federal Initiatives	
	based payment structures incent payers and providers to change service delivery to reduce cost and improve care.
CPC+/other multi-payer models	Washington does not have any providers or payers participating in CPC+. Nevertheless, HCA recognizes the value and quality of the CPC+ model and intends to align with its foundational principles. We are aiming to drive multi-payer alignment on quality measures and practice transformation through our payment model work, particularly Model 4, by leveraging the quality improvement model of our ACP, the statewide common measure set, and the Hub.

Because of the broad interagency and stakeholder engagement in the development of Washington's State Health Care Innovation Plan, which served as the foundation for Healthier Washington, many health systems innovation activities are already well coordinated with the SIM grant. Even with close coordination, SIM funding neither duplicates nor supplants federal or state funds that support such activities.

C. Detailed SIM Operational Plan by Driver

Our planning approach for AY4 is heavily focused on the "how" and the "action steps" that we need to take to successfully achieve our SIM project goals – and to develop clear sustainability strategies for all valuable concepts and pilots. Operational work plans are separated by driver or project area. Milestones are prefixed with reference to Healthier Washington goals: G1 through G9. (Goals are outlined in section A.1 Summary of Model Test).

Accountable Communities of Health (ACH) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G1: Evaluation data collection provides evidence toward how ACHs add value to the regional work of ongoing health system transformation for the entire community.*				
1.1	ACHs actively participate in evaluation through survey/reporting	Q1	Q4	Katharine Weiss	Regional ACHs, CCHE
1.2	ACHs participate in shared learning events and HW coordination opportunities	Q1	Q4	Christine Quinata	Regional ACHs
1.3	ACHs design and implement Demonstration alignment strategy to support population health and ACH vision	Q1	Q3	Katharine Weiss	Regional ACHs
1.4	Demonstration opportunities identified to align with whole-population HW vision and reinforce broader ACH value	Q1	Q1	Katharine Weiss	
1.5	Tangible opportunities identified to coordinate proactively with Tribal Affairs and/or Tribal Nations ahead of policy decisions and communications	Q1	Q1	Christine Quinata/TBD	
1.6	Resources and collaboration opportunities are provided to ACHs in a coordinated, timely and accessible manner	Q1	Q4	Christine Quinata	
1.7	Interagency and program levers identified and implementation plan developed	Q3	Q3	Chase Napier	
1.8	Defined role for ACH as a partner in purchasing with a roadmap that includes specific activities	Q1	Q4	Chase Napier	
2	***Milestone:*** *G9: Health equity tools/guidelines/best practice resources are delivered to each ACH.*				
2.1	Tangible opportunities identified to apply health equity resources to Healthier Washington	Q2	Q2	Katharine Weiss	
2.2	Pilot program launched for an MCO to collect disaggregated data around race, ethnicity and language	Q4	Q4	Katharine Weiss	

**we will work to re-scope additional funds to this activity, as efficiencies are realized*

Practice Transformation Support Hub (Hub) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G4: By end of Q4, practices enrolled in Hub coaching services show practice transformation advancement compared to previous/initial assessment.*				
1.1	Continue to assess enrolled and non-enrolled practices (upon request and with available resources).	Q1	Q4	Mary Beth Brown	Qualis Health
1.2	Continue coaching up to 125 enrolled practices at through end Q4.	Q1	Q4	Mary Beth Brown	Qualis Health
1.3	Close out transition of practices and other sources of technical assistance and practice transformation support by Q4	Q1	Q4	Mary Beth Brown	Qualis Health
1.4	Report final summary status of practice transformation assessments and action plans for enrolled practices	Q1	Q4	Mary Beth Brown	Qualis Health
1.5	Provide final listing of active coaches, assignments and caseloads by ACH and practice type	Q1	Q4	Mary Beth Brown	Qualis Health
2	***Milestone:*** *G4: By end of Q2, a Hub sustainability/transition assessment, strategy and process will be delivered for a decision on disposition.*				
2.1	Implement transition process including scaled down coaching and number of enrolled practices based on practice engagement and/or handoff to other resources	Q1	Q1	Mary Beth Brown	Qualis Health
2.2	Communicate and connect to ACHs, AICH, and other to AY4 work plan and enrolled practices to AY4 work plan and connect to enrolled practices.	Q1	Q4	Mary Beth Brown	Qualis Health
3	***Milestone:*** *G4: By Q4, respond to providers' practice transformation support needs, refining coaching interventions.*				
3.1	Provide final aggregate assessment data to relevant workgroups, evaluators, and leaders	Q4	Q4	Mary Beth Brown	Qualis Health
3.2	Deliver short-term TA to non-enrolled practices within available resources. • 2 Cohort Learning Series • 2 Webinars	Q1	Q4	Mary Beth Brown	Qualis Health
4	***Milestone:*** *G9: By Q4, options for practice transformation support are delivered to each ACH.*				

No.	Deliverable	Start Date	End Date	Resources	Vendor
4.1	Communicate and connect relevant Practice Transformation information and resources to providers, ACHs, AIHC and others, through sustainable resource	Q1	Q4	Mary Beth Brown	Qualis Health
5	***Milestone:*** *G1: Provide direction to ACHs about Practice Transformation resources and assets available in their regions.*				
5.1	Monitor and adapt the SIM TCPi Alignment Plan through the PT Consortium.	Q1	Q4	Mary Beth Brown	Qualis Health

Shared Decision Making (SDM) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G3: By Q3, build a business case to transition SDM and certification into HCA (CQCT).*				
1.1	Develop financial model for sustaining process to review and certify patient decision aids	Q1	Q2	Laura Pennington	Karen Merrikin
1.1.1	Develop draft cost plan for PDA certification submissions	Q1	Q2	Laura Pennington	Karen Merrikin
1.2	Develop staffing model for implementing SDM/certification of PDAs within CQCT	Q2	Q2	Laura Pennington	
1.3	Develop plan to implement certification process/SDM project within CQCT	Q2	Q2	Laura Pennington	
1.4	Pilot internal business model for certification process/SDM	Q3	Q4	Laura Pennington	
1.5	Implement application costs into submission process	Q4	Q4	Laura Pennington	
2	***Milestone:*** *G3: By end of AY4, develop a roadmap for implementing SDM and certified Patient Decision Aids into practice across Washington.*				
2.1	Develop a sustainable online training model for training clinical providers in SDM	Q1	Q1	Laura Pennington	Healthwise
2.2	Convene thought leaders to design draft roadmap for sustaining and spreading SDM	Q1	Q2	Laura Pennington	
2.3	Convene SDM stakeholders, including providers, plans, patients, developers, etc., to develop a roadmap for sustaining and spreading SDM in Washington and promoting the use of certified PDAs	Q2	Q3	Laura Pennington	Healthwise

No.	Deliverable	Start Date	End Date	Resources	Vendor	
2.4	Finalize implementation plan for sustaining and spreading SDM and promoting the use of certified PDAs across Washington	Q4	Q4	Laura Pennington		
3	***Milestone:*** *G3: By the end of AY4, measurable increase in SDM requirements into state-based contracts.*					
3.1	Meet with Medicaid program leadership to discuss proposal for supporting SDM in state-based contracts	Q1	Q1	Laura Pennington		
3.2	Convene all MCOs to discuss / get commitment for supporting SDM in contracts	Q1	Q1	Laura Pennington		
3.3	Draft SDM contract language based on outcome of meeting and submit to Medicaid leadership for input / approval	Q1	Q2	Laura Pennington		
3.4	Submit draft SDM contract language to MCOs for negotiation / approval	Q1	Q2	Laura Pennington		
3.5	Enter into final SDM contract language with MCOs for 2019	Q3	Q3	Laura Pennington		
3.6	Build plan for future SDM contracting requirement, with input from MCOs	Q4	Q4	Laura Pennington		
3.7	Repeat process for PEBB contracts; since final language needs to be complete in Q2, follow up in 2019 may be needed	Q4	Q4	Laura Pennington		

Payment Model 1 (PM1) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G6: Plan and implement integrated care in at least 2 more regions by January 1, 2019.*				
1.1	Collaboratively develop the integrated care model design in each Mid-Adopter region, including defining parameters of transition year sub-contractual relationships	Q1	Q2	Alice Lind	
1.2	Complete procurement for integrated care plans	Q2	Q2	Alice Lind	
1.3	Complete procurement for BH-ASO	Q3	Q3	Alice Lind	
1.4	Complete rate setting for integrated care rates	Q2	Q2	Christy Vaughn	
1.5	Determine distribution of non-Medicaid funds between MCOs and BH-ASO and any other entities	Q3	Q3	Savannah Parker	
1.6	Conduct readiness review to verify that MCOs are prepared for 1/1/19 go-live	Q2	Q2	Penny Bichler	
1.7	Conduct readiness review to verify that the BH-ASO is prepared for 1/1/19 go-live	Q2	Q2	Penny Bichler	
1.8	Conduct "knowledge transfer" to educate MCOs on BH programs and services	Q3	Q4	Isabel Jones	
1.9	Host a Learning Collaborative for MCOs and BHOs to facilitate shared learning in advance of 2019 transition	Q3	Q4	Jessica Diaz	
1.10	Send client notifications per CMS requirements, informing clients of transition from BHO coverage to integrated MCO coverage	Q4	Q4	Jessica Diaz	
1.11	Clients transferred to new integrated care plans	Q4	Q4	Alice Lind	
1.12	Establish an Early Warning System Committee in each Mid-Adopter integrated care region	Q2	Q2	Isabel Jones	
1.13	Successful execution and transition of Medicaid beneficiaries in Mid-Adopter integrated care regions	Q4	Q4	Alice Lind	
1.14	Distribute SIM TA dollars through interagency agreements to regions that submit binding letters of intent to become Mid-Adopters	Q1	Q4	Isabel Jones	Mid-Adopter Regions
2	***Milestone:*** *G9: Build HW / SIM work into other agency efforts that fit into priority areas.*				
2.1	Transition NC and SW operations to MPOI Staff and prep for transition of 2019 regions to Medicaid operations staff	Q3	Q4	Isabel Jones	

No.	Deliverable	Start Date	End Date	Resources	Vendor
3	***Milestone:*** *G9: By Q4, align agency business processes to support health systems transformation.*				
3.1	BHI: Facilitate interagency coordination and execute Transition Plan	Q1	Q2	Jody Costello	PCG
3.2	BHI: Monitor project performance metrics and provide ongoing reporting	Q1	Q2	Jody Costello	PCG
3.3	BHI: Develop organizational maturity recommendations and performance-tuning approach	Q1	Q2	Jody Costello	PCG
3.4	BHI: Plan, facilitate, and drive Systems Integration to support communication and collaboration between inter-agency staff	Q1	Q3	Jody Costello	PCG
3.5	BHI: Implement change management plans and provide transformation support/facilitation	Q1	Q3	Jody Costello	Mass Ingenuity
3.6	BHI: Maintain project management infrastructure	Q1	Q3	Jody Costello	Mass Ingenuity
3.7	BHI: Monitor progress and support any mitigation efforts needed to ensure effective results	Q1	Q3	Jody Costello	Mass Ingenuity
3.8	BHI: Provide Inter-Agency Executive Oversight support for Behavioral Health Integration	Q1	Q3	Jody Costello	Cambria

**we will work to re-scope additional funds to this activity, as efficiencies are realized*

Payment Model 2 (PM2) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor	
1	***Milestone:*** *G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.*					
1.1	APM4 - Recruit four additional FQHCs for APM4	Q4	Q4	Gary Swan		
1.2	APM4 - Review and implement solutions for small providers and support their participation in APM4	Q3	Q3	Gary Swan		
1.3	APM4 - At least one (1) RHC added to APM4 by January 31, 2019	Q4	Q4	Gary Swan		
1.4	APM4 - Identify and implement modifications for APM4 sustainability	Q2	Q2	Gary Swan		
1.5	APM4 - Compile and review lessons learned for spread and scale	Q2	Q2	Gary Swan		
1.6	APM4 - Review implications of expended services and determine if there will be specific carve outs for APM4 going forward in the future	Q1	Q1	Gary Swan / Madina Cavendish		

No.	Deliverable	Start Date	End Date	Resources	Vendor	
2	***Milestone:*** *G2: Executed agreement with providers and payers (1 commercial and 1 MCO) for implementation of a rural multi-payer demonstration by January 1, 2019.*					
2.1	Rural Multi-Payer - Agreed upon waiver for rural multi-payer model by December 31, 2018	Q2	Q4	Gary Swan		
2.2	Rural Multi-Payer - Commitment to pilot model from providers by December 31, 2018	Q2	Q4	Gary Swan		
2.3	Rural Multi-Payer - Commitment to pilot model from at least one commercial payer by December 31, 2018	Q2	Q4	Gary Swan		
2.4	Rural Multi-Payer – Pending 2019 legislation, attain early implementation of model on January 1, 2019	Q4	Q4	Gary Swan		
2.5	Rural Multi-Payer - Alignment and implementation plan for HW initiatives	Q2	Q4	Gary Swan		
2.6	Rural Multi-Payer - External stakeholder engagements to promote advocacy	Q4	Q4	Gary Swan		
2.7	Rural Multi-Payer - Agreement with CMS that the model qualifies for an advanced APM under MACRA	Q2	Q4	Gary Swan		

Payment Model 3 (PM3) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor	
1	***Milestone:*** *G2: 40% of commercially-financed health care payments are in VBP arrangements as defined by the HCP-LAN APM Framework*					
1.1	Purchaser Support - Engage employer groups to promote VBP	Q1	Q4	Kristin Villas		
1.1.1	Individual meetings and webinars with purchasers to share ACO Year 1 Results, post all HCA contracts online, work with PBGH and WHA to engage purchasers	Q1	Q4	Kristin Villas		
1.2	MACRA support – Get payment models certified as APMs	Q4	Q4	JD Fischer		
1.2.1	Work to certify Medicaid and SIM models certified to adhere to final rule, work with CMMI/CMS to certify public employee payment models as other advanced APMs (Total Joint Replacement bundle)	Q4	Q4	JD Fischer		
1.3	Engage HBE and QHPs in VBP and other transformation activities (i.e. equity, adequacy, evidence-based standards)	Q1	Q4	Kristin Villas		

No.	Deliverable	Start Date	End Date	Resources	Vendor	
1.3.1	Work with Exchange staff to require inclusion of HCA key VBP components in Qualified Health Plans	Q1	Q4	JD Fischer		
2	***Milestone:*** *G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.*					
2.1	Implement bundles in ACPs	Q1	Q3	JD Fischer		
2.2	Decision to extend/re-procure ACP contract(s)	Q1	Q1	Kristin Villas		
2.3	Launch workgroup to explore how to align all state-financed plans (i.e. fully insured) with VBP strategies	Q1	Q4	JD Fischer		
2.4	Include ACH participation, through engagement on leadership teams and boards, as a requirement for participation in all HW payment models	Q2	Q2	JD Fischer		
2.5	Develop and implement spread and scale sustainability plan	Q1	Q1	Kristin Villas		
3	***Milestone:*** *G2: Increase the number of covered lives involved in HW payment models by 35%*					
3.1	Engage health plans in HW payment models (example: offer TA funds to a payer and provider partner from MCOs to disaggregate a subset of common measures by race/ethnicity as part of C&E HILN)	Q1	Q2	Kristin Villas		
3.2	Launch promotional tour to share results from ACP and TJR COE programs	Q1	Q2	Kristin Villas		
4	***Milestone:*** *G2: Two additional counties in ACP for 2019 plan year (as of January 1, 2019)*					
4.1	Expand ACP into two new counties for plan year 2019	Q4	Q4	Kristin Villas		
5	***Milestone:*** *G3: Align health literacy messages and strategies across HW and agency programs*					
5.1	Increase enrollment/State employee health literacy (health plan selection, key benefits terms (e.g. deductible), use of the provider search, VBP, obtaining high quality care, importance of a PCP and participating in open enrollment)	Q1	Q4	Kristin Villas		
6	***Milestone:*** *G9: Build HW / SIM work into other agency efforts that fit into priority areas.*					
6.1	Hold purchaser conference	Q3	Q4	JD Fischer		
6.2	Develop ACP Sustainability Plan	Q4	Q4	Kristin Villas		
6.3	Develop VBP Sustainability Plan	Q1	Q4	JD Fischer		

No.	Deliverable	Start Date	End Date	Resources	Vendor	
7	***Milestone:*** *G9: By Q4, align agency business processes to support health systems transformation.*					
7.1	Add Demonstration alignment measures to HW payment models and other state-financed health care contracts	Q1	Q4	Gary Swan		

Payment Model 4 (PM4) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor	Budget
1	***Milestone:*** *G2: 40% of commercially-financed health care payments are in VBP arrangements as defined by the HCP-LAN APM Framework*					
1.1	Explore incentives for ACHs to increase VBP in non-Medicaid payment models	Q3	Q3	JD Fischer		
2	***Milestone:*** *G2: 50% of state-financed payments are VBP, in alignment with HCA VBP roadmap.*					
2.1	Explore episodes of care and/or bundled payments in Medicaid, building on Model 4 infrastructure	Q1	Q3	JD Fischer		
2.2	Facilitate full contracts with each Model 4 Contractor and at least one additional MCO	Q4	Q4	JD Fischer	Summit Pacific/NPN	
2.3	Facilitate incorporation of one or both Model 4 partners in one or both ACP networks	Q4	Q4	JD Fischer		
2.4	Explore incorporation of Model 4 partners into other HW payment models and state-financed programs (i.e. DEMO, APM4, multi-payer)	Q3	Q4	JD Fischer		
2.5	Supply UMP claims data to NPN for Model 4	Q1	Q4	JD Fischer	Milliman	

Analytics, Interoperability, & Measurement (AIM) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G8: HCA/ Analytics, Interoperability and Measurement (AIM) and ETS /HIT section support use systems, data, measurement and analysis tools to support and sustain SIM priorities.*				
1.1	Acquire and integrate data needed to support SIM deliverables and operationalize subsequent transmissions (e.g., Medicare, PEBB, EDIE, other high value data sources identified)	Q1	Q4	Karen Jensen	TBD
1.2	Create and deliver data products for VBP payment models including deliverables for PM2, PM3 and PM4	Q1	Q4	Karen Jensen	TBD

No.	Deliverable	Start Date	End Date	Resources	Vendor
1.3	Provide data needed for SIM evaluation deliverables including UW, CCHE, RTI & RDA	Q1	Q4	Shuva Dawadi	TBD
1.4	Expand HW AIM team Data/Analytics capacity through Data/Analytics training	Q1	Q4	Kirsta Glenn	TBD
1.5	Provide AIM Project Management/Lean Projects support through OTB Solutions contract	Q1	Q4	Kirsta Glenn	OTB Solutions
1.6	Build HW AIM team capacity through the purchase of SAS (x7) and STATA (x4) Licenses	Q3	Q4	Kirsta Glenn	TBD

**We will work to re-scope additional funds to this activity, as efficiencies are realized*

Performance Measurement and Reporting (PMR) – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G1: By end of AY4, ACHs understand how the information in the Community Check Up can support their consumer and provider engagement efforts.*				
1.1	Promote use of the Statewide Common Measure Set and data provided on the Community Check Up to support HW activities, including the use of the provider level data and consumer engagement messaging to support the work of the Accountable Communities of Health	Q1	Q4	Laura Pennington	Washington Health Alliance
2	***Milestone:*** *G8: By end of AY4, PMCC / Statewide Common Measure Set management is built into QMMI process.*				
2.1	Convene the PMCC quarterly to develop a plan for the ongoing implementation and evaluation of the Statewide Common Measure Set, including the role and process for PMCC to provide oversight	Q1	Q4	Laura Pennington	Washington Health Alliance
2.2	Develop a process with QMMI to provide recommendations and communication to the PMCC	Q1	Q2	Laura Pennington	
2.3	Publicly report results for the Statewide Common Measure Set, using a web-based platform	Q1	Q4	Laura Pennington	OFM
2.4	Deliver pricing and quality data for the Washington State Common Measure Set on Health Care Quality and Cost	Q1	Q4	Laura Pennington	OFM

2.5	Updates of the Washington State Common Measures Set for Health Care Quality and Cost Performance Outcomes Website	Q1	Q4	Laura Pennington	OFM
2.6	Develop WA-APCD Analytic Enclave to Provide Access to Healthier Washington State Partners and the Accountable Communities of Health	Q1	Q4	Laura Pennington	OFM

HW Project Management & Communications – AY4 Work Plan

No.	Deliverable	Start Date	End Date	Resources	Vendor
1	***Milestone:*** *G9: By Q4, implement sustainability activities or conduct efforts to discontinue programs, according to the sustainability assessment results*				
1.1	Provide state evaluation of SIM through UW contract	Q1	Q4	Shuva Dawadi	UW
1..2	Provide state evaluation of SIM through CCHE contract	Q1	Q4	Chase Napier	CCHE
1.3	Support cross-cutting SIM operational deliverables through OTB Solutions project management contract	Q1	Q4	Bonnie Wennerstrom	OTB Solutions
1.4	Create strategic plan and action steps for Healthier Washington sustainability beyond the SIM grant end-date	Q1	Q4	Kennedy Soileau	TBD

**We will work to re-scope additional funds to this activity, as efficiencies are realized*

D. Program Evaluation and Monitoring

The measures outlined in *Appendix 2: Core Progress Metrics and Accountability Targets* identify and detail the specific quality performance metrics intended to capture data on quality, cost, utilization, and population health. The cross-system measures were selected for their ability to demonstrate performance across all SIM investment areas. While CMMI provided a set of recommended metrics, as permissible HCA chose alternative metrics that better reflect Washington State's demographics, needs, and priorities. The following information will be collected and reported annually for each performance metric:

- Metric area
- Metric title
- Metric definition/description
- Numerator definition
- Denominator definition
- NQF number, if applicable
- Alignment to other CMS programs
- Baseline value
- Accountability target

These metrics will allow us to better identify, track and understand the impacts Healthier Washington activities have on quality, cost, utilization, and population health over the performance period.

1. State-led Evaluation

The Healthier Washington project builds the capacity to move health care purchasing from volume to value, improve the health of state residents, and deliver coordinated whole-person care. Through focused and collaborative engagement of the public and private sectors, the Healthier Washington project will achieve better health, better care and lower costs for at least 80 percent of state residents by accomplishing the following three aims and goals:

Aim 1: Build healthy communities and people through prevention and early mitigation of disease throughout the life course.
Goal: By 2019, 90 percent of Washington residents and their communities will be healthier.

Aim 2: Improve quality of care by integrating health care and social supports for individuals with physical and behavioral comorbidities.
Goal: By 2019, all with physical and behavioral (mental health/substance abuse) comorbidities will receive high quality care.

Aim 3: Pay for value, instead of volume, with the state leading by example as "first mover."

Interim goal (quarterly/annually): 80 percent of state-financed and 50 percent of commercial health care are in value-based payment arrangements.

Ultimate Goal: By 2019, Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

Washington is uniquely positioned to improve health delivery, transform payment systems, and advance population health through the Healthier Washington project.

A discussion of the state's main evaluation questions and data sources

The overall SIM evaluation performed by the University of Washington will answer the following three revised questions:

1. What is the effect of the Washington State Innovation Model on population health and health equity across population groups in Washington?
2. What is the effect of the SIM on quality of care in Washington State, particularly for those persons living with physical and behavioral health comorbidities?
3. What is the effect of the Washington State Innovation Model (SIM) on the annual growth of health care costs per capita in Washington State?

An overview of revisions to the state's evaluation plan and activities from AY3

During AY3, we concentrated on revising analysis plans, data collection, data inquiries, and preliminary descriptive analyses.

Notable achievements during AY3 include the following:

Completion of the revised Overall SIM Evaluation Plan which clarified the subset of priority measures from the original February 2016 list that are ultimately feasible to include in analyses of the overall impact of SIM, as well as those that will be examined for trends but which are not feasible for impact analysis because of small numbers of observations, absence of an appropriate comparison group, or delays in availability of data.

The first round of 12 key informant interviews regarding the implementation of SIM has been completed, as well as a protocol for coding responses, identifying emergent themes, and relating those themes to the conceptual framework for our overall SIM evaluation.

We completed the final version of the methods for the overall SIM evaluation. In AY3, UW submitted the preliminary version of the methods to document our progress.

About half of the priority measures for the overall SIM evaluation are annual rates for Washington's population, which are listed below. We accomplished our goal of collecting baseline data (2013-2015) for Washington for 11 of the 12 rates, except childhood immunizations. We are in the process of collecting the childhood

immunization rates from the Department of Health. We also have discovered that some measures lack annual rates for each year of 2013, 2015 and 2015 baseline period. We are also collecting the rates for the United States population to use as a comparison group, if the national rates are available.

1. Mortality (various measures)
2. Childhood immunization status
3. Well-child visits
4. Child and adolescent access to primary care
5. First trimester care
6. Adult access to preventive/ambulatory care
7. Diabetes – Hemoglobin A1c poor control
8. Patient experience with primary care
9. State-purchased health care spending growth relative to state GDP
10. Medicaid spending per enrollee
11. Public employee and dependent per enrollee spending
12. How well providers use information to coordinate care

In Quarters 1 and 2 the University of Washington evaluation team completed 10 key informant interviews for the overall SIM evaluation. Interviews are audio-recorded and transcribed, and we have started content analysis, which will continue into the next quarter.

Evaluation of Payment Models

Payment Redesign Model 1 (Integration of Medicaid Purchasing for Behavioral and Physical Health) Evaluation:
We made significant progress on the first round of key informant interviews (KIIs) for Payment Redesign Model 1, which represent baseline qualitative data for the first year of PM1 and developed a structure of coding the responses. Additional potential interviewees have been identified and are being approached. The UW team is coordinating these qualitative analyses with the Research and Data Analysis (RDA) team of the state Department of Social and Health Services, which is carrying out the quantitative impact evaluation of PM1.

Payment Redesign Model 2 (Encounter to Value) Evaluation:
We completed comprehensive vetting with the HCA and RDA sub teams and data experts of the Analysis Plan and Data Questions for Payment Redesign Model 2. The UW Team received the original PM2 dataset for 2013-2015 from RDA in April 2017, and has completed descriptive analyses of the PM2 data regarding individual Medicaid recipients, eligibility, providers caring for those recipients, and utilization of health services. Our UW team prepared a set of questions related to the baseline data and has received initial answers to those questions from RDA. RDA will be provided a “refresh” including data for 2014 – 2016 on September 30, 2017. A second set of data questions will be discussed (and answered) during a planned meeting in late August 2017 of UW and RDA analysts and data experts in Olympia. The first round of KIIs for PM2 is now underway. Six interviews are now completed, with several more planned for completion by end of Q3.

Payment Redesign Model 3 (Accountable Care Program) Evaluation:
The UW Team has now vetted a set of data questions related to the dataset "refresh" recently received from Milliman Consulting for Payment Redesign Model 3. The first round of KIIs for PM3 are complete, with eight interviews conducted.

Payment Redesign Model 4 ("Greater Washington Multi-Payer:" Data Aggregation Solution) Evaluation:
The UW Team is performing only key informant interview analysis and content analysis of administrative data. This mutual decision by HCA operations staff for PM4 was driven by the fact that implementation of PM4 did not occur until July 2017, so a controlled before-after impact evaluation of PM4 would not be possible. Three KIIs have been completed, and three more are scheduled for August 18, 2017. So far, both participating provider organizations (Northwest Physicians Network and Summit Pacific Medical Center) and the data aggregation vendor (Clinigence) have been represented in the KIIs, with four more being scheduled for completion by September 30, 2017.

Practice Transformation Support Hub Evaluation

The Hub Evaluation Team has prepared a Rapid Cycle Process Improvement Report covering Award Year 3. The team collected and analyzed quantitative and qualitative data from April through June 2017. During this period, Hub developments include exceeding the practice coaching recruitment goals set for the year, strengthening the relationship with ACHs and tribes; hosting a webinar on community clinical-linkages, doing practice coaching and facilitation work funded by non-SIM funding streams, and launching Hub Resource Portal version 1.1.

To address evaluation questions about implementation from an external perspective, the UW team conducted four key informant interviews (KIIs) with individuals involved in selected ACHs. These KIIs focused on the relationship between the Hub and the ACHs, and revealed that in general, ACHs have positive views of the Hub, but feel it is too early to tell if the Hub is meeting its ACH-related objectives.

An overview of the key evaluation activities planned for AY4

Data for evaluation measures will be collected in 2017 through the summer of 2018. Because the final evaluation report is due January 2019, data collection must be completed no later than the summer of 2018, allowing five months to complete analyses and the final report. Because data collection stops in summer 2018, the impact evaluation of SIM's short-term impacts is limited to data for YR1 and YR2 of SIM rollout (2016-2017). Data exist for Washington and comparison states for measures in national surveys with individual-level responses. We expect the 2017 public data for national surveys will be available by summer 2018.

ACH Evaluation

The Kaiser (formerly Group Health) Center for Community Health and Evaluation (CCHE) team is actively engaged in evaluation of ACHs. In AY4 they will continue to monitor the ACH entities and their projects for success. They will be looking at the total system of care, inclusive of community stakeholders, providers, CHWs, and other players.

The purpose of this specific evaluation of ACHs is for CCHE to evaluate the extent to which ACHs achieve short, intermediate and long-term goals and outcomes. We will continue to rely on CCHE to engage as a thought partner with Healthier Washington by providing timely formative feedback and participating in ongoing strategy sessions to inform key decisions regarding the ACH model, strategy, funding, scale, and vision. This evaluation style provides support for continuous improvement of ACH efforts and goal advancement by identifying success factors, barriers, and lessons learned that may be useful in real time, including providing evaluation consulting and technical assistance to ACHs. CCHE also will continue to document best practices among ACHs, especially criteria or actions that promote optimum effectiveness in advancing health improvement goals. CCHE will disseminate results in a timely and effective way to key stakeholder audiences and look for opportunities to inform the field regarding what it takes to develop, implement and sustain ACHs.

CCHE's strategic learning questions for ACHs are:

1. How can Healthier WA support the development of ACHs' organizational capacity to coordinate regional health improvement activities?
2. How can Healthier WA support ACHs as they collaboratively implement projects and policy/practice changes in their regions?
3. What are the concrete ACH roles and requirements in broader Healthier WA health system capacity building efforts? How can Healthier WA support ACH success?
4. How can Healthier WA support the development of a long term vision for ACHs, including clarifying what is expected of ACHs beyond the Demonstration?

CCHE's evaluation questions for ACHs are:

1. Have the ACHs been successful in developing strong, functional, multi-sector community organizations with broad representation, strong governance structures, and the operational capacity to support their regional health improvement efforts?
2. To what extent have the ACHs collaboratively implemented health improvement projects (SIM/MDT) and policy/practice changes to broadly impact their region?
3. Have the ACHs productively contributed to broader Healthier WA activities and statewide capacity building efforts (VBP, workforce, IT)?
4. Have ACHs developed & implemented a shared vision for a collaborative model, including the ACHs' long term role in the region, and demonstrated their value-add in their region?

5. To what extent did the ACH model contribute to the creation of a well-functioning, high capacity, transformed health system (in their region)?

A Role for Data

CMMI may already possess some required Washington beneficiary data: TMSIS data (Medicaid) has been provided to CMS per our agreement and we also submit BRFSS data to CMS. CMS would already have access to the Medicare contingent and could leverage that for Medicare surveys.

One of the foundational Healthier Washington data components is the state's Link4Health Clinical Data Repository (CDR). The Link4Health CDR is in the process of gathering data from "first movers" in the state who have a stake in building a clinical data repository and having it available in the state's HIE.

Data security is of paramount importance to the Healthier Washington's AIM initiative. Part of the strategy driving the AIM endeavor is to further secure and control access to our mission-critical data and protect our clients. Across the Washington State agencies involved in health and health care, we have modernized our Identity and Access Management systems, locked down our desktop and laptop and mobile computing devices, and maintained strict data access approval requirements for all state data.

Under the direction of our Healthier Washington privacy and security manager, we have ensured we have the requisite data sharing agreements in place.

Both RDA and HCA have methods of identifying patients (for Medicaid services) to compile a picture of services delivered across the continuum. In its Medicaid business, HCA uses a client ID within ProviderOne, and RDA has created a patient identifier in their Integrated Client Database. Medicare beneficiaries are identified with a CMS-generated ID. We also track "duals" with a unique ID. Both Milliman and the Alliance have models for patient identification and a common identifier – across payers. We are able to identify dual-eligibles and track them across the continuum.

Our Evaluation Plan calls for comparing select SIM populations against non-SIM comparable populations. It will be necessary to pinpoint individuals impacted by each model test – and to find other like non-SIM populations against which to measure the SIM effect. While the data will be de-identified, individuals will be assigned an identifier which will allow our Evaluation team to pull data related to the evaluation of each test model. Comparison states (Hawaii, California, etc.) have been identified to provide a synthetic control group and a comparison model. Long-term, AIM will provide a unifying identification mechanism to map individuals across payers to planned interventions. At that point, given the strength of the Link4Health CDR and the Washington APCD strategies, we will have claims and clinical encounter data in our AIM data warehouse that will cover every individual in Washington.

2. Federal Evaluation, Data Collection, and Sharing

Washington State has been collaborating with RTI in AY3. Washington looks forward to any meaningful analysis that RTI can provide.

Related to the Federal evaluation, we will be able to: release data for Medicaid patients and PEBB beneficiaries (subject to the appropriate data sharing agreements).

Related to the Federal evaluation, we will not be able to: guarantee payer compliance with data requests, give precise lists of populations impacted by SIM, or guarantee participation by all providers of which CMMI may make requests.

Healthier Washington is committed to measuring client experience. We recently partnered on a survey with DSHS to survey clients on their experience. Also, HCA conducts a small, routine survey monthly to confirm clients received services billed; we do about 500 of those a month to ensure bills are for services received. While we have not previously conducted a focus group on patient experience, we have quality improvement targets built into our contracts for administering the PEBB program (which is CAHPS reporting with de-identified data). We also measure client experience in some SIM areas:

- The Alliance has been conducting "Your Voice Matters" surveys for the last 4 years to measure patient experience related to CG CAHPS provider groups.

- Under Model 3 (ACP), 5 CAHPS measures are in the quality improvement model which impacts payment – either gainsharing or payment penalties.

- We have also asked the two ACPs to use the Alliance CAHPS questions in their surveys. There are two measures in common measure set of 52 related to patient experience (they are CAHPS questions and build upon the WHA survey) – and Model 3 has already built these into their contracts.

- As outlined in the ACH Evaluation Plan, the Center for Community Health and Evaluation (CCHE) will use several data sets to evaluate the regional ACHs and the initiative as a whole. Related to client experience, data used to inform the evaluation will include ACH multi-sector member feedback based on regional surveys.

- Finally, there are future plans to survey the Practice Transformation Support Hub stakeholders related to client experience, and the Link4Health CDR team will be sampling to measure client experience in the provider environment.

We do plan, as part of our state-based evaluation, to conduct broader surveys, focus groups, and key informant interviews as a key component of our formative and process-oriented evaluation. We would be happy to share those data and results with CMMI. We share our SIM quarterly updates with CMMI.

Our state evaluator, University of Washington, has a long history of running evaluations concurrently with other federal or private entities. We firmly believe in collaborating with the state and federal entities and allowing for concurrent efforts and non-duplication of efforts where possible.

It is our intent to cooperate with CMS regarding any and all needs and requirements for the evaluation. We agree not to receive additional reimbursement for providing data or other information to CMS, noting that mutual negotiations may be necessary to deliver on any requests not currently funded or resourced.

3. Program Monitoring and Reporting

Project Management Structure/Oversight of program work streams and contractors

Healthier Washington sourced a full-time project manager in AY3 to coordinate regular reporting and to help the leads manage and update their work plans. The addition of this resource has been a tremendous asset to the SIM grant project management structure. OTB Solutions has been our project management partner since May 2015.

On a weekly basis our PM team:

- Aligns activities across project management, operations, and program leads.
- Monitors budget activity.
- Assists with assessment and processing of change requests.
- Processes issues and risks.
- Collaborates with team leads to revise work plans and maintain plan status.
- Creates a weekly status report.
- Attends CMMI program / admin meetings

On a monthly basis, our PM team:

- Issues a monthly report of consolidated HW project status
- Conducts budget “spend down” meetings with each investment area.
- Researches late deliverables.
- Escalates risks to governance bodies.
- Updates risk mitigation plans.

On a quarterly basis, our PM team:

- Develops QPR content.
- Gathers metrics for QPR.

On an annual basis, our PM team:

- Assists with the annual Operations Plan, budget narrative, and supporting documentation.
- Supports program leads in the translation of Operational work plans into executable project plans

Changes in Strategy to Monitor Existing Contracts

There have been no changes in strategy to monitor existing contracts in AY3. We do not anticipate changes in AY4 as our vendors are performing to standards.

Sustainability

Please see Section E / Sustainability for a discussion on how we plan to deliver on sustainability requirements in AY4.

4. Fraud and Abuse Prevention, Detection and Correction

HCA is nationally recognized as a leader in program and payment integrity. With ongoing emphases on data analytics, algorithms, audits, and close coordination between program integrity, policy, and technical systems, HCA maintains optimal oversight of both provider payments and quality of care.

With the goal of identifying and preventing fraud, waste, and abuse, program integrity has largely been the domain of HCA's Office of Program Integrity (OPI), a team of more than 40 auditors, analysts, clinicians and coders dedicated to identifying and recovering improper payments and otherwise saving Medicaid dollars through waste prevention. In the last three biennia, OPI has saved and recovered more than $140 million in Medicaid dollars. OPI's efforts are augmented by additional similar activities throughout the agency, including program and contract monitoring, recovering on third-party liability, and managed care oversight.

The state does plan to assess its ability to take on fraud and abuse detection within the ProviderOne system – as opposed to the current practice where data is extracted, analyzed, and reported out by a third-party vendor (Optum). The HIT roadmap for 2018 includes some ProviderOne analysis that will likely result in some changes to the system that enable fraud and abuse detection earlier in the claims payment process.

E. Plan for Sustainability

As we have highlighted throughout this document, our plan for sustainability is focused on leveraging the mechanism of value-based payment and appropriate incentives to drive health system transformation, using our numerous other projects as supportive mechanisms to achieve the Triple Aim. Sustainability is about the system and its component parts. Sustainability is about both building functions into our current infrastructure within state government, and finding outside funding streams both within and outside of our agencies to ensure the environment continues to move toward meaningful and transformative change. SIM has been a catalyzing force within our agency business and has resulted in strategic planning that aligns with our aims and goals under SIM. For example, HCA's Value-Based Roadmap expands on the VBP goals and objectives put forward under Healthier Washington. Payment Models 2 and 3 have found a place within the business of our agency, since the work is now considered vital to the direction we want to go as a state.

While our accomplishments are worthy of noting, we still have work to do in sustaining the system we have worked hard to transform. Because the Medicaid Transformation Demonstration was built to accelerate the foundational strategies and goals of SIM, it is a natural sustainability mechanism for much of this work. Throughout AY4 we will be assessing where SIM efforts naturally dovetail with the Demonstration, and where it makes more sense to align with other efforts or other parts of agency business. AY4 will be a time of reflective analysis, working closely with CMMI on required sustainability deliverables that will help us reconcile our current state and determine whether and how programs should be sustained.

F. Appendices

1. Driver Diagram: Appendix 1

See separate Excel document to read the Driver Diagram in clearer detail.

2. Core Progress Metrics and Accountability Targets: Appendix 2

Healthier Washington's Portfolio of Reporting Metrics captures model participation and core outcomes metrics with accountability targets. This portfolio of metrics will assist in tracking progress toward SIM goals, identify trends in progress, and identify gaps and barriers to implementation over the three-year test.

The model participation metrics are intended to capture data on the participation of providers and provider organizations in SIM as well as the number of beneficiaries impacted. Through the SIM grant, we are testing four payment models. Model participation metrics will be reported quarterly by individual payment model, in addition to an aggregated total, demonstrating progress and adoption of value-based payment strategies by providers, provider organizations, and beneficiaries impacted. All model participation metrics were defined by the CMMI SIM program.

3. HW Governance Structure: Appendix 3

See separate PDF that offers a graphic illustration of the Healthier Washington team.

4. HIT Plan: Appendix 4

See separate Excel document to read the Health IT Operational Plan.

5. UW Evaluation Progress report: Appendix 5

See separate progress report.

6. CCHE P4IPH Work Plan: Appendix 6

See separate work plan.

7. HILN Action Agenda: Appendix 7

See separate action plan.

8. 2017 Washington Statewide Common Measure Set: Appendix 8

See separate PDF of the measure set.