

# Medicaid Transformation Project Evaluation

## **BASELINE REPORT**

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**CENTER FOR HEALTH SYSTEMS EFFECTIVENESS**



**Prepared for:**

Washington State Health Care Authority



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## About us

The Center for Health Systems Effectiveness at Oregon Health & Science University is a research organization that uses economic approaches and big data to answer pressing questions about health care delivery. Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system.

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# Medicaid Transformation Project Evaluation: Baseline Report

Washington State's Medicaid Transformation Project (MTP) is a five-year effort that will provide up to \$1.5 billion to transform health care delivery and payment for the state's Medicaid members. It consists of four initiatives:

- **Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program.** Initiative 1 provides funding for Washington State's Accountable Communities of Health (ACHs) to carry out health improvement projects. Its goals include increasing health system capacity, including value-based payment (VBP) adoption, workforce capacity, and health information technology (HIT) use; integrating physical and behavioral health care; and improving population health and health equity.
- **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).** Initiative 2 provides new services for people at risk of needing long-term supports and services (LTSS) and for their unpaid caregivers. Its goals include delaying or avoiding use of more intensive Medicaid-funded LTSS and helping the State control LTSS costs.
- **Initiative 3: Foundational Community Supports (FCS).** Initiative 3 provides services to help the most vulnerable Medicaid members gain and keep housing and employment. Its goals include improving social outcomes linked to health, improving health care quality, and reducing health care spending. It excludes payment for buying or renting housing, room and board, and wages.
- **Initiative 4: Substance Use Disorder (SUD) Amendment.** Initiative 4 provides federal funding for extended substance use disorder (SUD) treatment in some settings and requires the State to achieve milestones in SUD care. Its goals include improving SUD care access, provider capacity, and care coordination.

This report describes the performance of Washington State's Medicaid system and its readiness for transformation as of 2019, when health improvement projects under Initiative 1 were being implemented. It is the first in a series that will assess MTP's impacts, explore the factors underlying these impacts, and communicate lessons learned from MTP.

This report was prepared as the novel coronavirus (COVID-19) entered Washington State. The data reflect Medicaid system performance and transformation efforts in the years immediately prior to the COVID-19 pandemic. Future reports will incorporate information about COVID-19's impact on MTP and the ways in which ACHs and their partners responded to COVID-19.

## Key Findings

Within the first two years of MTP, Washington State's Medicaid system performed well in a number of areas. Among primary care practices, participation in VBP arrangements and use of HIT for important patient care tasks were widespread. However, practices reported a small proportion of revenue linked to quality goals and limited use of EHRs for sharing information with long-term care and social-service

providers. Workforce capacity represented a substantial concern: Practices reported widespread shortages, and barriers existed to expanding specific workforces needed for MTP projects.

ACHs carried out activities to promote VBP adoption, workforce capacity, and HIT use. In addition, they partnered with a variety of organizations on health improvement projects. ACH informants expressed a desire for the State to clarify the role of ACHs in promoting VBP and workforce capacity, and to define a statewide strategy for health information exchange (HIE) and community information exchange (CIE). On health improvement projects, challenges emerged that may affect ACHs' ability to meet MTP goals and sustain projects after MTP ends. Greater connection between MTP initiatives could help achieve MTP's goals, but few connections exist.

### **Medicaid System Performance**

- Within MTP's first two years, Washington State's Medicaid system performed well in domains related to mental health care and substance use care.
- Performance was mixed in other domains, and Black and American Indian/Alaska Native members experienced worse outcomes across domains.

### **Value Based Payment (VBP) Adoption**

- Participation in VBP arrangements was widespread among primary care practices, a finding consistent with reports from the State that Medicaid managed care organizations (MCOs) met statewide VBP targets.
- However, practices reported a low proportion of Medicaid revenue tied to quality goals. This finding suggests that the State's definition of VBP adoption may provide an incomplete picture of VBP progress.
- ACH informants described a lack of clarity differentiating the State's role and ACHs' role in promoting VBP.

### **Workforce Capacity**

- Widespread workforce shortages existed for primary care practices in 2018. Practices were concerned that shortages would result in suboptimal outcomes for MTP's focus populations.
- Barriers exist to expanding specific workforces needed for health improvement projects. These include behavioral health care providers, community health workers and peer counselors, and physicians who provide medications for SUD.
- ACH informants expressed concerns that the State had not clearly defined the ACHs' role in meeting workforce needs.

### **Health Information Technology (HIT) Use**

- Among primary care practices, electronic health record systems (EHRs) were widely used to accomplish important patient care tasks.
- ACHs focused on filling HIT gaps among behavioral health care providers and gaps in providers' ability to store and share information about social determinants of health (SDOH).
- ACH informants described barriers to statewide health information exchange (HIE) and expressed a desire for a statewide approach to HIE and community information exchange (CIE).

## Impact of Health Improvement Projects

- ACHs have contracted with a variety of organizations to carry out work on health improvement projects. ACHs vary in their approach to defining and carrying out these projects.
- ACH informants described challenges obtaining data to assess project performance and make course corrections. This may reflect both the limitations of claims data and tension in MTP's design.
- ACHs are positioned to address social and community-level determinants of health, but MTP's design has narrowed their focus to clinical factors. As a result, they may limit investments in SDOH that might otherwise yield long-term gains.
- There does not appear to be a plan for sustaining health improvement projects beyond the last year of MTP.

## Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

- Enrollment in TSOA increased steadily in the first two years, but there may be more caregivers eligible for MAC and TSOA who have not yet been engaged and enrolled.
- A majority of TSOA participants represented in a State-administered survey said the program would help keep them from moving to a nursing home or adult family home.
- Greater connection between Initiatives 1 and 2 could help achieve MTP goals, but few connections exist between the initiatives.

## Foundational Community Supports (FCS)

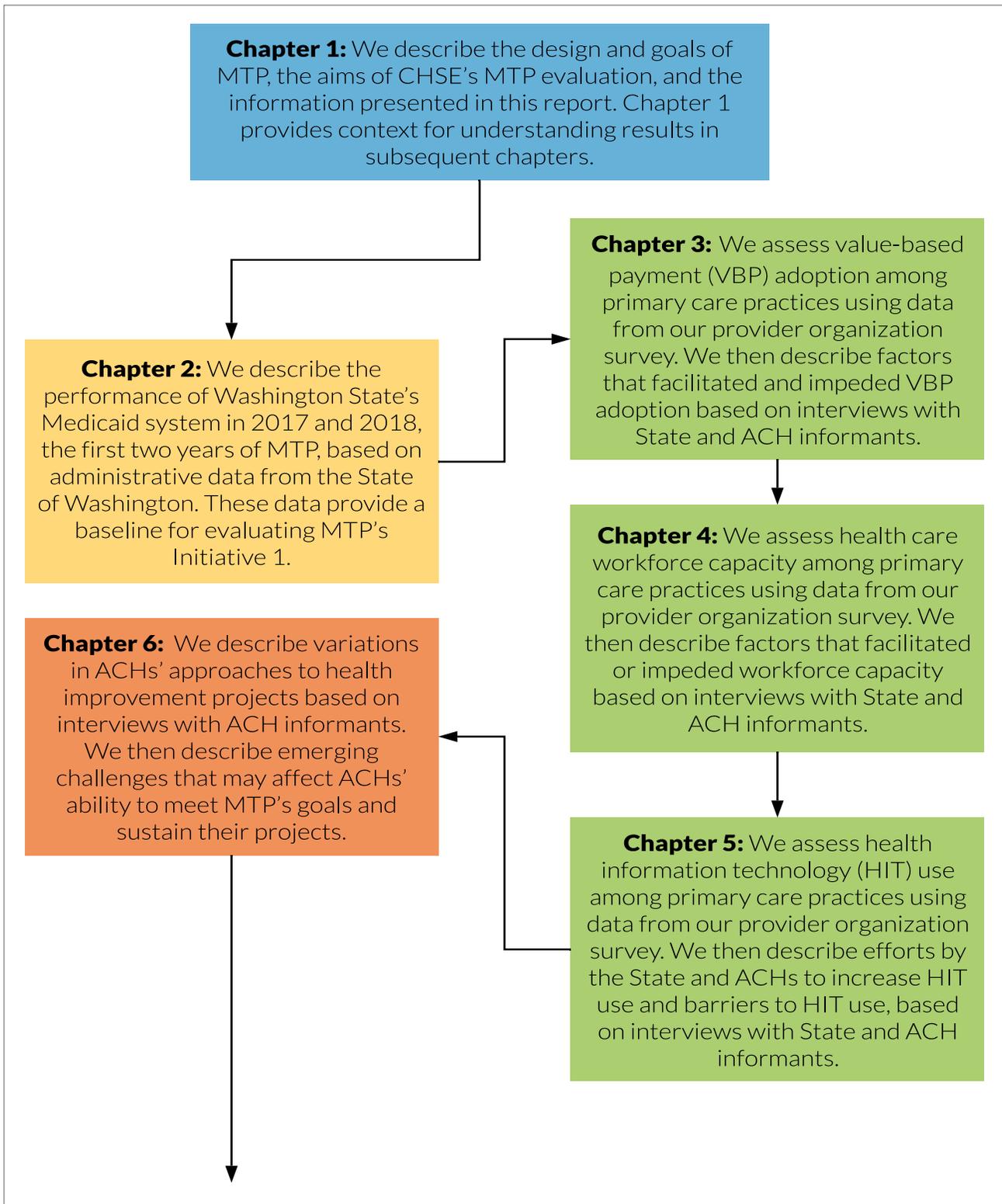
- Enrollment in supportive housing and supportive employment increased steadily in the program's first two years.
- A lack of FCS service providers in rural areas and a lack of affordable housing across the state presents challenges for the program.
- Although FCS services could potentially be used to support ACH health improvement projects, most ACHs were unaware of opportunities to connect the initiatives.

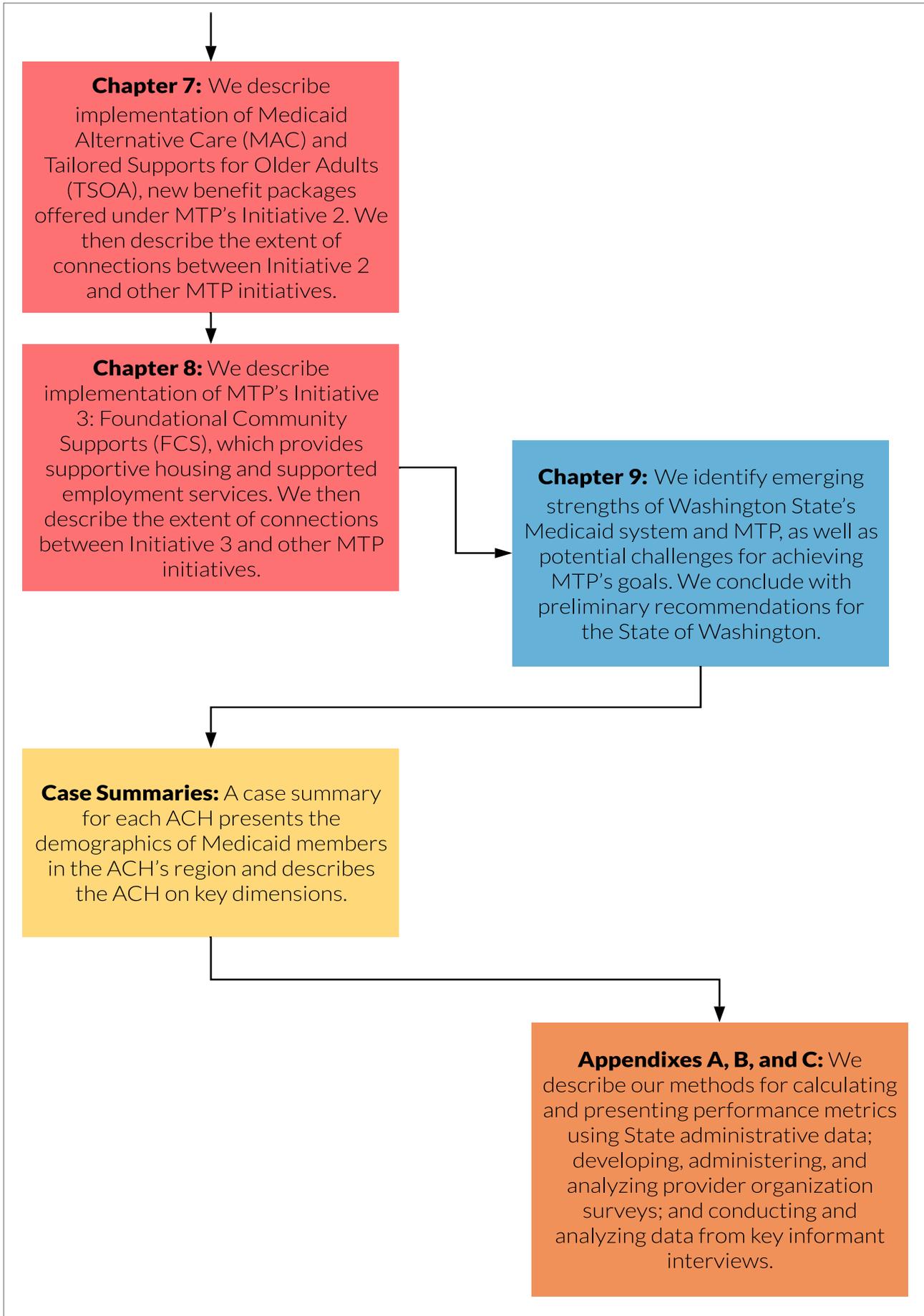
## Recommendations for the State of Washington

Based on data and findings from the first two years of MTP, we believe the following actions may improve the potential for the State to meet its goals:

- 1 Provide clarity on sustainability and expectations for ACHs beyond 2021.
- 2 Provide ACHs with specific strategies and guidance on health information exchange (HIE) and community information exchange (CIE).
- 3 Clarify the role of ACHs in meeting workforce needs.
- 4 Evaluate ways to connect MTP initiatives and facilitate connections.
- 5 Enhance VBP reporting to track dollars directly tied to quality and efficiency.

# Roadmap to the Report





# Background on Washington State's Medicaid Transformation Project

## Overview

Across the US, states are testing health care delivery and payment reforms to improve care, improve health outcomes, and control costs among their Medicaid populations. Medicaid waivers granted by the federal Centers for Medicare & Medicaid Services (CMS) allow states to test new health care delivery and payment reforms to their Medicaid programs. Among 46 states with approved or pending waivers, 19 focus on delivery payment system reform (Kaiser Family Foundation 2020). Areas of emphasis include the integration of physical and behavioral health care, value-based payment, substance use disorder treatment, long-term services and supports, and social determinants of health.

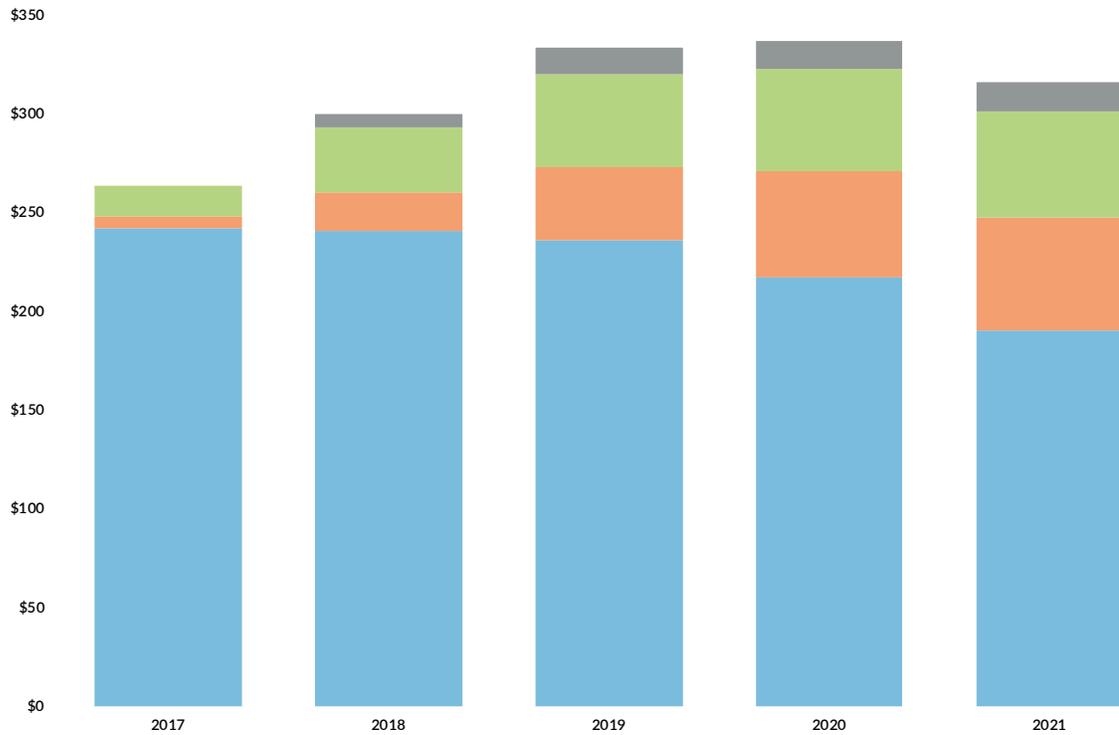
In 2017, the State of Washington received federal approval through a Section 1115 Medicaid Waiver to implement the Medicaid Transformation Project (MTP), a five-year effort that will provide up to \$1.5 billion to improve health care delivery and payment for Washington State Medicaid members. MTP comprises four initiatives:

- **Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program.** This initiative provides incentive payments to Washington State's Accountable Communities of Health (ACHs) and Medicaid managed care organizations (MCOs) for carrying out activities to transform health care delivery and payment. It includes incentive payments for activities to build health care provider capacity, implement health improvement projects, promote value-based payment (VBP), and implement integrated managed care (IMC).
- **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).** This initiative provides supportive services for people who need long-term supports and services (LTSS) and for their unpaid caregivers.
- **Initiative 3: Foundational Community Supports (FCS).** This initiative provides services to help the most vulnerable Medicaid members gain and keep housing and employment.
- **Initiative 4: Substance Use Disorder (SUD) Amendment.** Washington State received a waiver amendment providing federal financial support for extended SUD treatment in inpatient facilities. The amendment requires the state to achieve milestones related to SUD treatment access, provider capacity, and care coordination for substance use care.

To convey the scale of MTP, Exhibit 1.1 presents dollar amounts associated with each initiative over the waiver period.

**Exhibit 1.1. The Medicaid Transformation Project's Initiative 1, Initiative 2, Initiative 3, and Initiative 4 will provide up to \$1.5 billion in potential funding for delivery system and payment reform from 2017 through 2021.**

Spending is presented in millions of dollars and includes state and federal funds. State administration funding is excluded.



- Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program:** Maximum project incentive payments for ACHs and Indian Health Care Providers, maximum VBP incentive payments for ACHs and MCOs, and integrated managed care incentives paid to ACH regions
- Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA):** Maximum spending on Medicaid Alternative Care and Tailored Supports for Older Adults
- Initiative 3: Foundational Community Supports (FCS):** Maximum spending on Foundational Community Supports, including supportive housing and supported employment services
- Initiative 4: Substance Use Disorder (SUD) Amendment:** Projected spending on approved substance use disorder treatment services provided to Medicaid members while residing in an institution for mental disease

Source: Washington State Health Care Authority. See Data Appendix, Table 1 for dollar amounts.

MTP has the following primary goals (Centers for Medicare & Medicaid Services 2018, 6):

- Integrate physical and behavioral health care
- Increase the percentage of dollars paid to health care providers through VBP arrangements
- Help health care providers adopt new health care delivery and payment models
- Improve population health and health equity
- Provide targeted services that address the needs of the state's aging populations and key social determinants of health

MTP addresses multiple areas that are high priorities for many states:

- Care coordination and integration of behavioral and physical health care
- Requirements and incentives to promote VBP adoption among health care providers and MCOs
- Components to address Medicaid members' health-related social needs, including specific health improvement projects aimed at coordinating health care and social services, supportive services for unpaid family caregivers, and benefits to help members gain and keep housing and employment

The sidebar below describes components of MTP that address these areas in greater detail. Lessons from MTP will help states implement reforms in these areas and improve the value of their Medicaid programs.

This report describes the performance of Washington State's Medicaid system and its readiness for transformation as of 2019, when ACH health improvement projects were underway. In addition, it provides preliminary information about the implementation and outcomes of Initiatives 2 and 3 based on data available as of 2019. The State received approval for Initiative 4 in mid-2018 and this initiative began later than other MTP initiatives. Information about Initiative 4 will be presented in future reports.

The report represents the first in a series of evaluation reports from the Center for Health Systems Effectiveness (CHSE) that will assess MTP's impacts, explore the factors underlying MTP's impacts, and communicate lessons learned to the State of Washington, other states, and the federal government. It provides baseline information for contextualizing and measuring MTP's impacts in the future.

This report was prepared as the novel coronavirus (COVID-19) entered Washington State. The data reflect Medicaid system performance and transformation efforts in the years immediately prior to the COVID-19 pandemic. Future reports will incorporate information about COVID-19's impact on MTP and the ways in which ACHs and their partners responded to COVID-19.

## MTP ADDRESSES IMPORTANT CHALLENGES FOR STATE MEDICAID PROGRAMS

Washington State's Medicaid Transformation Project is noteworthy for its ambitious attempts to address issues at the forefront of every state's Medicaid program.

**Delivery System Reform:** Historically, health care providers and organizations with different roles in a health have been disconnected. This includes, for example, separation among physical, behavioral, and oral health care providers, as well as primary care practices, hospitals, and long-term services and supports (LTSS) settings. Lack of integration and coordination among providers and care settings may lead to poor outcomes. MTP provides incentives for ACHs to implement projects aimed at improving the coordination of care. Examples include projects to promote physical and behavioral health care integration and support transitions between care settings.

**Value-Based Payment (VBP):** Recent federal and state health care reforms have tied provider payment to measures of health care quality, service use, or spending through VBP. The State of Washington has set targets for the percentage of Medicaid dollars paid through VBP and incorporated these targets into its Medicaid waiver. MTP provides incentives for ACHs and MCOs to promote VBP among providers and make progress toward VBP goals.

**Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA):** Nationally, approximately 30 percent of total Medicaid spending goes to LTSS, defined as ongoing support for activities of daily living for the elderly and disabled (America's Health Insurance Plans 2019). As the population ages, the cost of LTSS may become a concern for state Medicaid programs. Many states, including Washington, have home and community-based services waivers or use the Community First Choice program to fund alternatives to nursing facilities. MTP goes a step further, providing MAC and TSOA services aimed at enabling people who need LTSS, but who are not yet using Medicaid-funded LTSS, to remain in their homes if they choose.

**Social Determinants of Health (SDOH):** SDOH represent the conditions in which people are born, grow, live, work, and age. They include factors like housing, employment, and community environments. Together, these factors exert a powerful influence on health outcomes. Recently, federal and state health care reforms have begun to address SDOH (Artiga and Hinton 2018). A centerpiece of MTP is the ACH, which is designed to connect and coordinate community health improvement efforts among health care, social service, and public health organizations. MTP also includes specific projects to address health-related social needs and new benefits to help the most vulnerable Medicaid members gain and maintain housing and employment.

**Substance Use Disorder (SUD) Treatment:** Medicaid is an important payer for SUD treatment, a role that has been enhanced as the program has been enlisted to fight the national opioid epidemic. MTP includes multiple initiatives aimed at addressing SUD, including ACH projects on behavioral health integration and opioid use disorder prevention and treatment. In mid-2018, the State received approval to amend its existing waiver to allow for federal funding to support extended SUD treatment in residential and institutional settings.

## Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program

Initiative 1 provides incentive payments to Washington State’s ACHs and MCOs for carrying out activities to transform health care delivery and payment and for achieving specific outcomes. This initiative also provided incentive payments to ACHs for early implementation of integrated managed care in their regions.

### Accountable Communities of Health (ACHs)

The centerpiece of Initiative 1 is the ACH. ACHs are regional partnerships meant to represent organizations concerned with health—including health care providers and hospitals, public health districts, and social service organizations—in nine regions of the state. ACHs do not provide or pay for health care. Rather, they are meant to bring together partner organizations to align their efforts toward common goals. Core functions of ACHs include identifying health needs within their regions and implementing health improvement projects to meet those needs. Exhibit 1.2 presents the regions of Washington State’s nine ACHs.

**Exhibit 1.2. Washington State’s Accountable Communities of Health**



Washington State began to establish ACHs in 2015 using a State Innovation Model (SIM) grant from CMS. The SIM grant and other resources supported planning and start-up of ACHs by local health care improvement organizations across the state. Under SIM, a designated “backbone” organization supported each ACH’s development and performed administrative functions like payroll. Examples of backbone organizations included local public health agencies and nonprofit community-based organizations. MTP required ACHs to become independent entities from their backbone organizations. (Center for Community Health and Evaluation 2019).

MTP dramatically expanded funding available to ACHs, shifted their focus from overall population health to improving the health of Medicaid members, and introduced new responsibilities and requirements for ACHs. Washington State’s Medicaid waiver describes ACHs as “the lead entity and single point of accountability” for a variety of projects in their regions (Centers for Medicare & Medicaid Services 2018, 95).

### Managed Care Organizations (MCOs)

Washington State contracts with MCOs to provide health care coverage for more than 85 percent of its Medicaid members (Medicaid and CHIP Payment Access Commission 2019). The State pays MCOs a per-member, per-month amount for each person an MCO enrolls. MCOs use this funding to pay health care providers for care rendered to Medicaid members. Currently, five MCOs provide coverage for Medicaid members in different regions of the state. Exhibit 1.3 shows the MCOs that provide coverage within each ACH’s geographic region.

**Exhibit 1.3. Medicaid Managed Care Organizations (MCOs) by ACH Region**

ACH Region	Amerigroup Washington	Community Health Plan of Washington	Coordinated Care Health Plan	Molina Healthcare of Washington	United Healthcare of Washington
Better Health Together	X	X		X	
Cascade Pacific Action Alliance <sup>1</sup>	X			X	X
Elevate Health	X		X	X	X
Greater Columbia ACH	X	X	X	X	
HealthierHere	X	X	X	X	X
North Central ACH	X		X	X	
North Sound ACH	X	X	X	X	X
Olympic Community of Health	X			X	X
SWACH	X	X		X	

<sup>1</sup>The Cascade Pacific Action Alliance region includes two integrated managed care regions: Thurston-Mason, comprising two counties, and Great Rivers, comprising the remaining five counties. The same three MCOs provide Medicaid coverage in both regions but may have different contract terms in each region Source: Washington State Health Care Authority 2018b.

Washington State’s Medicaid waiver encourages MCOs to “serve in a leadership or supportive capacity in every ACH,” participate in design and implementation of health improvement projects, and collaborate with health care providers in their networks to implement VBP arrangements (Centers for Medicare & Medicaid Services 2018, 19–20). In addition, MCOs can earn incentive payments for activities to promote VBP adoption among health care providers and for progress towards the State’s VBP goals.

### Health Improvement Projects

To earn DSRIP incentive payments, ACHs must carry out health improvement projects in three domains.

- **Domain 1: Health Systems and Community Capacity Building.** This domain consists of “foundational activities” to build the capacity of Washington State’s health care system in three areas: VBP, the health care workforce, and health information technology (HIT). (Centers for Medicare & Medicaid Services 2018, 100).

- **Domain 2: Care Delivery Redesign.** Projects in this domain are intended to connect the different kinds of health care providers, social service providers, and other organizations that influence health in order to ensure that Medicaid members receive the right care in the right setting. Each ACH must carry out Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care) and at least one other project in Domain 2.
- **Domain 3: Prevention and Health Promotion.** Projects in this domain are intended to address specific conditions and areas of health. The projects emphasize eliminating disparities and achieving health equity (Centers for Medicare & Medicaid Services 2018, 102). Each ACH must carry out Project 3A (Addressing the Opioid Use Public Health Crisis) and at least one other project in Domain 3.

The Washington State Health Care Authority (HCA) developed a *Project Toolkit* that describes evidence-based approaches that ACHs may use for each project, along with milestones that must be achieved and performance metrics that must be improved, for ACHs to earn project incentive payments (Washington State Health Care Authority 2019b). Exhibit 1.4 summarizes the goals and approaches for projects in Domains 1, 2, and 3.

## Exhibit 1.4. Goals and Approaches for Initiative 1 Health Improvement Projects

### Domain 1: Health Systems and Community Capacity Building

#### Financial Stability through Value-Based Payment (VBP)

VBP is designed to reward providers for performance on health care quality, service use, or cost, rather than the volume of services they provide. Washington State has established targets for the percentage of dollars paid to providers through VBP arrangements, including the goal of paying 90 percent of Medicaid dollars to providers through VBP arrangements by 2021.

The *Project Toolkit* directs ACHs to carry out activities that promote the use of VBP arrangements by health care providers. These include encouraging providers to complete HCA's annual Value-Based Purchasing Survey, connecting providers to training or technical assistance, and supporting providers that struggle to implement VBP.

*Chapter 3 describes findings about the level of VBP adoption among Washington State's primary care practices and factors that facilitated and impeded VBP adoption.*

#### Health Care Workforce Capacity

Achieving MTP's goals may require increasing the capacity of Washington State's health care workforce. For example, integrating physical and behavioral health care will likely require more licensed behavioral health care clinicians, as well as non-clinical staff to help coordinate physical and behavioral health care. Connecting medical and non-medical services may require more trained health care workers, such as community health workers and peer support workers, to coordinate services and help with care transitions.

The *Project Toolkit* directs ACHs to incorporate strategies to address workforce gaps and training needs into their project plans. Specific strategies include identifying regulatory barriers to team-based care and incorporating cultural competency and health literacy training.

*Chapter 4 describes health care workforce capacity among Washington State's primary care practices and factors that facilitated and impeded workforce capacity.*

#### Health Information Technology (HIT)

Achieving MTP's goals may require or benefit from greater use of HIT by health care providers and other organizations. For example, physical and behavioral health care integration may require providers to share records and care plans electronically. Connecting medical and non-medical services may require exchange of information about health and health-related social needs among health care organizations and community-based organizations. Such projects may benefit from health information exchanges (HIEs) or community information exchanges (CIEs). In addition, providers may need HIT that aggregates different kinds of data (e.g., claims and medical records) and generates reports on health outcomes and costs in order to improve health care quality and earn payment through VBP arrangements.

The *Project Toolkit* directs ACHs to share information with the state about the data needs of health care providers and local health system stakeholders. In addition, it directs ACHs to incorporate HIT needs into their project plans.

*Chapter 5 assesses HIT use among Washington State's primary care practices and describes efforts by the State and ACHs to increase HIT use and remove barriers to HIT use.*

## Exhibit 1.4 (continued). Goals and Approaches for Initiative 1 Health Improvement Projects

### Domain 2: Care Delivery Redesign

**Project 2A: Bi-Directional Integration of Physical and Behavioral Health Care (Required):** This project is intended to integrate behavioral health care into primary care settings and primary care into behavioral health care settings. Evidence-based approaches for integrating behavioral health into primary care settings include the Collaborative Care Model and the Bree Collaborative; evidence-based approaches for integrating physical health care into behavioral health settings are based on a Milbank Report Framework. All approaches emphasize team-based care, aligned care plans, and population-based approaches for recording, tracking, and following up with patients based on screening results. The goal is for physical health and behavioral health providers to collaborate effectively using shared plans that incorporate patient goals, allowing patients to get all their needed care in one familiar location.

**Project 2B: Community Based Care Coordination:** This project is intended to help Medicaid members with complex health care and social needs—such as diabetes, mental illness, unstable housing, or food insecurity—access the health care and social services they need to improve their health. Its evidence-based approach is the Pathways Community HUB model, wherein a single organization identifies people most likely to have poor health outcomes in a given community, assigns care coordinators from local agencies to connect at-risk people with the health care and social services they need, and pays the agencies when client needs are met.

**Project 2C: Transitional Care:** This project is intended to ensure that Medicaid members have the right care through transitions between health care settings, including transitions from acute care or inpatient care to home or supportive housing, or transitions from jail or prison to the community. Evidence-based approaches include the BRIDGE Model, in which social workers engage patients, coordinate care, identify unresolved needs, and connect relevant post-acute providers to resolve gaps in care; the Transitional Care Model, in which nurses help older adults at risk for poor outcomes as they move across health care settings and between clinicians; and the APIC Model for Jail Transitions, which involves assessment of needs and risks, plans for treatment, identification of services, and coordination of the transition plan via linkages to community supports.

**Project 2D: Diversion Interventions:** This project is intended to target Medicaid members who use the emergency department (ED) or emergency medical services (EMS) for non-emergent conditions, as well as members with mental health or substance use disorders who come into contact with law enforcement, directing them away from inappropriate use of the ED and toward primary care and social services. Evidence-based approaches include: Emergency Department Diversion, in which ED staff help people who use the ED for non-emergent conditions find primary care providers; Community Paramedicine, in which paramedics connect people to primary care or alternatives to the ED, such as a mental health center, a sobering center, or urgent care; and Law Enforcement Assisted Diversion, in which police officers refer members with unmet behavioral health needs to intensive case management instead of the ED or jail.

*Chapter 6 describes important variations in ACHs' approaches to their health improvement projects.*

## Exhibit 1.4 (continued). Goals and Approaches for Initiative 1 Health Improvement Projects

### Domain 3: Prevention and Health Promotion

**Project 3A: Addressing the Opioid Use Public Health Crisis (Required):** This project is intended to help achieve the State's goals of reducing opioid-related illnesses and deaths, as set forth in Governor Inslee's Executive Order 16-09. It requires ACHs and partners to implement programs aimed at preventing opioid use and misuse, linking people with opioid use disorder to treatment, intervening in opioid overdoses to prevent death, and helping people with recovery and long-term stabilization. Efforts include promoting the use of Washington State's prescription drug monitoring program by providers, expanding use of medications for opioid use disorders, providing training for overdose response, and supporting the provision of peer and other recovery support services.

**Project 3B: Reproductive and Maternal or Child Health:** This project is intended to ensure that women of reproductive age, pregnant women, and mothers have access to high quality reproductive health care. Evidence-based approaches include expanding a nursing program, conducting chlamydia screening, undertaking outreach to children who are overdue for well-child visits or immunization visits, and improving providers' knowledge and practice around preconception care and risk.

**Project 3C: Access to Oral Health Services:** This project is intended to increase access to oral health services. Evidence-based approaches include the Oral Health Delivery Framework, in which primary care providers screen for oral health problems and make referrals to oral health care providers, and the Mobile-Portal Dental Manual, a set of guidelines for providing dental care for school-age children using mobile dental units and portable dental equipment.

**Project 3D: Chronic Disease Prevention and Control:** This project is intended to integrate health system and community approaches to chronic disease management for Medicaid members who have a chronic disease or who are at risk for a chronic disease, such as asthma, diabetes, or cardiovascular disease. Evidence-based approaches include the Chronic Care Model (CCM) from Improving Chronic Illness Care, which is designed to transform health care from a reactive system to a proactive one focused on "keeping a person as healthy as possible." The CCM coordinates the efforts of community and health systems to produce improved outcomes.

*Chapter 6 describes important variations in ACHs' approaches to their health improvement projects.*

## Value-Based Payment Incentives

Under MTP's Initiative 1, ACHs and MCOs can earn incentive payments for activities to promote VBP adoption among health care providers and for progress toward the State of Washington's VBP targets. Payment for progress toward targets is tied to VBP reporting requirements in HCA's contracts with MCOs.

Washington State has established targets for the percentage of dollars that will be paid through VBP arrangements for all health care purchased by HCA, including care for Medicaid members, public employees, and school employees (Washington State Health Care Authority 2019c). Exhibit 1.5 presents the State's VBP targets.

**Exhibit 1.5. Washington State's Value-Based Payment (VBP) Targets**

Year	2017	2018	2019	2020	2021
Dollars paid through VBP arrangements in Learning Action Network Category 2C and above	30%	50%	75%	85%	90%
Dollars Paid through VBP arrangements in Learning Action Network Category 3A through 4B	NA	10%	20%	30%	50%

Source: Washington State Health Care Authority 2019c, 6.

The State uses the *Alternative Payment Model Framework* developed by the Health Care Payment Learning & Action Network (LAN), a national network of organizations with health care payment expertise, to define and measure VBP adoption (Health Care Payment Learning & Action Network 2016). Exhibit 1.6 summarizes VBP arrangements defined by the *APM Framework*. Importantly, the LAN states that a payment arrangement must take quality and value into account in order to be designated as value-based.

The State of Washington uses two primary levers to promote VBP adoption in its Medicaid program: MCO contracting and MTP's Initiative 1 VBP incentives. These incentive programs are separate but related.

### MCO Contracting

Under HCA's contracts with MCOs, HCA withholds a portion of premiums it pays to each MCO to cover Medicaid members. MCOs can earn back 75 percent of the withhold based on achievement of health care quality benchmarks or improvement targets among enrolled Medicaid members, 12.5 percent based the proportion of dollars paid to providers through VBP arrangements, and 12.5 percent based on the percentage of provider incentives—such as bonus payments made to providers or financial penalties collected from providers—linked to quality and financial goals (Washington State Health Care Authority 2019c, 8–12).

To measure the proportion of total dollars paid through VBP and the proportion of provider incentives linked to quality, HCA requires MCOs to report these quantities in a standardized template. A third-party contractor then validates the reports using a sample of MCO provider contracts. The template requires ACHs to break out VBP dollars by LAN category and ACH region.

Under the VBP reporting system described above, all dollars paid to providers through a provider contract with any VBP component count as dollars paid through a VBP arrangement. For example, all dollars paid to providers through a fee-for-service (FFS) contract with bonuses for quality

performance—including all FFS payments for health care services and all bonus payments for quality—would count as dollars paid through a VBP arrangement. This could allow an MCO to count all dollars paid under a large MCO contract with relatively small financial incentives for VBP as dollars paid through VBP.

**Exhibit 1.6. Health Care Learning & Action Network (LAN) Value-Based Payment (VBP) Categories<sup>1</sup>**

<b>CATEGORY 1:</b> Fee-for-service payment with no link to quality	Not a value-based payment arrangement
<b>CATEGORY 2:</b> Fee-for-service payment with links to quality	<b>2A:</b> Providers receive payments for infrastructure and operations, such as payments for care coordination or health information technology investments.
	<b>2B:</b> Providers receive bonus payments for reporting quality data, or penalties for not reporting data.
	<b>2C:</b> Providers receive bonus payments for meeting quality goals.
	<b>2D:</b> Providers receive bonus payments for meeting quality goals, or incur penalties for failing to meet quality goals.
<b>CATEGORY 3:</b> Fee-for-service payment with shared savings or shared risk and a link to quality	<b>3A:</b> Providers receive a portion of savings when health care service use or costs are below established targets.
	<b>3B:</b> Providers receive a portion of savings when health care service use or costs are below established targets, or incur a portion of losses when service use or costs are above targets.
<b>CATEGORY 4:</b> Population-based payment with a link to quality	<b>4A:</b> Providers receive up-front payments covering all costs for a specific condition, such as cancer care.
	<b>4B:</b> Providers receive up-front payments covering all costs for a specific group of patients.

<sup>1</sup>The Health Care Payment Learning & Action Network states that a payment arrangement must take quality and value into account in order to be designated as value-based. For the purpose of measuring VBP adoption, the State of Washington considers the shaded arrangements as VBP arrangements. Source: Health Care Payment Learning & Action Network 2016; Centers for Medicare & Medicaid Services 2018

**Initiative 1 VBP Incentives**

From 2018 to 2021, MCOs and ACHs will be able to earn VBP incentive payments under MTP’s Initiative 1 (Washington State Health Care Authority 2019a, 30–33, 35–39). MCOs and ACHs will earn a portion of available incentives based on their activities to promote VBP adoption: MCOs will earn incentive payments by reporting data on VBP adoption as required by their contracts; ACHs will earn dollars by achieving Domain 1 VBP milestones, as described in semi-annual reports they submit to HCA.

MCOs and ACHs will earn the remaining portion of available incentives based on progress toward the State’s VBP targets. MCOs will earn incentive payments based on VBP adoption measured across their Medicaid contracts and ACHs will earn incentive payments based on VBP adoption in their regions, as reported by the MCOs. Thus, VBP incentive payments that MCOs and ACHs earn for achieving outcomes will be based on data reported by MCOs.

**Integrated Managed Care (IMC) Incentives**

In addition to incentive payments for health improvement projects and VBP adoption, Initiative 1 provides incentive payments related to integrated managed care (IMC). Under IMC, a single MCO covers physical and behavioral health care for Medicaid members. Vesting responsibility for physical and behavioral health care payment in a single organization was intended to improve integration of

physical and behavioral health care by provider organizations (Washington State Health Care Authority 2017a).

The Washington Legislature required all counties to implement IMC by January 2020. ACHs could receive IMC incentive payments if counties in their regions chose to implement IMC before the deadline (Washington State Health Care Authority, n.d.).

## **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)**

Medicaid covers long-term supports and services (LTSS), defined as medical and personal care assistance that people may need when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability (Reaves and Musumeci 2015). Federal rules require state Medicaid programs to cover nursing facility care and states may use federal funds to cover less intensive types of LTSS—called home and community-based services (HCBS)—through Medicaid waivers and amendments to their Medicaid state plans. HCBS includes assisted living facilities, adult residential care facilities, and in-home care. Providing HCBS as an alternative to nursing facility care may help state Medicaid programs control LTSS spending and improve the experience of people who need long-term care.

Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) are new benefit packages not offered by the traditional Medicaid LTSS system. They represent alternatives to traditional LTSS and additional options for controlling LTSS spending and improving consumer experience. Both packages provide supportive services for unpaid caregivers of people who need LTSS but who are not yet using Medicaid-funded LTSS. In addition, TSOA provides some supportive services to people without a caregiver who are not yet using Medicaid-funded LTSS. By providing a limited set of supportive services, TSOA and MAC are intended to delay or avoid the need for more intensive and costly Medicaid-funded LTSS later on. Unpaid caregivers provide 80 percent of LTSS for Washingtonians; if one-fifth of caregivers stopped providing care, LTSS costs are estimated to double (Washington State Health Care Authority 2017b). Thus, programs to support unpaid caregivers may be highly cost-effective.

### **Medicaid Alternative Care (MAC)**

MAC provides supportive services for unpaid family caregivers of Medicaid members who are eligible to receive—but who are not yet receiving—Medicaid-funded LTSS. To be eligible, a person must need the level of care provided by a nursing facility, meet Medicaid financial eligibility requirements, and have an unpaid family caregiver who is willing to continue providing care and receive support from the MAC program (Washington State Health Care Authority 2017b).

Unpaid family caregivers may receive a variety of supportive services through MAC. These include: training and education, (e.g., training from a physical therapist on transferring a person needing care in and out of a bathtub); counseling on adapting to the role of a caregiver; specialized medical equipment and supplies; and caregiver assistance services, such as respite care or home-delivered meals to relieve burden on the caregiver.

### **Tailored Supports for Older Adults (TSOA)**

TSOA provides the same supportive services as MAC for unpaid family caregivers of people who need LTSS, *but who do not yet meet the financial eligibility requirements for Medicaid-funded LTSS* (i.e., TSOA participants are not Medicaid members). Specifically, a person must be “at risk” of spending down

his or her financial assets in order to pay for needed care and become financially eligible for LTSS, as determined by a state assessment. In addition, TSOA provides assistance with everyday activities, such as home-delivered meals or home modifications and repairs, to people who meet the above criteria but do not have unpaid family caregivers.

Exhibit 1.7 summarizes the eligibility requirements for MAC and TSOA and describes the supportive services provided by each benefit package. Full eligibility assessments for MAC and TSOA are conducted every 12 months. The Tailored Caregiver Assessment and Referral (TCARE) system, a proprietary assessment that collects information about the needs of caregivers and outputs a list of support services they may need, is used to identify the type and dollar value of supportive services provided.

**Exhibit 1.7. Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)**

	MAC	TSOA
Eligibility	<ul style="list-style-type: none"> <li>• Age 55 or older</li> <li>• Needs nursing facility level of care</li> <li>• Financially eligible for Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Age 55 or older</li> <li>• Needs nursing facility level of care</li> <li>• Not yet financially eligible for Medicaid, but “at risk” of spending down assets to become eligible</li> </ul>
Supportive Services	<ul style="list-style-type: none"> <li>• Supportive services for unpaid family caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive services for unpaid family caregivers</li> <li>• Limited help with everyday activities for people without unpaid family caregivers</li> </ul>
Dollar Amount for Supportive Services	<ul style="list-style-type: none"> <li>• Step 1 and 2: Up to \$500 per year</li> <li>• Step 3: Up to \$550 per month and \$3,300 in a six-month period</li> </ul>	<ul style="list-style-type: none"> <li>• Step 1 and 2: Up to \$500 per year</li> <li>• Step 3 for people with an unpaid caregiver: Up to \$550 per month and \$3,300 in a six-month period</li> <li>• Step 3 for people without an unpaid caregiver: \$550 per month</li> </ul>

Source: Washington State Health Care Authority 2017b; Columbia Legal Services 2017.

**MAC and TSOA Administration**

Washington State’s Aging and Long-Term Services Administration (AL TSA) and local Area Agencies on Aging (AAAs) administer Initiative 2.

- AL TSA, the division of the Department of Social and Health Services (DSHS) that administers Medicaid-funded LTSS, makes final eligibility determinations for MAC and TSOA and contracts with providers that provide supportive services for both programs. Washingtonians can apply for MAC or TSOA at an AL TSA Home and Community Office.
- Washington State’s 13 AAAs, which play a broad role in planning and administering LTSS and other aging services, can make presumptive eligibility determinations for MAC and TSOA that must be confirmed by AL TSA. In addition, they have conducted outreach for LTSS by notifying people seeking aging services about the existence of the two benefit packages.

MAC and TSOA began enrolling beneficiaries in September 2017.

*Chapter 7 describes the policy context for MAC and TSOA, implementation of the benefit packages, and the extent of connections between Initiative 2 and other MTP initiatives.*

## Initiative 3: Foundational Community Supports (FCS)

Initiative 3, Foundational Community Supports, is intended to address two key social determinants of health—housing and employment—among specific groups of Medicaid members. FCS was included in the MTP demonstration due to well-recognized connections between housing, employment, and physical and mental health outcomes (Washington State Health Care Authority 2017c).

### Eligibility and Benefits

FCS provides two kinds of benefits: supportive housing services and supported employment services for Medicaid members with complex health needs. These benefits are intended to help members gain and maintain housing and employment. However, they exclude payment for buying or renting housing, room and board, and wages.

To receive supportive housing or supportive employment services, a Medicaid member must have at least one risk factor and at least one health need. Exhibit 1.8 summarizes FCS eligibility requirements and benefits.

Examples of groups eligible for services under the eligibility requirements include:

- People experiencing chronic homelessness
- People with physical and behavioral health conditions that create barriers to employment
- Vulnerable youth and young adults

### FCS Administration

The State of Washington plans to deliver supportive housing and supported employment services using two evidence-based models.

- **Permanent Supportive Housing:** This model was defined by the federal Substance Abuse and Mental Health Services Administration (United States Interagency Council on Homelessness, n.d.). It combines housing and health care services for people with serious and complex medical conditions. Services can include housing assistance and substance abuse or mental health counseling. Like many other Permanent Supportive Housing models, FCS's supportive housing benefit uses a Housing First approach by providing access to housing assistance with minimal preconditions.
- **Individual Placement and Support:** This approach for FCS's supported employment benefit emphasizes integration of employment and clinical services, competitive employment as a goal, rapid job search, ongoing supports, and services provided in the community (Drake 1998). The model was developed by researchers at Dartmouth University and has been found to be effective in a large number of studies (Drake and Bond 2014).

While the amount of services a person can receive is limited within an authorization period, State informants report that the model is not time-limited; the intent is to provide ongoing support and services that can be reauthorized.

Amerigroup, one of Washington State's MCOs, serves as the third-party administrator for FCS. It contracts with provider organizations that provide supportive housing and supported employment services, assesses eligibility of people who apply for benefits, authorizes services, and reimburses providers on a fee-for-service basis. Providers must meet Medicaid credential requirements and demonstrate expertise and capacity to provide the services, such as certification from DSHS. Technical

assistance has also been provided to train FCS providers on the Permanent Supportive Housing and Individual Placement and Support Models.

**Exhibit 1.8. Supportive Housing and Supported Employment**

	Supportive Housing	Supported Employment
At least one risk factor:	<ul style="list-style-type: none"> <li>• Chronic homelessness</li> <li>• Frequent or lengthy stays in an institution, such as a nursing facility or correctional facility</li> <li>• Frequent stays in adult residential care facilities, such as an assisted living facility or adult care home</li> <li>• Frequent turnover of in-home caregivers</li> <li>• High risk of expensive care and negative outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to be employed for at least 90 days due to a mental or physical condition</li> <li>• Severe and persistent mental illness (SPMI) or substance use disorder (SUD), including vulnerable youth and young adults with behavioral health needs</li> <li>• More than one instance of SUD treatment within the last two years</li> <li>• Eligibility for long-term care</li> </ul>
At least one health need:	<ul style="list-style-type: none"> <li>• Mental health need</li> <li>• Assistance with activities of daily living</li> <li>• Substance use disorder treatment need</li> <li>• Complex physical health need</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health need</li> <li>• Assistance with activities of daily living</li> <li>• Physical impairment requiring assistance with work activities</li> </ul>
Examples of services	<ul style="list-style-type: none"> <li>• Assessment to identify a person's housing needs</li> <li>• Help with applying for housing</li> <li>• Help developing skills to live independently</li> <li>• Help with landlord relations</li> <li>• Crisis management</li> </ul>	<ul style="list-style-type: none"> <li>• Job coaching and training</li> <li>• Help with job placement</li> <li>• Help negotiating with employers over accommodations or adaptive technology</li> </ul>
Amount of services	<ul style="list-style-type: none"> <li>• Up to 30 days per six-month authorization period</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 30 hours per six-month authorization period</li> </ul>

Source: Washington State Health Care Authority 2018a; 2017c; Amerigroup Corporation 2018.

Initiative 3 began enrolling beneficiaries in January 2018.

*Chapter 8 describes FCS enrollment, implementation, and the extent of connections between Initiative 3 and other MTP initiatives.*

**Initiative 4: Substance Use Disorder (SUD) Waiver Amendment**

Care for people with SUD is an area of national attention and a focus for state Medicaid programs. SUD affected almost 20 million Americans over age 12 in 2017, but fewer than 20 percent received treatment (Bose et al. 2018). Medicaid is an important payer for SUD treatment. However, federal statute currently prohibits the use of federal Medicaid matching funds for patients in SUD residential treatment facilities with more than 16 beds.

To support access to SUD treatment, Washington State executed an SUD amendment to its Medicaid waiver that applies from July 17, 2018 through December 31, 2021. The amendment allows the State to receive federal matching funds for services in institutions for mental disease (IMDs) provided during stays of up to 30 days. The amendment also requires the state to achieve important milestones in care delivery and treatment for people with SUD. These include a requirement that residential treatment facilities offer medications for addiction treatment on-site (or facilitate access to these medications off-site) and expanding coverage of and access to naloxone, a life-saving drug that can be used in the event of an overdose. In addition, the amendment requires the State to report on 22 monitoring metrics, ranging from receipt of any SUD treatment to emergency department use and hospital readmissions for people with SUD.

The SUD amendment requires Washington State to carry out an independent evaluation of the amendment. HCA contracted with CHSE to conduct the evaluation. Data needed to evaluate the amendment's effects was unavailable at the time this report was being prepared. We will present estimates of the amendment's impacts, controlling for other factors that may have affected SUD outcomes, in future evaluation reports.

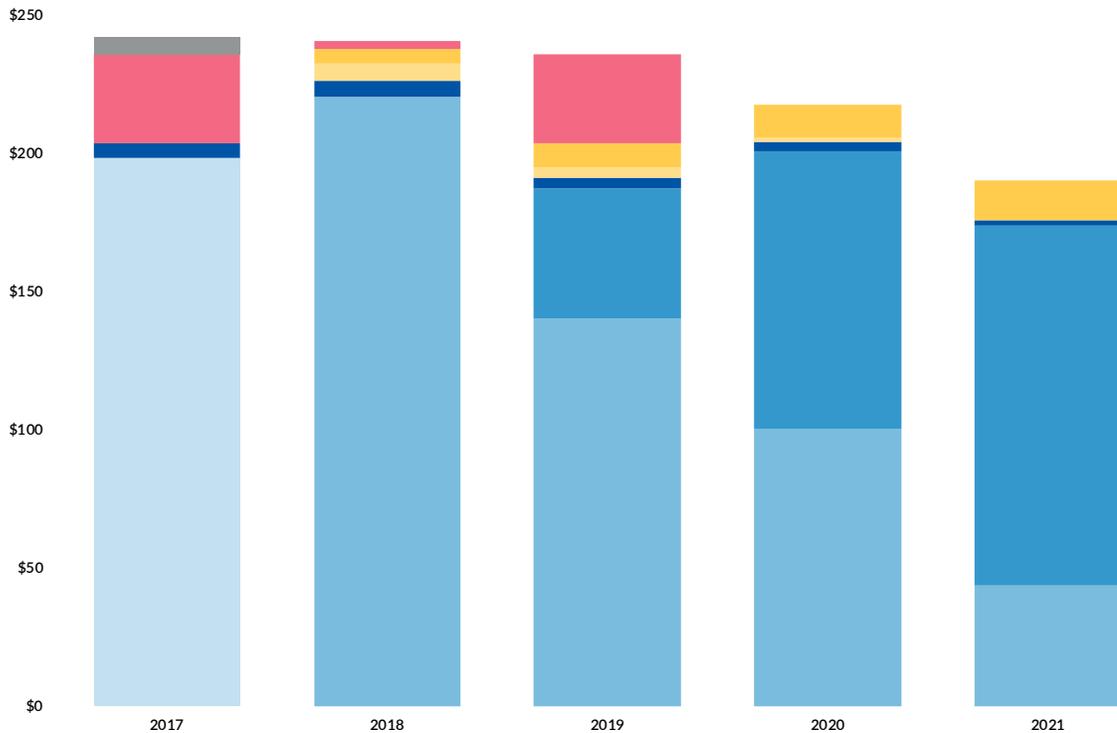
## Timing of MTP Initiatives

Exhibit 1.9 presents maximum dollar amounts that ACHs and MCOs could earn for health improvement projects, VBP, and early adoption of IMC from 2017 to 2021 under Initiative 1. Along with Exhibit 1.1, which presents dollar amounts for each MTP initiative, Exhibit 1.9 illustrates the timing of MTP's initiatives and components:

- **In 2017, ACHs focused on project design and planning.** Each ACH completed a certification process, which demonstrated its readiness to lead health improvement projects, and submitted a project plan.
- **In 2018, ACHs could earn payment for reporting on project implementation.** In addition, MCOs and ACHs could earn incentive payments based on reporting their activities to promote VBP adoption (termed pay-for-reporting payments, or P4R), and incentive payments based on progress toward the State's VBP targets (termed pay-for-performance payments, or P4P).
- **In 2019, ACHs began implementing their projects.** From 2019 through 2021, ACHs earn payments based on a combination of P4R and improvements in health care performance metrics within their regions (P4P).
- **All regions of the state were required to implement IMC by January 2020.** ACHs whose regions implemented IMC in 2016 (called early adopters), and in 2018 or 2019 (called mid-adopters), received DSRIP incentive payments in 2017, 2018, and 2019.
- **The State began enrollment in Initiatives 2 and 3 before ACHs began implementing projects.** Enrollment in MAC and TSOA began in September 2017. Enrollment in FCS began in January 2018.
- **The SUD waiver amendment was effective in July, 2018.** This waiver provided expanded federal funding for approved SUD treatment services in selected residential and institutional settings.

**Exhibit 1.9 Initiative 1 will provide up to \$1.1 billion in incentive payments for health improvement projects, value-based payment, and integrated managed care 2017 through 2021.**

Spending is presented in millions of dollars and includes state and federal funds. State administration funding is excluded. Amounts reflect the year in which incentives were *earned*, not necessarily the year in which they were *paid out*.



- ACH Design and Project Planning:** Maximum payments that can be earned by ACHs based on ACH certification and project plan submission
- ACH Project Incentives, Pay for Reporting:** Maximum payments that can be earned by ACHs by reporting on project implementation
- ACH Project Incentives, Pay for Performance:** Maximum payments that can be earned by ACHs based on improvements in performance metrics in their regions
- Indian Health Care Provider (IHCP) payments:** Maximum payments that can be earned by IHCPs based on project planning and reporting on project implementation (P4R)
- Value-Based Payment (VBP), Pay for Reporting:** Maximum payments that MCOs and ACHs can earn based VBP activities (e.g., MCOs reporting data; ACHs reporting Domain 1 activities)
- Value-Based Payment (VBP), Pay for Performance:** Maximum payments that MCOs and ACHs can earn based on progress toward the State's VBP adoption targets, as reported by MCOs
- Integrated Managed Care Incentives:** Incentives paid to ACH regions that implemented integrated managed care before Washington State's January 2020 deadline
- Year 1 Bonus Pool Incentives:** One-time incentive for ACHs that selected more than four projects in their project plans

Source: Washington State Health Care Authority. See Data Appendix, Table 1 for dollar amounts.

## MTP Evaluation

CHSE's evaluation will measure changes in outcomes associated with each MTP initiative, examine qualitative factors that help explain these changes, and share lessons for improving Medicaid with the State of Washington, other states, and CMS. Exhibit 1.10 summarizes the evaluation's aims.

This report describes the performance of Washington State's Medicaid system and its readiness for transformation as of 2019, when ACH health improvement projects were being implemented. In addition, it provides preliminary information about the implementation and outcomes of Initiatives 2 and 3 based on data available as of 2019. We used information from the following activities to prepare this report:

- **Analysis of State of Washington administrative data:** We analyzed performance metrics reflecting health care access, health care quality, and health-related social outcomes for the state as a whole, ACH regions, and select subgroups of Medicaid members in 2017 and 2018. (Appendix A and the Data Appendix, Table 2 describe the metrics in detail.)
- **Provider organization surveys:** We surveyed a sample of primary care clinics and hospitals across Washington State. The survey captured data on respondents' participation in VBP arrangements, workforce shortages, and HIT use in 2016 and 2018. (Appendix B describes the surveys in detail.)
- **Key informant interviews:** We interviewed representatives of State agencies involved in designing and implementing MTP as well as representatives of each ACH. (Appendix C describes the key informant interviews in detail.)
- **Analysis of secondary data on Initiatives 2 and 3:** We analyzed aggregated enrollment information from Initiatives 2 and 3 as well as a survey of TSOA participants conducted by DSHS.

Future reports will present changes in performance metrics associated with MTP initiatives and projects. Exhibit 1.10 displays the aims of the evaluation and summarizes the content of this report and its alignment with the aims. We also highlight plans for future evaluation reports.

## Exhibit 1.10. Summary of Evaluation Aims and Content of this Report

**AIM 1:** Assess Medicaid System Performance Under the Delivery System Reform Incentive Payment (DSRIP) Program

- To what extent did health care access, quality, and spending, as well as health-related social outcomes, change from a baseline period to the waiver period?
- What kinds of contextual factors explain changes in performance?

**CHAPTER 2** presents a variety of performance metrics representing health care and health-related social outcomes in 2017 and 2018. These metrics paint a picture of Medicaid system performance at the outset of MTP Initiative 1, the DSRIP program.

Future reports will describe changes in performance metrics from a baseline period to waiver period. In addition, we will describe contextual factors that help explain these changes based on additional interviews with representatives of State agencies, ACHs, and provider organizations.

**AIM 2:** Assess Progress Toward Value-Based Payment (VBP) Adoption Targets

- To what extent did VBP adoption increase from a baseline period to the waiver period?
- What kinds of factors facilitated or impeded VBP adoption?
- To what extent was VBP adoption associated with changes in health care delivery and health system performance?

**CHAPTER 3** describes VBP adoption among primary care practices in 2016 and 2018 based on our provider organization surveys. In addition, it describes factors that facilitated and impeded VBP adoption, based on key informant interviews.

Future reports will describe VBP adoption and factors that facilitated or impeded it, based on additional surveys and key informant interviews. In addition, we will describe changes associated with VBP using interviews with provider organization representatives and analysis of performance metric data.

**AIM 3:** Assess MTP's Impact on Health Care Workforce Capacity

- To what extent did demand for specific kinds of health care workers change from baseline to program periods?
- To what extent did demand for skills among existing health care workers change?
- What kinds of barriers existed to meeting workforce needs?

**CHAPTER 4** describes shortages of specific types of health care workers in 2016 and 2018 based on our provider organization surveys. In addition, it describes factors that facilitated or impeded workforce capacity based on key informant interviews.

Future reports will describe workforce shortages and barriers to meeting workforce needs, based on additional surveys and key informant interviews. In addition, we will describe change in demands on the existing workforce based on interviews with provider organization representatives.

**AIM 4:** Assess MTP's Impact on Health Information Technology (HIT) Use

- To what extent did MTP affect HIT use?
- Which areas of HIT received the largest investment?
- To what extent did HIT promote care coordination, quality improvement, and other MTP goals?
- What kinds of barriers exist to using HIT for care coordination, quality improvement, and other MTP goals?

**CHAPTER 5** describes HIT use and investment among primary care practices and hospitals in 2016 and 2018 based on our provider organizations surveys. In addition, it describes factors that facilitated and impeded HIT use based on key informant interviews.

Future reports will describe HIT use and barriers to HIT use based on additional surveys and key informant interviews. In addition, we will describe the impacts of DSRIP-supported HIT efforts on care coordination, quality improvement, and other areas based on interviews with provider organization representatives.

## Exhibit 1.10 (continued). Summary of Evaluation Aims and Content of this Report

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### **AIM 5:** Measure the Impacts of ACH Health Improvement Projects

- To what extent were specific projects associated with changes in health care access, quality, spending, and social outcomes?
- What kinds of contextual factors explain changes in performance associated with specific projects?
- To what extent did projects promote VBP adoption, health care workforce capacity, and HIT adoption?

**CHAPTER 6** describes important variations among ACHs' approaches to health improvement projects and emerging challenges with projects as of 2019.

Future reports will present estimates of changes in performance metrics associated with specific projects and describe contextual factors that help explain these changes based on additional interviews with State officials, ACH representatives, and provider organization representatives.

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### **AIM 6:** Assess the Implementation and Impacts of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)

- Were MAC and TSOA associated with improved outcomes—including physical health, mental health, and quality of life—among care receivers and caregivers?
- Were care receivers and caregivers satisfied with MAC and TSOA?
- Following implementation, was statewide long-term supports and services spending per capita lower than projected spending in the *absence* of MAC and TSOA?

**CHAPTER 7** describes enrollment in MAC and TSOA, followed by an early look at TSOA implementation and outcomes based on a specialized survey of beneficiaries conducted by DSHS. In addition, Chapter 7 describes the relationship between Initiative 2 and other MTP initiatives based on key informant interviews.

Future reports will present estimated impacts of MAC and TSOA on physical and mental health, quality of life, spending, and other outcomes.

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### **AIM 7:** Assess the Implementation and Impacts of Foundational Community Supports (FCS)

- Were supportive housing and supported employment associated with improvements in health care access, quality, spending, and social outcomes?
- Were supportive housing and supported employment implemented with fidelity to specific evidence-based models of care?
- To what extent was HIT used to support FCS?

**CHAPTER 8** describes enrollment in supportive housing and supported employment and the demographics of participants. In addition, it describes the relationship between FCS and other MTP initiatives based on key informant interviews.

Future reports will present estimates of the impacts of supportive housing and supported employment on social outcomes and health care access, quality, and spending.

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### **AIM 8:** Assess the Impacts of the Substance Use Disorder (SUD) Waiver Amendment

- Was the amendment associated with changes in outcomes for people with SUD, including access to SUD treatment, use of physical health care, opioid-related overdose deaths, SUD services spending, and total health care spending?

The SUD amendment went into effect in July 2018. Future reports will present estimated impacts of the SUD amendment on a variety of outcomes.

# Medicaid System Performance under the Delivery System Reform Incentive Payment Program

## Overview

In this chapter, we describe the performance of Washington State's Medicaid system in 2017 and 2018, the first two years of MTP and the years immediately before ACHs could earn incentive payments based on improvements in performance metrics. We measure performance with 45 metrics categorized into 10 domains.

### ► KEY FINDINGS

- *Washington State's Medicaid system performed well in the domains of Mental Health Care, Substance Use Disorder Care, and Opioid Use and Treatment. Metrics in these domains generally improved or were above national benchmarks in the two years prior to MTP.*
- *Performance was mixed in the domains of Prevention and Wellness; Care for People with Chronic Conditions; and Emergency Department, Hospital, and Institutional Care Use.*
- *Across most domains, Black and American Indian/Alaska Native Medicaid members experienced worse outcomes than the average Medicaid member.*

## Performance Metrics

To assess the performance of Washington State's Medicaid system, we selected 45 metrics from two sources: Metrics used to pay ACHs on a pay-for-performance (P4P) basis, and additional metrics in the State's *MTP Evaluation Design* ("Medicaid Transformation Project Demonstration Evaluation Design" 2019). Twenty-two metrics were specified by National Committee for Quality Assurance (NCQA) and can be calculated based on Medicaid data. NCQA collects metrics from Medicaid MCOs across the US and publishes the results (National Center for Quality Assurance, n.d.), allowing us to compare the performance of Washington State's Medicaid system to the performance of US as a whole, subject to some limitations. (Appendix A describes the data we used.)

For ease of interpretation, we categorize the metrics into 10 domains. Exhibit 2.1 presents the domains and metrics. (The Data Appendix, Table 2, provides details on each metric.)

## Exhibit 2.1. Performance Metrics Used in the Evaluation

Domain	Metrics
<b>SOCIAL DETERMINANTS OF HEALTH</b>	<ul style="list-style-type: none"> <li>• Homelessness<sup>P4P</sup></li> <li>• Employment</li> <li>• Arrest Rate<sup>P4P</sup></li> </ul>
<b>ACCESS TO PRIMARY AND PREVENTIVE CARE</b>	<ul style="list-style-type: none"> <li>• Children and Adolescents' Access to Primary Care<sup>P4P</sup></li> <li>• Adults' Access to Primary Care</li> </ul>
<b>REPRODUCTIVE AND MATERNAL HEALTH CARE</b>	<ul style="list-style-type: none"> <li>• Timely Prenatal Care<sup>NCQA,P4P</sup></li> <li>• Effective Contraception<sup>P4P</sup></li> <li>• Long-Acting Reversible Contraceptives</li> <li>• Effective Contraception within 60 Days of Delivery<sup>P4P</sup></li> </ul>
<b>PREVENTION AND WELLNESS</b>	<ul style="list-style-type: none"> <li>• Well-Child Visits in the First 15 Months<sup>NCQA,P4P</sup></li> <li>• Well-Child Visits Age 3 to 6<sup>NCQA,P4P</sup></li> <li>• Immunizations for Children<sup>NCQA,P4P</sup></li> <li>• Body Mass Index Assessment for Adults<sup>NCQA</sup></li> <li>• Chlamydia Screening for Women<sup>P4P</sup></li> <li>• Cervical Cancer Screening<sup>NCQA</sup></li> <li>• Breast Cancer Screening<sup>NCQA</sup></li> <li>• Colorectal Cancer Screening</li> </ul>
<b>MENTAL HEALTH CARE</b>	<ul style="list-style-type: none"> <li>• Mental Health Treatment Penetration<sup>P4P</sup></li> <li>• Antidepressant Medication for Adults (12 Weeks)<sup>NCQA,P4P</sup></li> <li>• Antidepressant Medication for Adults (6 Months)<sup>NCQA,P4P</sup></li> <li>• Antipsychotic Medication for People with Schizophrenia<sup>NCQA</sup></li> <li>• Diabetes Screening for People with Schizophrenia/Bipolar Disorder</li> <li>• 30-Day Follow-Up After ED Visit for Mental Illness<sup>NCQA,P4P</sup></li> <li>• 30-Day Follow-Up After Hospitalization for Mental Illness<sup>NCQA,P4P</sup></li> <li>• 30-Day Hospital Readmission for a Psychiatric Condition</li> </ul>
<b>ORAL HEALTH CARE</b>	<ul style="list-style-type: none"> <li>• Preventive or Restorative Dental Services<sup>P4P</sup></li> <li>• Topical Fluoride at a Medical Visit<sup>P4P</sup></li> <li>• Periodontal Exam for Adults<sup>P4P</sup></li> </ul>
<b>CARE FOR PEOPLE WITH CHRONIC CONDITIONS</b>	<ul style="list-style-type: none"> <li>• Controller Medication for Asthma<sup>NCQA,P4P</sup></li> <li>• Eye Exam for People with Diabetes<sup>NCQA,P4P</sup></li> <li>• Hemoglobin A1c Testing for People with Diabetes<sup>NCQA,P4P</sup></li> <li>• Nephropathy Screening for People with Diabetes<sup>NCQA,P4P</sup></li> <li>• Statin Medication for Cardiovascular Disease<sup>NCQA,P4P</sup></li> </ul>
<b>ED, HOSPITAL, AND INSTITUTIONAL CARE USE</b>	<ul style="list-style-type: none"> <li>• Emergency (ED) Department Visit Rate<sup>P4P</sup></li> <li>• Acute Hospital Use among Adults<sup>P4P</sup></li> <li>• Hospital Readmission within 30 Days<sup>P4P</sup></li> <li>• Ratio of Home and Community-Based Care Use to Nursing Facility Use</li> </ul>
<b>SUBSTANCE USE DISORDER CARE</b>	<ul style="list-style-type: none"> <li>• Substance Use Disorder (SUD) Treatment Penetration<sup>P4P</sup></li> <li>• Alcohol or Other Drug (AOD) Treatment: Initiation<sup>NCQA</sup></li> <li>• Alcohol or Other Drug (AOD) Treatment: Engagement<sup>NCQA</sup></li> <li>• 30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence<sup>P4P</sup></li> </ul>

<sup>P4P</sup>: Pay-for-performance metric for at least one ACH health improvement project. <sup>NCQA</sup>: National 2017 Medicaid HMO rate available from National Center for Quality Assurance (National Center for Quality Assurance, n.d.).

## Exhibit 2.1 (continued). Performance Metrics Used in the Evaluation

Domain	Metrics
<b>OPIOID PRESCRIBING AND OPIOID USE DISORDER TREATMENT</b>	<ul style="list-style-type: none"> <li>• People with an Opioid Prescription <math>\geq</math> 50mg MED<sup>P4P</sup></li> <li>• People with an Opioid Prescription <math>\geq</math> 90mg MED<sup>P4P</sup></li> <li>• People with an Opioid Prescription who were Prescribed a Sedative<sup>P4P</sup></li> <li>• Opioid Use Disorder Treatment Penetration<sup>P4P</sup></li> </ul>

<sup>P4P</sup>: Pay-for-performance metric for at least one ACH health improvement project. <sup>NCQA</sup>: National 2017 Medicaid HMO rate available from National Center for Quality Assurance (National Center for Quality Assurance, n.d.).

## Medicaid Population and Subgroups

We used data on outcomes for approximately 2.5 million Medicaid members as of December 2018. In the results section below, we present metrics for the total population and specific subgroups of Medicaid members defined in Exhibit 2.2. (Appendix A describes our methods for identifying people in each subgroup. The Data Appendix, Table 3 presents demographics of the study population.)

### Exhibit 2.2: Subgroups of Medicaid Members

<b>HEALTH CONDITION</b>	Chronic condition	People diagnosed with at least one chronic physical health condition, such as asthma or diabetes, from a list of chronic conditions
	Severe mental illness (SMI)	People diagnosed with at least one mental health condition, such as schizophrenia or bipolar disorder, from a list of chronic conditions
<b>GEOGRAPHY OF RESIDENCE</b>	Rural	People who resided in zip codes with a population center of less than 49,000
	High-poverty	People who resided in zip codes where the median income was in the bottom fifth of Washington State's income distribution
<b>RACE/ETHNICITY</b>	American Indian/Alaska Native Asian Black Hawaiian or Pacific Islander Hispanic White	Race/ethnicity group from Medicaid enrollment records

## Interpreting the Results

The following information should be considered when interpreting the metrics in this report:

- **Rates presented by the State in other reports may differ from rates in this report.** Although we use performance metrics data from Washington State agencies for this report, metrics presented in other reports may have been calculated differently.
- **US rates from the NCQA cannot be directly compared to rates in this report.** To help understand performance of Washington State's Medicaid system, we include US rates published by the NCQA for Medicaid where available. These rates are based on data from diverse Medicaid managed care organizations across the US that report to NCQA. This is a self-selected sample, and the data reported to NCQA are not necessarily comparable to our Washington State data.

- **Data from 2018 were the most recent data available at the time this report was prepared.**

Administrative data used to calculate the performance metrics, including Medicaid and other data, are typically available with a nine-month lag. For example, we expect to receive complete administrative data from 2019 in late 2020.

## Overview of Medicaid System Performance

**Overall, health care quality and service use metrics were stable in four domains:** Social Determinants of Health, Access to Primary and Preventive Care, Reproductive and Maternal Health Care, and Oral Health Care. Metrics in these domains changed relatively little from 2017 to 2018. State and national performance on most metrics in these domains could not be compared, as national data were not available for most metrics.

**Washington State generally performed well in three domains:** Mental Health Care; Substance Use Disorder Care; and Opioid Prescribing and Opioid Use Disorder Treatment:

- In the Mental Health Care domain, the state performed better than the national average on three of five metrics where national data were available. However, the state was slightly below the national benchmark for measures of antidepressant medication management for adults.
- In the Substance Use Disorder Care domain, all metrics improved from 2017 to 2018. Performance on Alcohol or Other Drug Treatment: Initiation was below the national average, while Alcohol or Other Drug Treatment: Engagement was above the national average.
- In the Opioid Use and Treatment domain, opioid prescribing rates decreased while treatment rates increased from 2017 to 2018.

**Performance was mixed in three domains:** Prevention and Wellness; Care for People with Chronic Conditions; and Emergency Department, Hospital, and Institutional Care Use.

- In the Prevention and Wellness domain, the state's performance exceeded the national average on two metrics and was below the national average on five metrics. The state made substantial improvements in Well-Child Visits in the First 15 Months, with the rate increasing by almost eight percentage points to a statewide rate of 69 percent.
- In the Care for Chronic Conditions domain, the state performed below the national average in four out of five metrics.
- In the Emergency Department, Hospital, and Institution Care Use domain, the Emergency Department Visit Rate declined slightly from 2017 to 2018, while Acute Hospital Use increased slightly.

**Across most domains, Black and American Indian/Alaskan Native Medicaid members experienced worse outcomes than the average Washington State Medicaid member.** One exception was the Substance Use Disorder Care domain, where quality measures for American Indian/Alaskan Native enrollees were generally higher than the state average.

## How to Read the Results

This section describes how to interpret the tables and maps in the following sections. We use results from Reproductive and Maternal Health Care, one of our ten domains, as an example.

The first table in each section presents the statewide average for each metric in 2018, the change in the rate for each metric from 2017 to 2018, and the US average for each metric, if available.

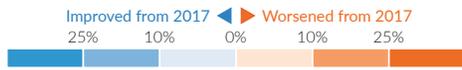
The middle column shows the change in the rate for each metric from 2017 to 2018. Shades of **blue** indicate the metric improved and shades of **orange** indicate the metric worsened. For example, Timely Prenatal Care increased by 0.7 percentage points from 2017 to 2018. A higher rate is better for this metric, so the change is shaded blue.

This column shows the national average for Medicaid managed care organizations in 2017, if available. Data were obtained from the National Center for Quality Assurance.

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Timely Prenatal Care	[1]	80.8 %	0.7 %	81.1 %
Effective Contraception	[1]	29.1 %	-0.1 %	NA
Long-Acting Reversible Contraceptives	[0]	6.4 %	-0.2 %	NA
Effective Contraception within 60 Days of Delivery	[1]	40.4 %	-0.7 %	NA



A key at the bottom of table explains the table shading.

A down arrow next to a metric means a lower rate is better.

↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

Numbers in brackets show the number of ACH health improvement projects for which the metric is a pay-for-performance metric. For example, Effective Contraception within 60 Days of Delivery is a P4P metric for one project.

The three remaining tables in each section present rates for subgroups of Medicaid members in 2018. The example below shows rates for three race/ethnicity groups.

Shades of **blue** indicate that the rate for the subgroup was better than the state average, and shades of **orange** indicate the rate was worse for the subgroup than the state average. For example, the rate for Timely Prenatal Care (a metric where a higher rate is better) was higher among Hispanic Medicaid members than the statewide average.

### Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Timely Prenatal Care	[1]	73.8 %	83.8 %	80.8 %
Effective Contraception	[1]	24.0 %	29.8 %	29.9 %
Long-Acting Reversible Contraceptives	[0]	5.5 %	7.4 %	6.3 %
Effective Contraception within 60 Days of Delivery	[1]	32.9 %	48.1 %	39.9 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

A key at the bottom of table explains the table shading. The shading scheme is the same for the last three tables and the map in each section, and *different* from the shading scheme in the first table.

## Social Determinants of Health

This domain reflects important social determinants of health. It includes three metrics:

- **Homelessness:** Percentage of members who were homeless at least one month in the year, as reported by the Washington State Department of Social and Health Services, Economic Services Administration.
- **Employment:** Percentage of members age 18 to 64 with any earnings in the year, as reported by the Washington State Employment Security Department.
- **Arrest Rate:** Percentage of members age 18 to 64 years of age who were arrested at least once in the year, as reported by the Washington State Patrol.

### ► KEY FINDINGS:

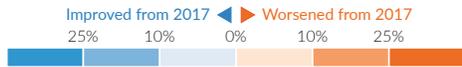
- *Homelessness and the Arrest Rate were essentially unchanged from 2017 to 2018. Employment declined by about 2 percent.*
- *Homelessness and the Arrest Rate were higher and Employment was lower among people with chronic conditions and severe mental illness.*
- *Homelessness was highest among American Indian/Alaska Native and Black Medicaid members.*
- *Homelessness was higher among ACH regions in western Washington State.*

# Social Determinants of Health

## Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Homelessness	[3] ↓	3.2 %	0.2 %	NA
Employment	[0]	49.0 %	-2.4 %	NA
Arrest Rate	[1] ↓	3.9 %	0.2 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Homelessness	[3] ↓	5.3 %	8.5 %	2.4 %	3.8 %
Employment	[0]	44.6 %	40.0 %	49.1 %	51.5 %
Arrest Rate	[1] ↓	6.4 %	9.2 %	3.5 %	4.6 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity, 2018

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Homelessness	[3] ↓	5.7 %	0.8 %	6.0 %
Employment	[0]	41.6 %	47.7 %	56.0 %
Arrest Rate	[1] ↓	7.6 %	1.3 %	6.3 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity, 2018

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Homelessness	[3] ↓	2.0 %	1.5 %	4.1 %
Employment	[0]	56.1 %	62.6 %	45.4 %
Arrest Rate	[1] ↓	2.1 %	2.5 %	4.8 %

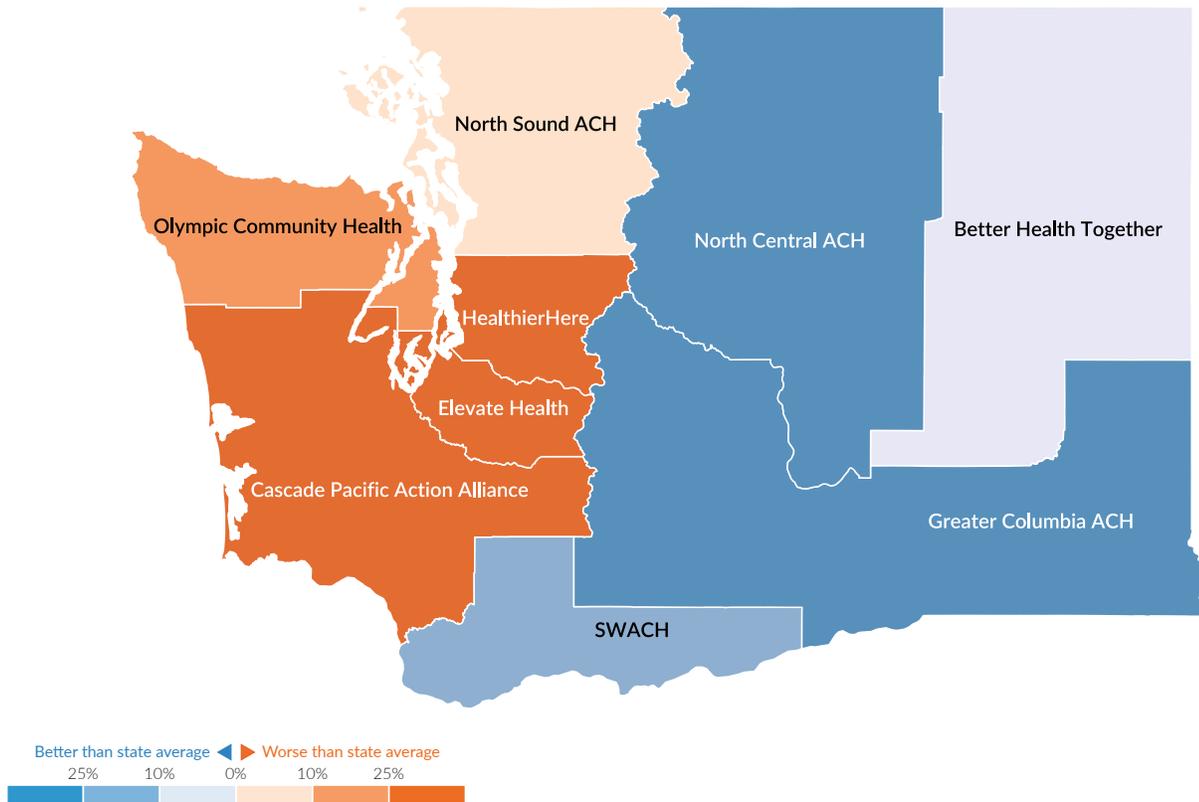


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Social Determinants of Health

### Percentage of members who were homeless at least one month in the year in 2018

Homelessness rates were higher among ACH regions in western Washington.



## Access to Primary and Preventive Care

This domain reflects access to primary and preventive care. It includes two metrics:

- **Children and Adolescents' Access to Primary Care:** Percentage of Medicaid members age one to 19 who had at least one ambulatory or preventive care visit.
- **Adults' Access to Primary Care:** Percentage of Medicaid members age 20 and older who had at least one ambulatory or preventive care visit.

### ► KEY FINDINGS:

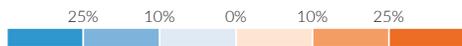
- *Metrics in this domain were almost unchanged from 2017 to 2018.*
- *Adults' Access to Primary Care was substantially higher among people with chronic conditions and people with severe mental illness than among Medicaid members overall.*
- *Adults' Access to Primary Care was notably lower for the Native Hawaiian/Pacific Islander subgroup than for other Medicaid members.*
- *Adults' Access to Primary Care was slightly higher among ACH regions in eastern Washington State.*

## Access to Primary and Preventive Care

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Children and Adolescents' Access to Primary Care	[2]	91.3 %	0.2 %	NA
Adults' Access to Primary Care	[0]	77.9 %	0.3 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Children and Adolescents' Access to Primary Care	[2]	98.1 %	98.9 %	92.5 %	92.0 %
Adults' Access to Primary Care	[0]	89.4 %	94.6 %	78.8 %	78.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity, 2018

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
		Children and Adolescents' Access to Primary Care	[2]	92.4 %
Adults' Access to Primary Care	[0]	78.7 %	76.6 %	77.5 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity, 2018

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
		Children and Adolescents' Access to Primary Care	[2]	84.8 %
Adults' Access to Primary Care	[0]	72.5 %	80.0 %	78.1 %

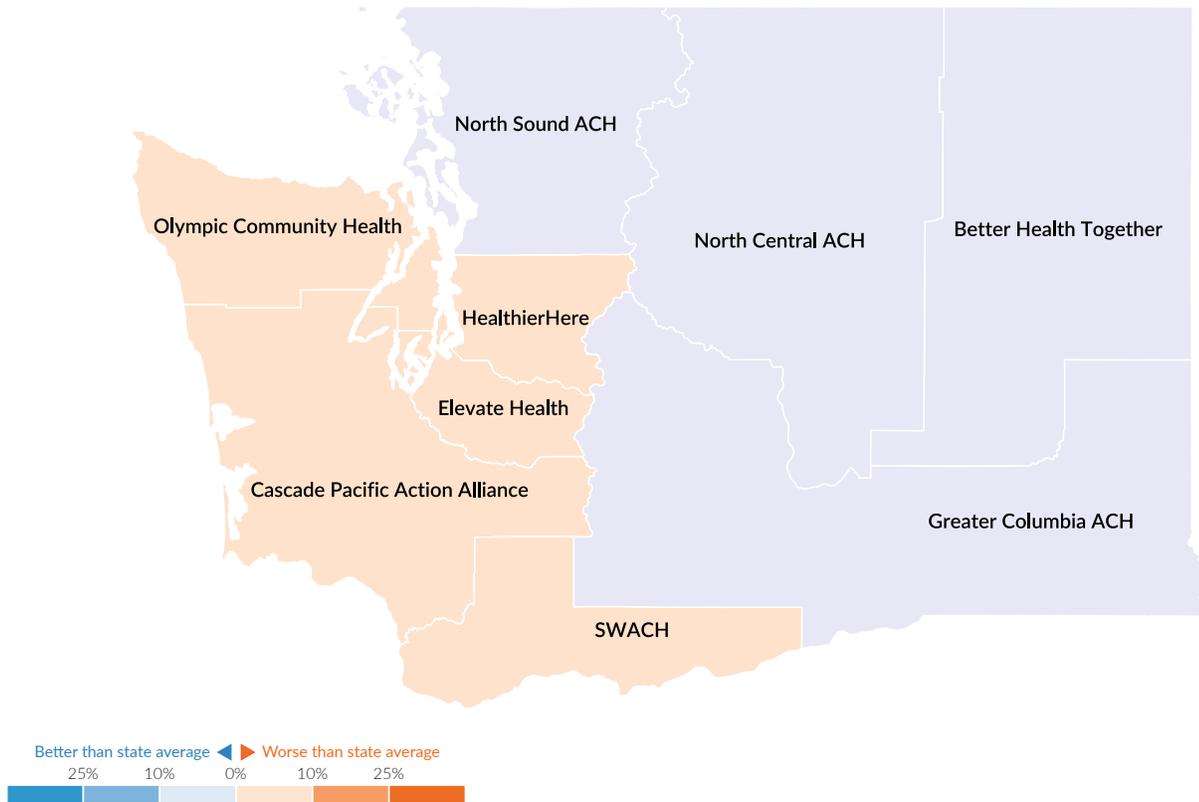


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Access to Primary and Preventive Care

### Adults' Access to Primary Care (Age 20 and Older) in 2018

Access rates were slightly higher among ACH regions in eastern Washington.



## Reproductive and Maternal Health Care

This domain reflects quality of reproductive and maternal health care. It includes four metrics:

- **Timely Prenatal Care:** Percentage of deliveries with a prenatal care visit in the first trimester, on the Medicaid enrollment start date, or within 42 days of enrollment.
- **Effective Contraception:** Percentage of female Medicaid members age 15 to 44 who received a most-effective or moderately-effective method of contraception.
- **Long-Acting Reversible Contraceptives:** Percentage of female Medicaid members age 15 to 44 who received a long-acting reversible method of contraception, defined as contraceptive implants, intrauterine devices, or intrauterine systems.
- **Effective Contraception within 60 Days of Delivery:** Percentage of female Medicaid members age 15 to 44 with a live birth who received a most-effective or moderately-effective method of contraception within 60 days of delivery.

### ► KEY FINDINGS:

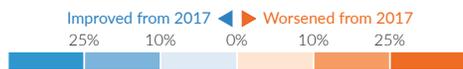
- *Metrics in this domain were essentially unchanged from 2017 to 2018.*
- *Timely Prenatal Care in Washington State was comparable to the national average.*
- *People with chronic conditions and people with severe mental illness had better outcomes than the state as a whole for all metrics reflecting contraceptive use.*
- *Asian Medicaid members and Hawaiian/Pacific Islander Medicaid members had worse outcomes than the state as a whole for all metrics reflecting contraceptive use.*

# Reproductive and Maternal Health Care

## Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Timely Prenatal Care	[1]	80.8 %	0.7 %	81.1 %
Effective Contraception	[1]	29.1 %	-0.1 %	NA
Long-Acting Reversible Contraceptives	[0]	6.4 %	-0.2 %	NA
Effective Contraception within 60 Days of Delivery	[1]	40.4 %	-0.7 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Timely Prenatal Care	[1]	82.4 %	82.8 %	82.3 %	81.5 %
Effective Contraception	[1]	32.9 %	34.8 %	30.4 %	29.9 %
Long-Acting Reversible Contraceptives	[0]	7.4 %	7.9 %	6.5 %	6.7 %
Effective Contraception within 60 Days of Delivery	[1]	44.2 %	45.9 %	43.9 %	44.8 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Timely Prenatal Care	[1]	73.4 %	76.3 %	78.3 %
Effective Contraception	[1]	27.7 %	25.0 %	27.1 %
Long-Acting Reversible Contraceptives	[0]	6.3 %	5.3 %	6.1 %
Effective Contraception within 60 Days of Delivery	[1]	37.9 %	31.1 %	37.6 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Reproductive and Maternal Health Care

## Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

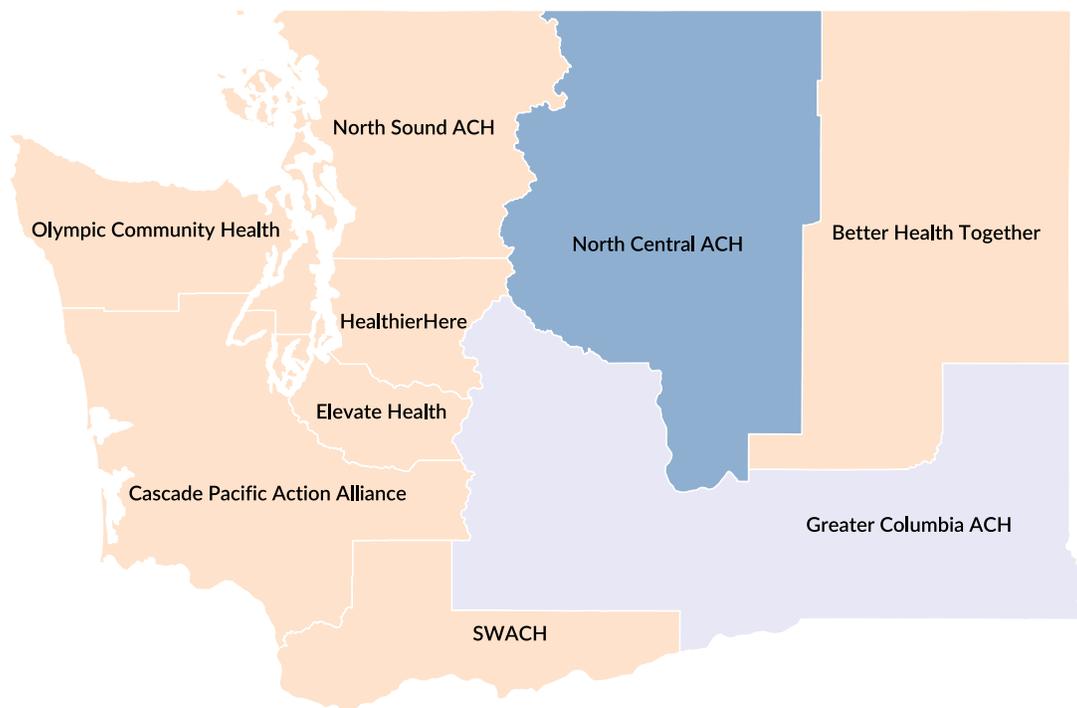
		HI/PI	Hispanic	White
Timely Prenatal Care	[1]	73.8 %	83.8 %	80.8 %
Effective Contraception	[1]	24.0 %	29.8 %	29.9 %
Long-Acting Reversible Contraceptives	[0]	5.5 %	7.4 %	6.3 %
Effective Contraception within 60 Days of Delivery	[1]	32.9 %	48.1 %	39.9 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Long-Acting Reversible Contraceptives (LARC) in 2018

The North Central ACH region had the highest rates of LARC use in Washington.



## Prevention and Wellness

This domain reflects quality of preventive health care services. It includes eight metrics:

- **Well-Child Visits in the First 15 Months:** Percentage of children who reached an age of 15 months in the year and who had six or more well-child visits during their first 15 months of life.
- **Well-Child Visits Age 3 to 6:** Percentage of children age three to six who had one or more well-child visits during the year.
- **Immunizations for Children:** Percentage of children age 2 who received all vaccinations in the combination 10 vaccination set by their second birthday.
- **Body Mass Index Assessment for Adults:** Percentage of Medicaid members age 18 to 74 who had an outpatient visit and whose body mass index was documented within the last two years.
- **Chlamydia Screening for Women:** Percentage of women age 16 to 24 identified as sexually active who received at least one chlamydia test during the measurement year.
- **Cervical Cancer Screening:** Percentage of women age 21 to 64 who were screened for cervical cancer.
- **Breast Cancer Screening:** Percentage of women age 50 to 74 who had a mammogram to screen for breast cancer.
- **Colorectal Cancer Screening:** Percentage of Medicaid members age 50 to 74 who were screened for colorectal cancer.

### ► KEY FINDINGS:

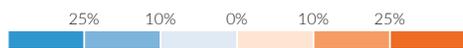
- *Most metrics in this domain changed little from 2017 to 2018. Well-Child Visits in the First 15 Months and Body Mass Index Assessment for Adults improved substantially.*
- *Washington State performed worse than the national average on 5 of 7 metrics where a national average was available.*
- *Metrics were generally better among people with chronic conditions and severe mental illness and slightly worse among rural residents.*
- *American Indian/Alaska Native Medicaid members experienced worse outcomes on 6 of 8 metrics.*

## Prevention and Wellness

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Well-Child Visits in the First 15 Months	[1]	69.3 %	7.8 %	64.1 %
Well-Child Visits Age 3 to 6	[1]	57.4 %	-1.2 %	73.0 %
Immunizations for Children	[1]	39.2 %	2.4 %	35.4 %
Body Mass Index Assessment for Adults	[0]	32.9 %	7.5 %	84.5 %
Chlamydia Screening for Women	[1]	51.4 %	-0.5 %	54.2 %
Cervical Cancer Screening	[0]	53.4 %	0.6 %	59.4 %
Breast Cancer Screening	[0]	50.5 %	-0.6 %	58.3 %
Colorectal Cancer Screening	[0]	41.1 %	1.7 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Well-Child Visits in the First 15 Months	[1]	74.1 %	72.7 %	67.4 %	69.6 %
Well-Child Visits Age 3 to 6	[1]	57.1 %	54.2 %	55.6 %	58.1 %
Immunizations for Children	[1]	47.5 %	30.8 %	38.0 %	40.4 %
Body Mass Index Assessment for Adults	[0]	38.8 %	43.5 %	28.1 %	33.3 %
Chlamydia Screening for Women	[1]	52.5 %	53.5 %	48.5 %	54.7 %
Cervical Cancer Screening	[0]	57.2 %	58.0 %	52.4 %	54.1 %
Breast Cancer Screening	[0]	55.3 %	54.9 %	48.1 %	49.5 %
Colorectal Cancer Screening	[0]	47.0 %	51.2 %	38.0 %	41.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Prevention and Wellness

### Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Well-Child Visits in the First 15 Months	[1]	53.6 %	79.6 %	69.3 %
Well-Child Visits Age 3 to 6	[1]	53.3 %	51.8 %	51.1 %
Immunizations for Children	[1]	33.7 %	58.4 %	35.0 %
Body Mass Index Assessment for Adults	[0]	24.6 %	33.3 %	38.4 %
Chlamydia Screening for Women	[1]	51.2 %	50.2 %	59.1 %
Cervical Cancer Screening	[0]	44.7 %	58.6 %	57.6 %
Breast Cancer Screening	[0]	36.1 %	65.0 %	47.7 %
Colorectal Cancer Screening	[0]	32.0 %	50.7 %	40.9 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Well-Child Visits in the First 15 Months	[1]	63.5 %	74.7 %	65.1 %
Well-Child Visits Age 3 to 6	[1]	56.8 %	56.1 %	59.3 %
Immunizations for Children	[1]	40.4 %	45.9 %	32.6 %
Body Mass Index Assessment for Adults	[0]	35.9 %	32.1 %	32.8 %
Chlamydia Screening for Women	[1]	52.5 %	54.3 %	49.2 %
Cervical Cancer Screening	[0]	52.4 %	60.4 %	51.8 %
Breast Cancer Screening	[0]	54.3 %	62.1 %	48.0 %
Colorectal Cancer Screening	[0]	40.2 %	45.5 %	40.1 %

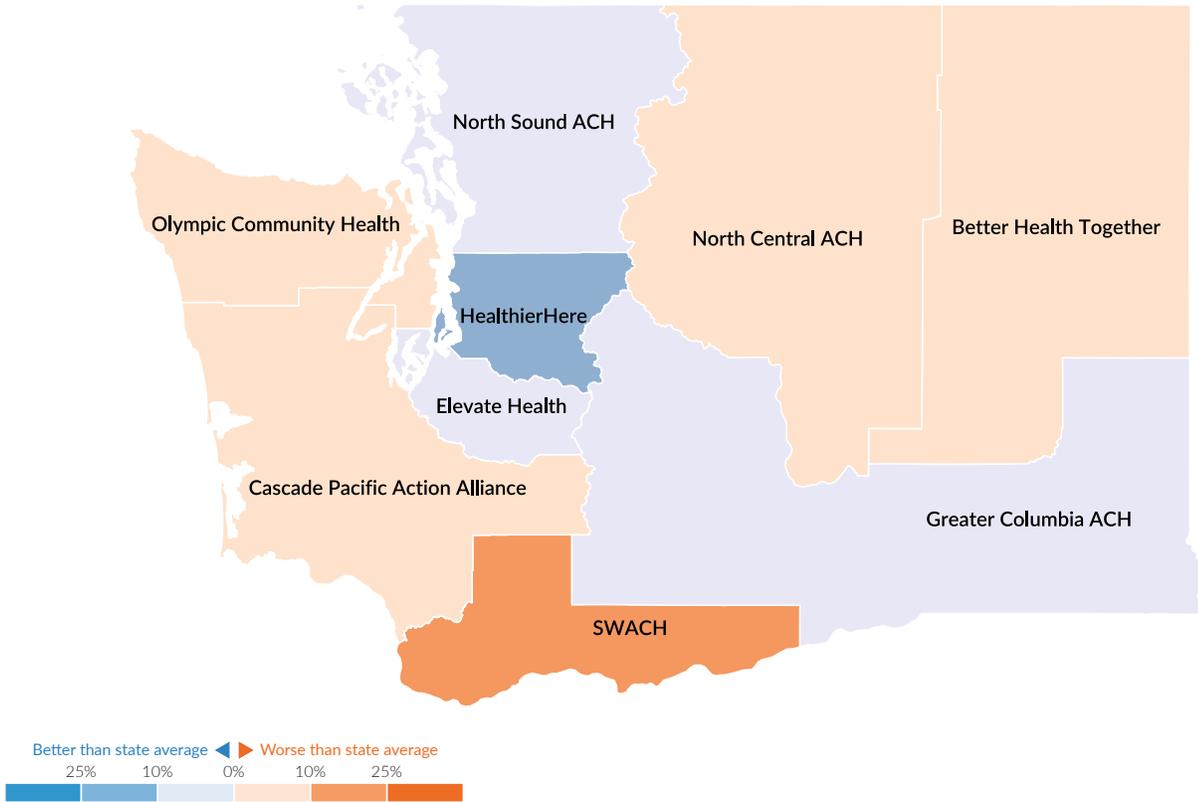


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Prevention and Wellness

### Well-Child Visits in the First 15 Months, 2018

The rate of well-child visits was highest in the HealthierHere region and lowest in the SWACH region.



## Mental Health Care

This domain reflects the quality of mental health care. It includes eight metrics:

- **Mental Health Treatment Penetration:** Percentage of Medicaid members age six and older with a mental health service need who received at least one mental health service.
- **Antidepressant Medication for Adults (12 Weeks):** Percentage of Medicaid members age 18 and older with depression who remained on antidepressant medication for 12 weeks.
- **Antidepressant Medication for Adults (6 Months):** Percentage of Medicaid members age 18 and older with depression who remained on antidepressant medication for six months.
- **Antipsychotic Medication for People with Schizophrenia:** Percentage of Medicaid members age 19 to 64 with schizophrenia who received and remained on an antipsychotic medication.
- **Diabetes Screening for People with Schizophrenia/Bipolar Disorder:** Percentage of Medicaid members age 18 to 64 with schizophrenia or bipolar disorder who received antipsychotic medication and had a diabetes test.
- **30-Day Follow-Up After ED Visit for Mental Illness:** Percentage of emergency department visits with a diagnosis of mental illness where the patient received follow-up within 30 days.
- **30-Day Follow-Up After Hospitalization for Mental Illness:** Percentage of discharges after hospitalization for mental illness where the patient received follow-up within 30 days.
- **30-Day Hospital Readmission for a Psychiatric Condition:** Percentage of inpatient psychiatric stays by adults that were followed by a readmission within 30 days.

### ► KEY FINDINGS:

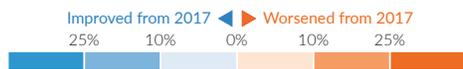
- *For the state as a whole, mental health metrics changed relatively little from 2017 to 2018.*
- *On 3 of 5 metrics where national data were available, Washington State performed better than the national average.*
- *People with chronic conditions, people with severe mental illness, and rural residents experienced slightly better or substantially better rates than the statewide average on most metrics.*
- *American Indian/Alaska Native and Black Medicaid experienced worse outcomes than the state average on most metrics.*
- *Rates for Antidepressant Medication for Adults were also low for Hispanic members.*

## Mental Health Care

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Mental Health Treatment Penetration	[3]	54.6 %	2.3 %	NA
Antidepressant Medication for Adults (12 Weeks)	[1]	50.7 %	-0.4 %	53.9 %
Antidepressant Medication for Adults (6 Months)	[1]	35.4 %	0.2 %	38.6 %
Antipsychotic Medication for People with Schizophrenia	[0]	62.2 %	-0.2 %	59.1 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	79.4 %	0.5 %	NA
30-Day Follow-Up After ED Visit for Mental Illness	[3]	74.6 %	0.8 %	54.7 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	78.7 %	-1.4 %	58.0 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	12.8 %	0.0 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Mental Health Treatment Penetration	[3]	55.2 %	74.7 %	54.6 %	55.7 %
Antidepressant Medication for Adults (12 Weeks)	[1]	50.6 %	53.1 %	49.6 %	48.7 %
Antidepressant Medication for Adults (6 Months)	[1]	35.5 %	38.3 %	33.4 %	32.2 %
Antipsychotic Medication for People with Schizophrenia	[0]	62.2 %	62.3 %	62.2 %	58.9 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	79.8 %	79.8 %	81.1 %	79.9 %
30-Day Follow-Up After ED Visit for Mental Illness	[3]	75.9 %	78.9 %	81.8 %	76.0 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	80.8 %	82.6 %	78.6 %	77.6 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	13.0 %	13.4 %	10.3 %	12.7 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Mental Health Care

### Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Mental Health Treatment Penetration	[3]	54.2 %	46.3 %	52.4 %
Antidepressant Medication for Adults (12 Weeks)	[1]	44.2 %	49.4 %	39.7 %
Antidepressant Medication for Adults (6 Months)	[1]	29.3 %	34.7 %	25.2 %
Antipsychotic Medication for People with Schizophrenia	[0]	51.4 %	71.7 %	51.8 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	82.9 %	76.6 %	76.7 %
30-Day Follow-Up After ED Visit for Mental Illness	[3]	69.0 %	70.7 %	70.3 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	74.7 %	81.5 %	77.2 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	11.5 %	15.8 %	16.2 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Mental Health Treatment Penetration	[3]	49.1 %	55.4 %	55.2 %
Antidepressant Medication for Adults (12 Weeks)	[1]	46.8 %	44.4 %	53.3 %
Antidepressant Medication for Adults (6 Months)	[1]	30.6 %	28.3 %	38.0 %
Antipsychotic Medication for People with Schizophrenia	[0]	57.6 %	56.1 %	65.0 %
Diabetes Screening for People with Schizophrenia/Bipolar Disorder	[0]	76.8 %	78.2 %	80.0 %
30-Day Follow-Up After ED Visit for Mental Illness	[3]	70.7 %	77.3 %	75.4 %
30-Day Follow-Up After Hospitalization for Mental Illness	[3]	76.8 %	72.5 %	80.7 %
30-Day Hospital Readmission for a Psychiatric Condition	[0] ↓	1.7 %	11.4 %	12.8 %

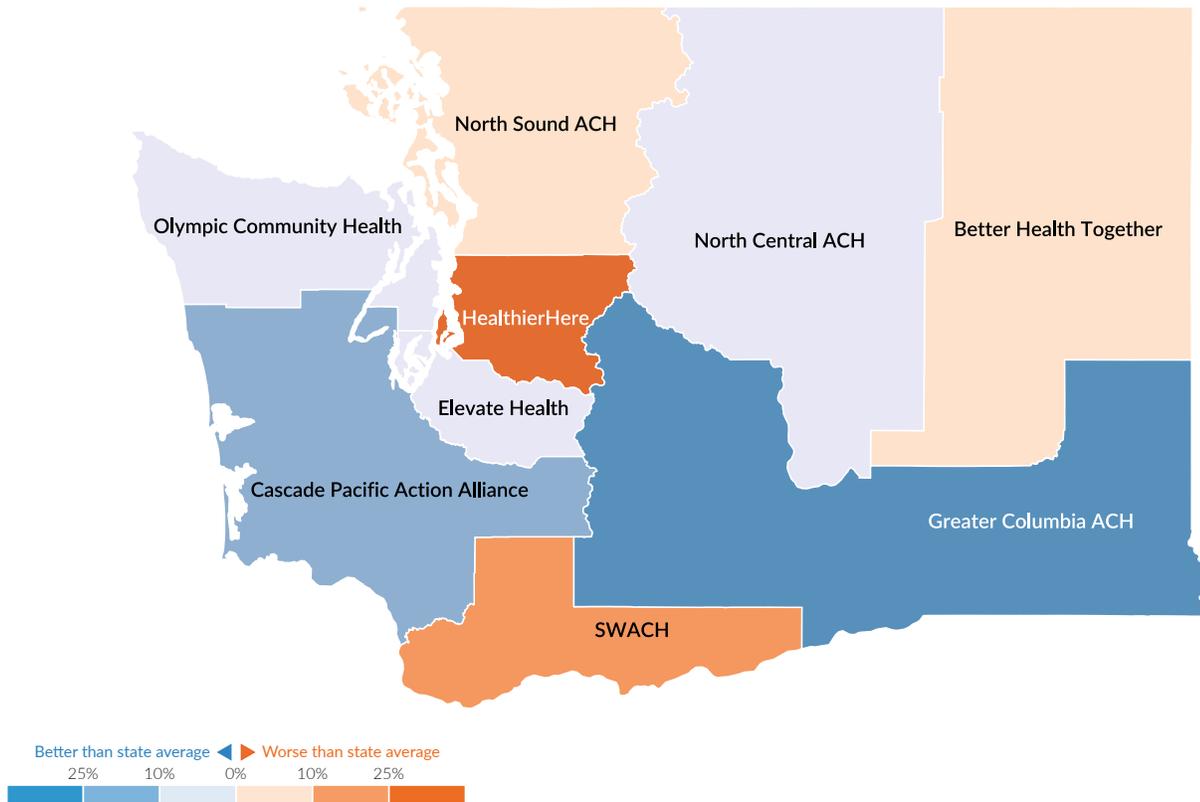


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Mental Health Care

## 30-Day Hospital Readmission for a Psychiatric Condition, 2018

The HealthierHere region had the highest rate of readmissions for a psychiatric condition in 2018.



## Oral Health Care

This domain reflects quality of oral health care. It includes three metrics:

- **Preventive or Restorative Dental Services:** Percentage of Medicaid members who received preventive or restorative dental services.
- **Topical Fluoride at a Medical Visit:** Percentage of children age five and younger who received topical fluoride from a non-dental medical provider during a medical visit.
- **Periodontal Exam for Adults:** Percentage of Medicaid members age 30 and over with a history of periodontitis who received an oral or periodontal evaluation.

### ► KEY FINDINGS:

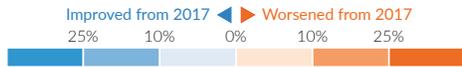
- *For the state as a whole, metrics changed relatively little from 2017 to 2018.*
- *People with severe mental illness had a substantially lower rate of Preventive or Restorative Dental Services than the state as a whole.*
- *Children in rural areas and high-poverty areas had substantially higher rates of Topical Fluoride at a Medical Visit.*
- *American Indian/Alaska Native Medicaid members experienced worse outcomes than the state as a whole.*

## Oral Health Care

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Preventive or Restorative Dental Services	[1]	47.3 %	1.0 %	NA
Topical Fluoride at a Medical Visit	[1]	4.6 %	-0.2 %	NA
Periodontal Exam for Adults	[2]	50.7 %	-0.1 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Preventive or Restorative Dental Services	[1]	44.0 %	39.7 %	49.2 %	50.5 %
Topical Fluoride at a Medical Visit	[1]	6.3 %	5.1 %	2.4 %	3.8 %
Periodontal Exam for Adults	[2]	50.6 %	50.7 %	47.1 %	49.3 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Preventive or Restorative Dental Services	[1]	45.7 %	48.0 %	45.4 %
Topical Fluoride at a Medical Visit	[1]	3.0 %	5.2 %	5.0 %
Periodontal Exam for Adults	[2]	43.4 %	60.6 %	47.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

		HI/PI	Hispanic	White
Preventive or Restorative Dental Services	[1]	42.8 %	61.7 %	40.7 %
Topical Fluoride at a Medical Visit	[1]	5.5 %	4.0 %	5.0 %
Periodontal Exam for Adults	[2]	50.5 %	52.2 %	49.0 %

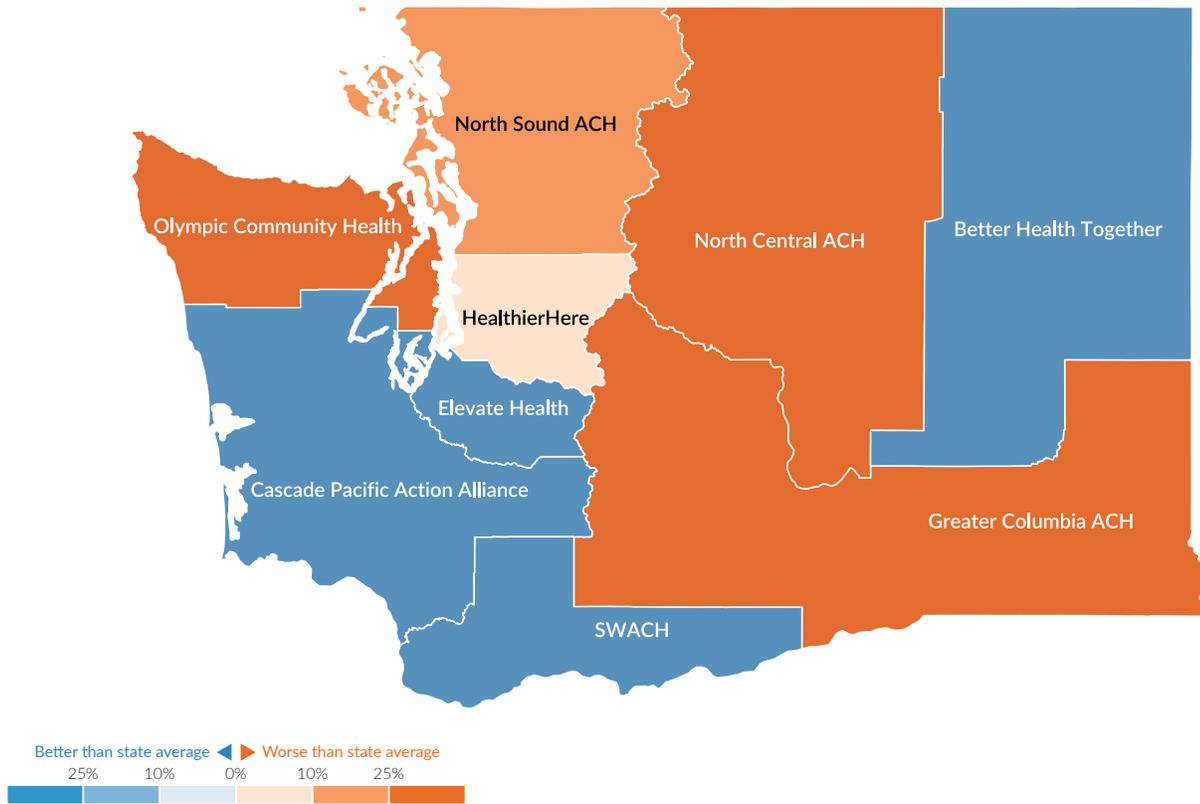


↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Oral Health Care

### Topical Fluoride at a Medical Visit, 2018

The percentage of children who received topical fluoride at a medical visit varied widely across Washington.



## Care for People with Chronic Conditions

This domain reflects quality of care for people with chronic conditions. It includes five metrics:

- **Controller Medication for Asthma:** Percentage of Medicaid members age five to 64 with persistent asthma who had a ratio of controller medication to total asthma medications of 0.5 or greater.
- **Eye Exam for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had an eye exam by an eye care professional.
- **Hemoglobin A1c Testing for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had a hemoglobin A1c test.
- **Nephropathy Screening for People with Diabetes:** Percentage of Medicaid members age 18 to 75 with diabetes who had a nephropathy screening or evidence of nephropathy.
- **Statin Medication for Cardiovascular Disease:** Percentage of men age 21 to 75 and women age 40 to 75 with atherosclerotic cardiovascular disease who received a high or moderate-intensity statin medication during the measurement year.

### ► KEY FINDINGS:

- *For the state as a whole, metrics changed relatively little from 2017 to 2018.*
- *On 4 of 5 metrics where national data were available, Washington State performed worse than the national average.*
- *American Indian/Alaska Native Medicaid members experienced worse outcomes on most metrics.*

## Care for People with Chronic Conditions

### Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Controller Medication for Asthma	[2]	52.5 %	-0.4 %	61.4 %
Eye Exam for People with Diabetes	[2]	45.6 %	1.5 %	57.2 %
Hemoglobin A1c Testing for People with Diabetes	[2]	82.4 %	-0.7 %	87.6 %
Nephropathy Screening for People with Diabetes	[2]	84.5 %	-1.0 %	90.1 %
Statin Medication for Cardiovascular Disease	[1]	82.0 %	0.6 %	76.1 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Controller Medication for Asthma	[2]	52.9 %	51.3 %	49.5 %	51.5 %
Eye Exam for People with Diabetes	[2]	46.4 %	46.8 %	45.4 %	46.2 %
Hemoglobin A1c Testing for People with Diabetes	[2]	82.9 %	83.4 %	84.1 %	81.9 %
Nephropathy Screening for People with Diabetes	[2]	85.0 %	86.5 %	85.0 %	84.8 %
Statin Medication for Cardiovascular Disease	[1]	82.0 %	79.4 %	80.9 %	81.6 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

### Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Controller Medication for Asthma	[2]	43.6 %	60.4 %	47.7 %
Eye Exam for People with Diabetes	[2]	40.6 %	54.5 %	41.3 %
Hemoglobin A1c Testing for People with Diabetes	[2]	77.6 %	89.7 %	77.6 %
Nephropathy Screening for People with Diabetes	[2]	84.6 %	87.7 %	83.7 %
Statin Medication for Cardiovascular Disease	[1]	72.0 %	93.2 %	75.3 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Care for People with Chronic Conditions

## Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

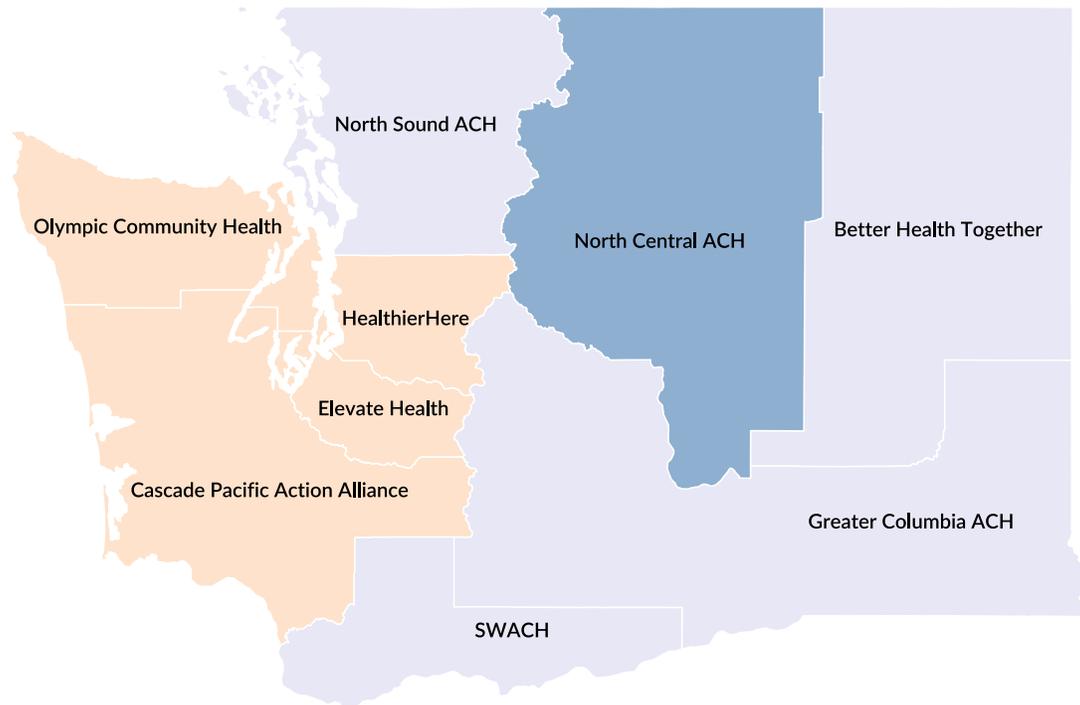
		HI/PI	Hispanic	White
Controller Medication for Asthma	[2]	56.9 %	52.5 %	52.3 %
Eye Exam for People with Diabetes	[2]	45.3 %	49.1 %	44.8 %
Hemoglobin A1c Testing for People with Diabetes	[2]	81.7 %	84.7 %	82.1 %
Nephropathy Screening for People with Diabetes	[2]	84.5 %	85.6 %	84.0 %
Statin Medication for Cardiovascular Disease	[1]	87.8 %	88.0 %	81.6 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Eye Exam for People with Diabetes, 2018

The North Central ACH region had the highest rate of eye exams for people with diabetes in 2018.



## Emergency Department, Hospital, and Institutional Care Use

This domain reflects use of emergency department (ED), hospital, and institutional care among Medicaid members. It includes four metrics:

- **Emergency Department (ED) Visit Rate:** Number of ED visits, including visits related to mental health and substance use disorder, per 1,000 member months.
- **Acute Hospital Use among Adults:** Number of acute inpatient discharges among Medicaid members age 18 or older per 1,000 members during the measurement year.
- **Hospital Readmission within 30 Days:** Percentage of hospital stays among Medicaid members age 18 and over with unplanned readmission to the hospital within 30 days.
- **Ratio of Home and Community-Based Care Use to Nursing Facility Use:** Months of home and community-based services received by Medicaid members age 18 and over as a percentage of total months of long-term care received.

### ► KEY FINDINGS:

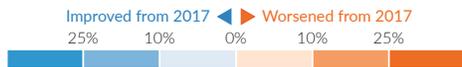
- *For the state as a whole, metrics changed relatively little from 2017 to 2018. The ED Visit Rate declined slightly, while Acute Hospital Use increased slightly.*
- *People with chronic conditions and people with severe mental illness experienced substantially worse outcomes on ED and hospital use metrics than the state average.*
- *American Indian/Alaska Native and Black Medicaid members experienced substantially worse outcomes on ED and hospital use metrics than the state average.*

# Emergency Department, Hospital, and Institutional Care Use

## Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Emergency Department Visit Rate (Visits Per 1,000 Member Months)	[8] ↓	50.2	-0.7	NA
Acute Hospital Use (Discharges Per 1,000 Members)	[5] ↓	69.6	1.0	NA
Hospital Readmission within 30 Days	[3] ↓	11.2 %	0.0 %	NA
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	92.8 %	0.4 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Emergency Department Visit Rate (Visits Per 1,000 Member Months)	[8] ↓	78.6	122.7	48.8	62.9
Acute Hospital Use (Discharges Per 1,000 Members)	[5] ↓	101.4	137.7	67.0	76.1
Hospital Readmission within 30 Days	[3] ↓	12.1 %	15.5 %	9.3 %	11.1 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.4 %	94.3 %	93.0 %	93.0 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Emergency Department Visit Rate (Visits Per 1,000 Member Months)	[8] ↓	69.8	21.0	62.3
Acute Hospital Use (Discharges Per 1,000 Members)	[5] ↓	107.8	27.6	73.3
Hospital Readmission within 30 Days	[3] ↓	12.8 %	10.0 %	13.0 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	89.2 %	95.0 %	93.3 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Emergency Department, Hospital, and Institutional Care Use

## Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

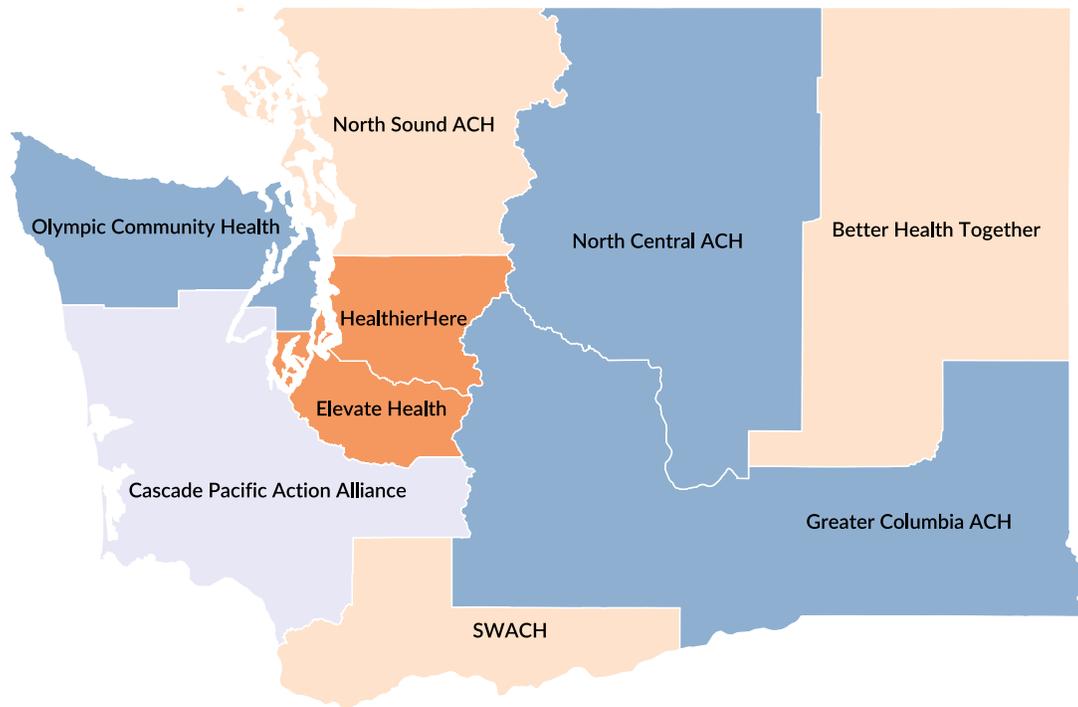
		HI/PI	Hispanic	White
Emergency Department Visit Rate (Visits Per 1,000 Member Months)	[8] ↓	40.2	47.1	53.9
Acute Hospital Use (Discharges Per 1,000 Members)	[5] ↓	54.9	51.0	76.3
Hospital Readmission within 30 Days	[3] ↓	7.5 %	8.6 %	11.6 %
Ratio of Home and Community-Based Care Use to Nursing Facility Use	[0]	93.8 %	94.0 %	92.5 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Hospital Readmission within 30 Days, 2018

Readmission rates were highest in the HealthierHere and Elevate Health regions.



## Substance Use Disorder Care

This domain reflects care for people with substance use disorder. It includes four metrics:

- **Substance Use Disorder (SUD) Treatment Penetration:** Percentage of Medicaid members age 12 and over with an SUD treatment need who received at least one qualifying SUD treatment.
- **Alcohol or Other Drug (AOD) Treatment: Initiation:** Percentage of Medicaid members age 13 and over with a new episode of AOD dependence who received treatment within 14 days of diagnosis.
- **Alcohol or Other Drug (AOD) Treatment: Engagement:** Percentage of members who initiated treatment and had two or more additional AOD services within 34 days of the initial visit.
- **30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence:** Percentage of emergency department visits among Medicaid members age 13 and over with a diagnosis of alcohol or other drug dependence (AOD) who had a follow-up visit for AOD within 30 days.

### ► KEY FINDINGS:

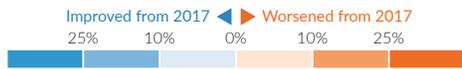
- *For the state as a whole, performance on all metrics improved substantially from 2017 to 2018.*
- *Outcomes for people with chronic conditions and people with severe mental illness were generally better than the state average, while outcomes for residents of rural areas and residents of high-poverty areas were generally worse. However, differences were slight.*
- *Asian, Black, Hawaiian/Pacific Islander, and Hispanic Medicaid members experienced worse outcomes than the state average.*

# Substance Use Disorder Care

## Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
Substance Use Disorder Treatment Penetration	[3]	33.7 %	3.4 %	NA
Alcohol or Other Drug Treatment: Initiation	[0]	37.5 %	5.1 %	42.3 %
Alcohol or Other Drug Treatment: Engagement	[0]	14.8 %	4.1 %	13.5 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	24.7 %	2.4 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
Substance Use Disorder Treatment Penetration	[3]	33.5 %	35.0 %	33.0 %	32.7 %
Alcohol or Other Drug Treatment: Initiation	[0]	38.0 %	38.4 %	35.5 %	36.8 %
Alcohol or Other Drug Treatment: Engagement	[0]	15.0 %	14.8 %	13.3 %	14.1 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	25.8 %	28.6 %	25.4 %	22.4 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
Substance Use Disorder Treatment Penetration	[3]	41.3 %	26.8 %	27.3 %
Alcohol or Other Drug Treatment: Initiation	[0]	39.4 %	34.4 %	35.1 %
Alcohol or Other Drug Treatment: Engagement	[0]	18.1 %	13.4 %	11.2 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	26.5 %	14.8 %	17.2 %



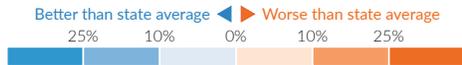
↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Substance Use Disorder Care

## Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

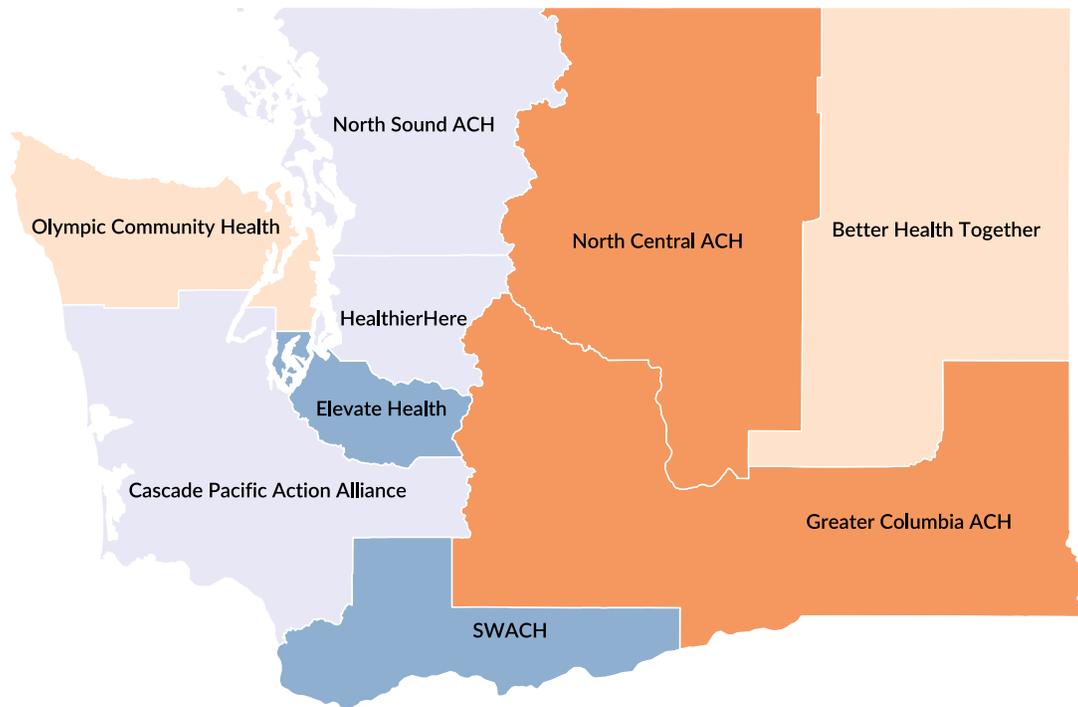
		HI/PI	Hispanic	White
Substance Use Disorder Treatment Penetration	[3]	31.1 %	31.8 %	34.8 %
Alcohol or Other Drug Treatment: Initiation	[0]	35.9 %	33.2 %	38.6 %
Alcohol or Other Drug Treatment: Engagement	[0]	13.6 %	12.7 %	15.3 %
30-Day Follow-Up After ED Visit for Alcohol/Drug Abuse/Dependence	[3]	16.4 %	20.8 %	26.8 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Alcohol or Other Drug Treatment: Initiation, 2018

The Elevate Health and SWACH regions had high rates of alcohol or other drug treatment initiation relative to the state as a whole. Rates were lower in the North Central ACH and Greater Columbia ACH regions.



## Opioid Prescribing and Opioid Use Disorder Treatment

This domain reflects opioid use and opioid use disorder treatment for Medicaid members with a treatment need. The domain includes four metrics:

- **People with an Opioid Prescription  $\geq$  50mg MED:** Percentage of Medicaid members prescribed chronic opioid therapy with dosage greater than or equal to 50mg morphine equivalent dose.
- **People with an Opioid Prescription  $\geq$  90mg MED:** Percentage of Medicaid members prescribed chronic opioid therapy with dosage greater than or equal to 90mg morphine equivalent dose.
- **People with an Opioid Prescription who were Prescribed a Sedative:** Percentage of Medicaid members prescribed chronic opioids who were also prescribed a chronic sedative.
- **Opioid Use Disorder Treatment Penetration:** Percentage of Medicaid members age 18 and over with an opioid use disorder (OUD) treatment need who received medication-assisted treatment or medication-only treatment for OUD.

### ► KEY FINDINGS:

- *For the state as a whole, performance on all metrics improved from 2017 to 2018. Opioid Use Disorder Treatment Penetration increased substantially.*
- *The rate of opioid prescription among people who were prescribed a sedative was substantially higher among people with severe mental illness than the state average.*
- *Outcomes on 3 of 4 metrics were substantially worse for Black Medicaid enrollees than for the state as a whole.*

# Opioid Prescribing and Opioid Use Disorder Treatment

## Statewide Rates, 2017-2018 Change, and US Comparison

Statewide rate in 2018, statewide change from 2017 to 2018, and US average in 2017

		2018 Statewide	2017-2018 Change	2017 US Average
People with an Opioid Prescription >= 50mg MED	[1] ↓	33.0 %	-0.4 %	NA
People with an Opioid Prescription >= 90mg MED	[1] ↓	14.1 %	-1.2 %	NA
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	19.4 %	-2.5 %	NA
Opioid Use Disorder Treatment Penetration	[3]	51.1 %	9.1 %	NA



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Health Condition and Geographic Area, 2018

Members with chronic illness, members with severe mental illness (SMI), members living in rural areas, and members living in high-poverty areas

		Health Condition		Geographic Area	
		Chronic	SMI	Rural	High-Poverty
People with an Opioid Prescription >= 50mg MED	[1] ↓	33.1 %	32.6 %	32.7 %	30.0 %
People with an Opioid Prescription >= 90mg MED	[1] ↓	14.1 %	13.2 %	14.0 %	11.2 %
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	19.7 %	25.7 %	18.8 %	17.9 %
Opioid Use Disorder Treatment Penetration	[3]	51.2 %	50.4 %	48.4 %	50.0 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## Measures by Race and Ethnicity

American Indian or Alaska Native (AI/AN), Asian, and Black members

		AI/AN	Asian	Black
People with an Opioid Prescription >= 50mg MED	[1] ↓	27.8 %	22.4 %	39.3 %
People with an Opioid Prescription >= 90mg MED	[1] ↓	11.1 %	8.2 %	17.5 %
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	15.7 %	19.4 %	16.8 %
Opioid Use Disorder Treatment Penetration	[3]	52.0 %	45.8 %	41.2 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

# Opioid Prescribing and Opioid Use Disorder Treatment

## Measures by Race and Ethnicity

Hawaiian or Pacific Islander (HI/PI), Hispanic, and White members

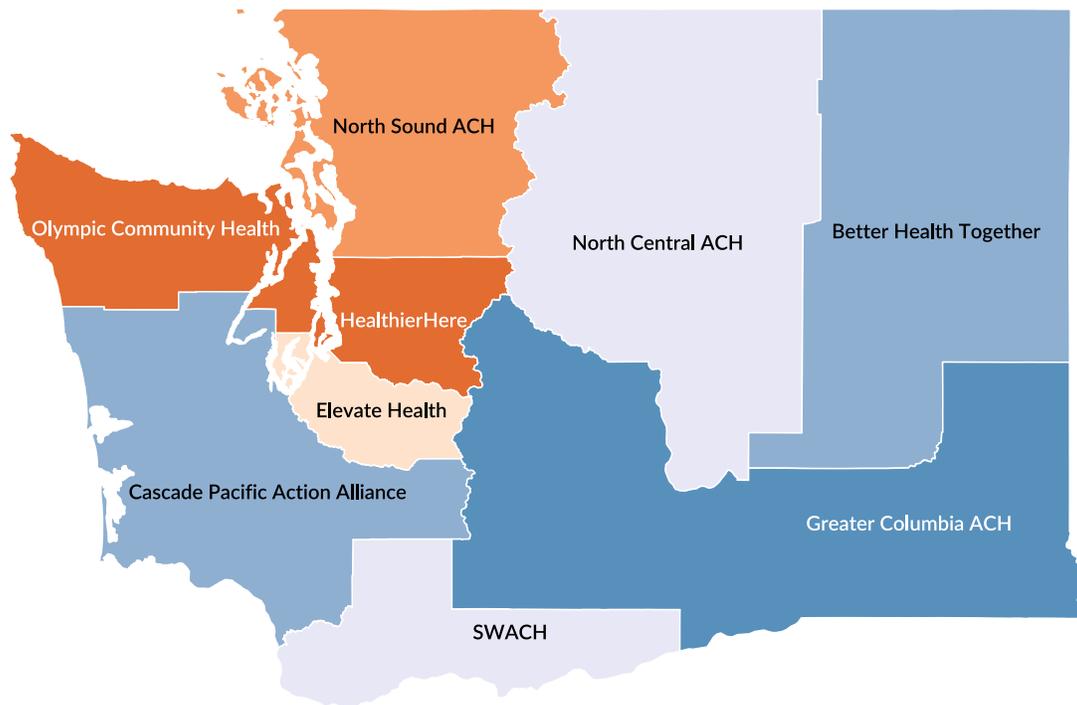
		HI/PI	Hispanic	White
People with an Opioid Prescription $\geq$ 50mg MED	[1] ↓	28.1 %	25.7 %	33.5 %
People with an Opioid Prescription $\geq$ 90mg MED	[1] ↓	14.0 %	9.0 %	14.5 %
People with an Opioid Prescription who were Prescribed a Sedative	[1] ↓	14.9 %	15.2 %	20.4 %
Opioid Use Disorder Treatment Penetration	[3]	41.5 %	47.5 %	52.7 %



↓ Lower is better [3] Projects where this metric is pay-for-performance (P4P)

## People with an Opioid Prescription $\geq$ 90mg MED, 2018

Rates of prescribing above 90 MED were highest in the HealthierHere and Olympic Community of Health ACH regions.



## Next Steps

We expect to receive performance metric data on outcomes in 2019—the year in which ACHs began implementing health improvement projects—in mid-2020. Using these data, and data from subsequent waiver years, we will describe changes in metrics over the waiver period and present estimates of changes that can be attributed to the DSRIP program, controlling for other factors that may affect outcomes, such as member demographics and health status. In addition, we will continue to interview State and ACH key informants about the factors that may have affected outcomes, including successes and challenges with MTP implementation and other health policy changes.

# Progress toward Value-Based Payment Adoption Targets

## Overview

In this chapter, we assess value-based payment (VBP) adoption among Washington State's primary care practices and describe factors that facilitated and impeded VBP adoption.

*Chapter 1, Exhibit 1.4 summarizes VBP activities in the Washington State Health Care Authority's (HCA's) Project Toolkit.*

### ► KEY FINDINGS

- *Our survey indicates widespread participation in VBP arrangements among primary care practices, a finding consistent with reports from the State that MCOs have met their VBP targets for MTP.*
- *However, practices reported a low proportion of Medicaid revenue tied to quality goals. This finding suggests that the State's definition of VBP adoption may provide an incomplete picture of VBP progress.*
- *While MCOs have built-in levers to promote VBP, MTP assigns partial responsibility for VBP adoption to ACHs. It is not evident that ACHs are ideally positioned to promote VBP among provider organizations.*
- *ACH informants described a lack of clarity differentiating the State's role and ACHs' role in promoting VBP. MTP appears to have transferred some responsibility for leading and supporting VBP from the State to ACHs, but it is unclear that ACHs are better positioned than the State to lead in this area.*

## VBP Adoption at the Outset of MTP

**The State of Washington reports that MCOs met MTP's VBP targets; our survey indicates widespread participation in VBP arrangements among primary care practices.** As described in Chapter 1, the State uses MCO contracting to incentivize and monitor achievement of the State's VBP targets. State informants reported that MCOs surpassed the targets in the first two years of MTP. MCOs reported that 66 percent of Medicaid dollars were paid through VBP arrangements in 2018, exceeding the State's 50 percent target for that year (Washington State Health Care Authority n.d.). (Exhibit 1.5 presents the State's VBP targets.)

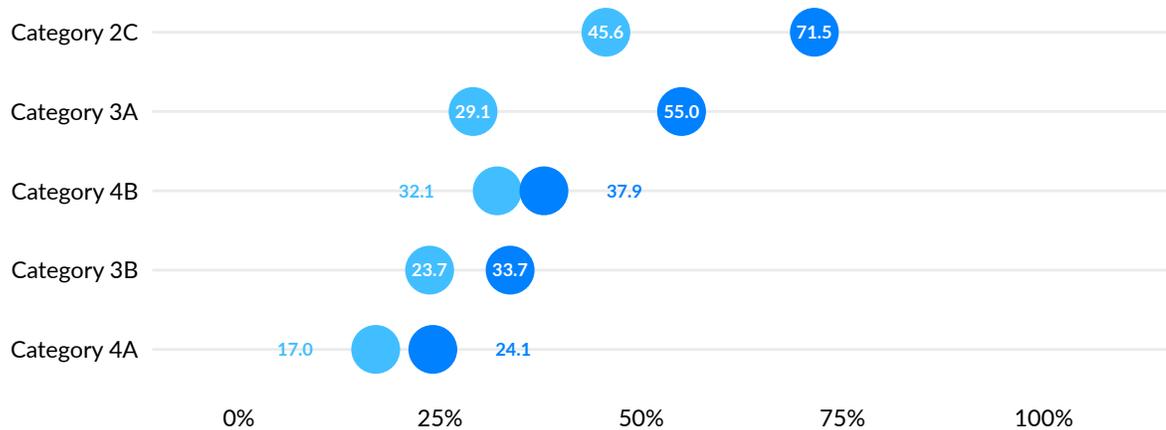
To measure VBP adoption among primary care practices over the waiver period, we included two questions about VBP on our survey:

- We asked whether practices participated in six kinds of VBP arrangements, with each arrangement corresponding to a VBP category defined by the Health Care Payment Learning & Action Network (LAN), in 2016 and 2018. (Exhibit 1.6 summarizes VBP categories defined by LAN.)
- To assess the overall importance of VBP arrangements to practices, we asked practices to indicate the percentage of their total Medicaid revenue from payments that were dependent on meeting quality goals in 2016 and 2018.

Exhibit 3.1 presents the percentage of practices participating in each kind of VBP arrangement. Seventy-two percent of practices participated in fee-for-service (FFS) contracts with rewards for quality goals in 2018, and 55 percent participated in contracts with potential savings from meeting cost or service use targets in the same year. The percentage of practices participating in these kinds of contracts increased substantially from 2016 to 2018.

In contrast, participation in VBP arrangements that exposed practices to “downside risk” (i.e., penalties for failure to meet cost or service use targets, or losses if the cost of care exceeds prospective payment amounts) was less common and increased less than participation in VBP arrangements with “upside risk.”

**Figure 3.1. From 2016 to 2018, the percentage of primary care practices participating in contracts with rewards for meeting quality goals, and in contracts with upside risk only, increased substantially.** Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.



**Category 2C:** Contracts with rewards for meeting quality goals on top of fee-for-service payments

**Category 3A:** Contracts with potential shared savings from meeting cost or utilization targets

**Category 3B:** Contracts with financial risk if cost or utilization targets were not met

**Category 4A:** Prospective payments covering total cost of care for specific conditions

**Category 4B:** Prospective payments covering total costs of all care for a specific panel of patients

Source: Population estimate based on responses to CHSE’s primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

**Practices reported a low proportion of Medicaid revenue tied to quality goals.** Exhibit 3.2 shows the percentage of Medicaid revenue that practices received from payments that were dependent on meeting quality goals in 2018. The overwhelming majority of practices received less than one-fifth of their Medicaid revenue from payments linked to quality.

**Exhibit 3.2. In 2018, 70 percent of primary care practices received less than 20 percent of their Medicaid revenue from payments linked to quality.**

Only four percent of practices received 80 percent or more of their Medicaid revenue from payments linked to quality.



Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

**The State's definition of VBP adoption does not measure the proportion of Medicaid revenue tied to quality.** As described in Chapter 1, all dollars paid to providers through a contract with any VBP component count as dollars paid through VBP under the State's VBP reporting system. As a result, MCOs may be reporting total dollars paid through contracts with relatively small VBP components (e.g., large FFS contracts with relatively small bonuses for quality) as dollars paid through VBP. In this case, MCOs would be reporting a high level of VBP adoption based on the State's definition, while the actual proportion of Medicaid revenue tied to quality would be low.

## Factors that Facilitated and Impeded VBP

**MCOs have built-in levers to promote VBP.** As entities that contract with provider organizations and pay for health care, MCOs have built-in levers to influence provider behavior through payment. Washington State uses its contracts with MCOs to incentivize incorporation of VBP into MCO contracts with providers, and MCOs can negotiate VBP arrangements into their contracts with provider organizations.

**MTP assigns partial responsibility for VBP adoption to ACHs.** MTP assigns responsibility for promoting VBP to ACHs in several ways: HCA's *Project Toolkit* requires ACHs to promote VBP through training, technical assistance, and other activities as part of their Domain 1 projects, and ACHs earn a portion of project incentive payments based on achievement of VBP milestones.

**ACHs' activities to promote VBP adoption align with activities in HCA's Project Toolkit.** ACH informants reported that they offered providers VBP readiness tools, communicated or provided VBP training and technical assistance, and facilitated VBP data collection by incentivizing provider participation in the State's Value-Based Purchasing Survey.

Training and technical assistance may be important for helping providers adopt VBP. In particular, smaller providers and behavioral health care providers may need more resources to assume the risks of VBP adoption. Smaller providers face challenges in assuming financial risks of VBP because they have lower revenue and smaller operating margins. In addition, both smaller providers and behavioral health care providers may have less capacity for reporting on quality metrics used to measure performance in VBP arrangements. Training and technical assistance may help these kinds of providers build capacity for quality reporting. However, it is not evident that ACHs—which were designed to convene and align the efforts of cross-sector partners within a region—are well-positioned to provide training and technical assistance on VBP, a highly technical and complex aspect of the health care delivery system.

**ACH informants are looking for State leadership regarding VBP.** One informant stated, “We're still looking for a little bit of clarification on where the ball ends [because] there's a lot of overlap between [the] Health Care Authority and the ACH's role. I think we're still trying to figure out how best to operate within our role.” (ACH 2, Participant 172) The State has previously carried out activities to promote VBP adoption. These include establishing the Practice Transformation Hub using support from the State Innovation Model (SIM) grant, which provided technical assistance on VBP, and establishing a Medicaid Value-Based Payment (MVP) Action Team comprised of State and industry leaders, which provided thought leadership and guidance on VBP. The Practice Transformation Hub ended with the SIM grant and informants reported that the MVP Action Team was disbanded in 2015.

MTP appears to have transferred some responsibility for promoting VBP from the State to ACHs, but it is unclear if ACHs are better positioned than the State to lead in this area. Some barriers to more widespread VBP adoption—such as the capacity of smaller providers to assume financial risk—may be difficult for ACHs to address.

## Next Steps

We will conduct a second round of provider organization surveys to collect data on VBP adoption in 2020 and continue interviewing State and ACH informants to understand factors that facilitate or impede VBP adoption as MTP continues. In addition, we will interview representatives from a sample of practices and hospitals about their participation in VBP arrangements and its effects on health care delivery.

# MTP's Impact on Health Care Workforce Capacity

## Overview

In this chapter, we assess health care workforce capacity among Washington State's primary care practices and describe factors that facilitated or impeded workforce capacity.

*Chapter 1, Exhibit 1.4 summarizes health care workforce activities in the Washington State Health Care Authority's (HCA's) Project Toolkit.*

### ► KEY FINDINGS

- *Staff shortages were widespread among primary care practices in 2018. For example, more than half of practices reported shortages of medical assistants, registered nurses, primary care physicians, and psychiatrists.*
- *A majority of practices expressed concern that staff shortages would result in suboptimal outcomes for people with severe mental illness (SMI), co-occurring behavioral and medical conditions, and substance use disorder (SUD), all of which represent focus populations for MTP.*
- *Barriers exist to expanding specific workforces needed for MTP health improvement projects. These include behavioral health care providers, community health workers and peer counselors, and physicians who provide medications for SUD.*
- *Specific barriers to meeting MTP's workforce needs include licensing and credentialing regulations, billing regulations, and concerns about sustainability of funding after MTP ends.*
- *ACH informants expressed concerns that the State had not clearly defined the role of the ACH in meeting workforce needs. Facing barriers to hiring new workers, ACHs have focused on providing training to existing workers to meet MTP's workforce needs.*

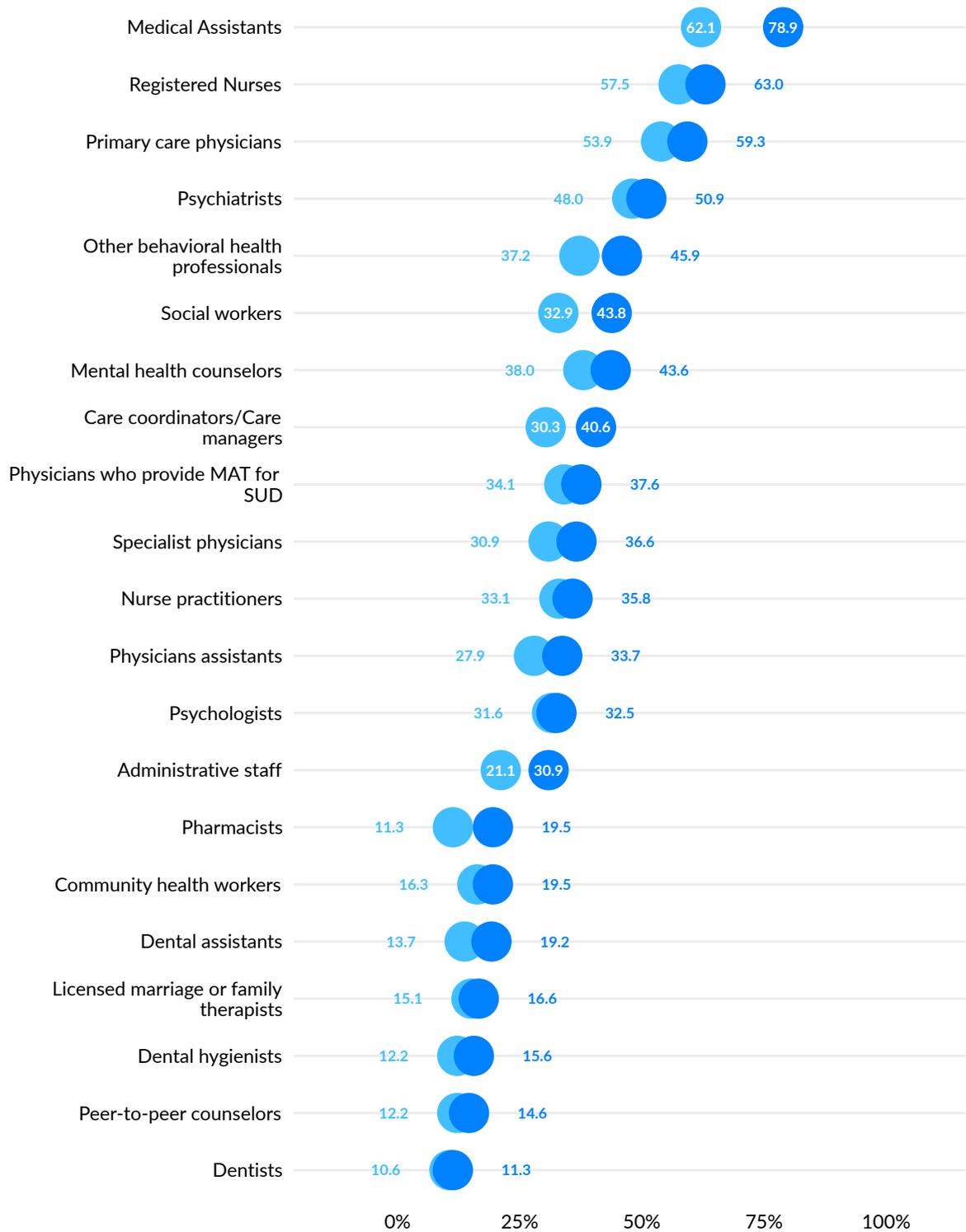
## Demand for Health Care Workers

To assess health workforce demand, we asked primary care practices whether they needed—but had difficulty hiring or retaining—21 types of health care workers in 2016 and 2018.

**Staff shortages were widespread in 2018.** Exhibit 4.1 shows the percentage of practices that reported shortages in 2016 and 2018. More than half reported shortages for medical assistants, registered nurses, primary care physicians, and psychiatrists in 2018.

**Exhibit 4.1. In 2018, over half of primary care practices reported shortages of medical assistants, registered nurses, primary care physicians, and psychiatrists.**

Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.

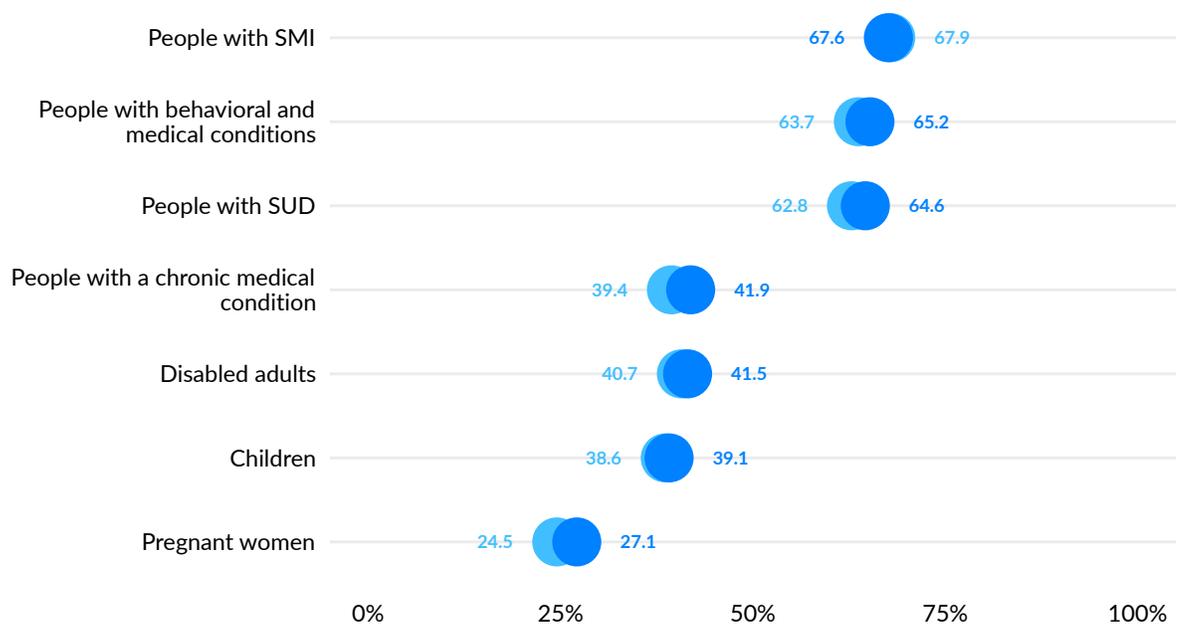


Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

**Concern was widespread about the effect of workforce shortages on specific focus populations for MTP.** We asked practices if they were concerned about suboptimal outcomes for seven subgroups of Medicaid members as a result of workforce shortages. Exhibit 4.2 shows that approximately two-thirds of practices expressed concerns about the effect of shortages on people with SMI, co-occurring behavioral and medical conditions, and SUD. Multiple components of MTP, including several health improvement projects and the SUD waiver, were designed to address the needs of these populations. Thus, workforce shortages may represent a barrier to meeting the needs of the very populations who are a focus of MTP.

**Exhibit 4.2. In 2016 and 2018, approximately two-thirds of practices expressed concerns about the effect of workforce shortages on people with severe mental illness (SMI), co-occurring behavioral and medical conditions, and substance use disorder (SUD).**

Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.



Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

## Factors that Facilitated and Impeded Workforce Capacity

**Certain health improvement projects depend on specific types of workers, but regulatory barriers exist to hiring and employing these workers.** These barriers may create challenges for Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care), Project 2B (Community-Based Care Coordination), and Project 3A (Addressing the Opioid Public Health Crisis), as well as other projects. (Exhibit 1.4 describes each project.)

- Behavioral health care workers:** The success of Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care), a required project for all ACHs, is dependent on the ability to integrate behavioral health care workers into primary care settings. ACH informants reported that current licensing and credentialing requirements limit the settings in which some kinds of behavioral health care workers can practice. For example, behavioral health counselors who practice within a community mental health center (CMHC) are not required to obtain individual credentials, as the

CMHC is credentialed at the facility level. However, a lack of individual credentials may limit the ability of counselors to practice in other settings.

- **Community Health Workers (CHWs) and peer counselors:** CHWs and peer counselors provide care coordination, health education, recovery and support services, and other health-related supports in their communities. CHWs may provide care coordination for Pathways Community HUBs, the evidence-based approach for Project 2B (Community-Based Care Coordination) selected by six ACHs. In addition, CHWs and peer counselors may play roles in a variety of other health improvement projects. ACH informants reported that these kinds of workers may receive low reimbursement rates for their services; some payers may not reimburse provider organizations for any CHW and peer counselor services. As a result, provider organizations may hesitate to employ CHWs and peer counselors to coordinate care and provide health-related supports.
- **Waivered SUD treatment providers:** Project 3A (Addressing the Opioid Public Health Crisis), a required project for all ACHs, as well as efforts under the SUD Waiver, may increase demand for providers with training and a waiver from the Drug Enforcement Administration to provide opioid use disorder treatment with buprenorphine, a controlled substance. ACH informants described the need for more waivered SUD providers in their regions, indicating that obtaining training and waivers for this service has been limited.

In addition, ACH informants described Washington State restrictions on reciprocity agreements as a barrier to meeting MTP's workforce needs. Reciprocity agreements enable a group of states to mutually recognize each other's health worker licenses. The State's restrictions on reciprocity agreements create challenges for recruiting a variety of health care workers from other states.

**ACHs are hesitant to hire new workers for health improvement projects due to sustainability concerns.** Informants expressed concerns that ACHs would be unable to continue employing workers hired using MTP funding after MTP ends.

**ACHs have primarily focused on meeting MTP's workforce needs by training existing workers.** Some ACHs are also considering advocating for policy changes to help address workforce shortages.

- **Topical training:** ACHs have provided training to partners and ACH staff on topics such as trauma-informed care, opioid prescribing practices, health equity, and value-based payment. Trainings are available via webinars, learning collaboratives, and peer-to-peer learning opportunities.
- **CHW training:** Some ACHs that selected the Pathways Community HUB model for Project 2B (Community-Based Care Coordination) have supported programs to train new or existing CHWs.
- **Advocating for policy change:** Some ACHs are beginning to consider advocacy and policy work, perceiving this as necessary to make progress. Examples included efforts to modify licensing requirements and increase reimbursement rates for services provided by certain kinds of workers.

**MTP requires ACHs to address workforce capacity as part of their Domain 1 activities, but the State did not clearly define the role of ACHs on workforce.** Policymakers anticipated that MTP would create new workforce demands and identified workforce capacity building as critical to achieving MTP's goals. However, the State did not provide clear direction to ACHs regarding their roles and responsibilities for addressing workforce gaps and needs. One State informant said, "I think that's just the challenge of Domain 1. Everybody thinks it's really important, but they don't really know why, or what that means, or how you focus on it." (State Participant 154)

## Next Steps

We will conduct a second round of provider organization surveys to collect data on workforce shortages in 2020 and continue interviewing State and ACH informants to understand barriers to meeting workforce needs as ACHs implement their health improvement projects. In addition, we will interview representatives from a sample of practices and hospitals about their workforce needs and the role of State and ACH efforts in helping to meet those needs.

# MTP's Impact on Health Information Technology Use

## Overview

In this chapter, we assess health information technology (HIT) use among Washington State's primary care practices. We then describe efforts by the State and ACHs to increase HIT use and remove barriers to HIT use.

*Chapter 1, Exhibit 1.4 summarizes HIT activities in the Washington State Health Care Authority's (HCA's) Project Toolkit.*

### ► KEY FINDINGS

- *Among primary care practices, electronic health record systems (EHR) were widely used to accomplish important patient care tasks and exchange information with outpatient clinics and hospitals. However, use of EHR systems to view information about patients' social determinants of health (SDOH) or exchange information with long-term care providers and social services organizations was less common.*
- *Financial investments in HIT were prevalent among practices in 2018, with the percentage of practices that made HIT investments increasing substantially from 2016 to 2018.*
- *ACHs focused their HIT investments on filling HIT gaps among behavioral health care providers and gaps in providers' ability to store and share SDOH information.*
- *ACHs have not made extensive efforts to establish regional health information exchanges (HIEs) or to connect providers to OneHealthPort, the designated lead HIE.*
- *ACH informants expressed a desire for a statewide approach to HIE and community information exchange (CIE). ACHs recognize that their partners need to share clinical and social information in order to meet MTP's goals, but they need coordination from a central authority to work toward this goal efficiently.*

The following sidebar defines HIT terms used frequently in this chapter.

## HEALTH INFORMATION TECHNOLOGY TERMS

**Electronic Health Record (EHR):** An electronic version of a patient's medical chart that makes information available instantly and securely to authorized users. EHRs may also contain a patient's medical history, diagnoses, medications, treatment plans, and demographic information, and provide clinical teams access to tools that support patient care decisions (Office of the National Coordinator for Health Information Technology 2019b).

**Health information exchange (HIE):** A system that allows health care providers to access and securely share patient medical information electronically, no matter where patients receive care. HIE may enable different providers to send and receive a patient's secure information electronically in order to coordinate care or request information on a patient from another provider in order to help provide unplanned care (Office of the National Coordinator for Health Information Technology 2019a).

**Clinical Data Repository (CDR):** A centralized database that aggregates patient information from practices, hospitals, labs, and other health care organizations. A CDR enables participating health care providers to access up-to-date information on patients from a variety of sources to help provide care. Providers push information to the CDR, and query information from the CDR, through an HIE (Washington State Health Care Authority n.d.).

**OneHealthPort:** The company contracted by the Washington State Health Care Authority and designated as the lead HIE and CDR organization for the state.

**Community information exchange (CIE):** A system that allows health care providers and social service providers to share information about a patient's health care and health-related social needs, with the goal of addressing all factors that contribute to a patient's health.

**Emergency Department Information Exchange (EDie):** A web-based tool that connects emergency departments (EDs) to track patients who visit multiple EDs (Bolton et al. 2017).

**Collective Ambulatory (formerly PreManage):** A tool for sharing medical history and care plans of patients with complex health care needs.

## MTP's Impact on HIT Adoption

To assess MTP's impacts on HIT adoption, our primary care practice survey included two questions:

- We asked practices whether clinicians used the practice's EHR to accomplish 17 specific tasks that are important for monitoring and improving patient care.
- We asked practices whether clinicians used the practice's EHR to exchange patient health information with five types of provider organizations outside their organization or health system. Exchanging information with outside organizations may be instrumental for achieving several MTP goals, including integrating physical and behavioral health care, improving transitions between care settings, and addressing social determinants of health (SDOH).

### **Use of EHRs to accomplish patient care tasks was common among practices in 2016 and 2018.**

Exhibit 5.1 presents the percentage of practices where clinicians used EHRs for the 17 specific tasks in 2016 and 2018.

- Clinicians at over 90 percent of practices used EHRs for basic functions, such as sending prescriptions to a pharmacy and ordering lab tests. These functions are required under federal programs such as Meaningful Use, which provide incentives for EHR use.
- Use of EHRs to view diagnoses and services that patients received outside the practice was also widespread. For example, clinicians at 96 percent of practices used EHRs to view summaries of patients' ED visits and clinicians at 88 percent of practices used EHRs to view diagnoses and treatments for substance use disorder (SUD).
- A relatively small proportion of practices used EHRs to view information about patients' SDOH, risk scores summarizing information about patients' health, and patient outcome measures based on both clinical and claims data.

### **EHRs were widely used to exchange information with outpatient clinics and hospitals, but less frequently used to exchange information with other types of provider organizations.**

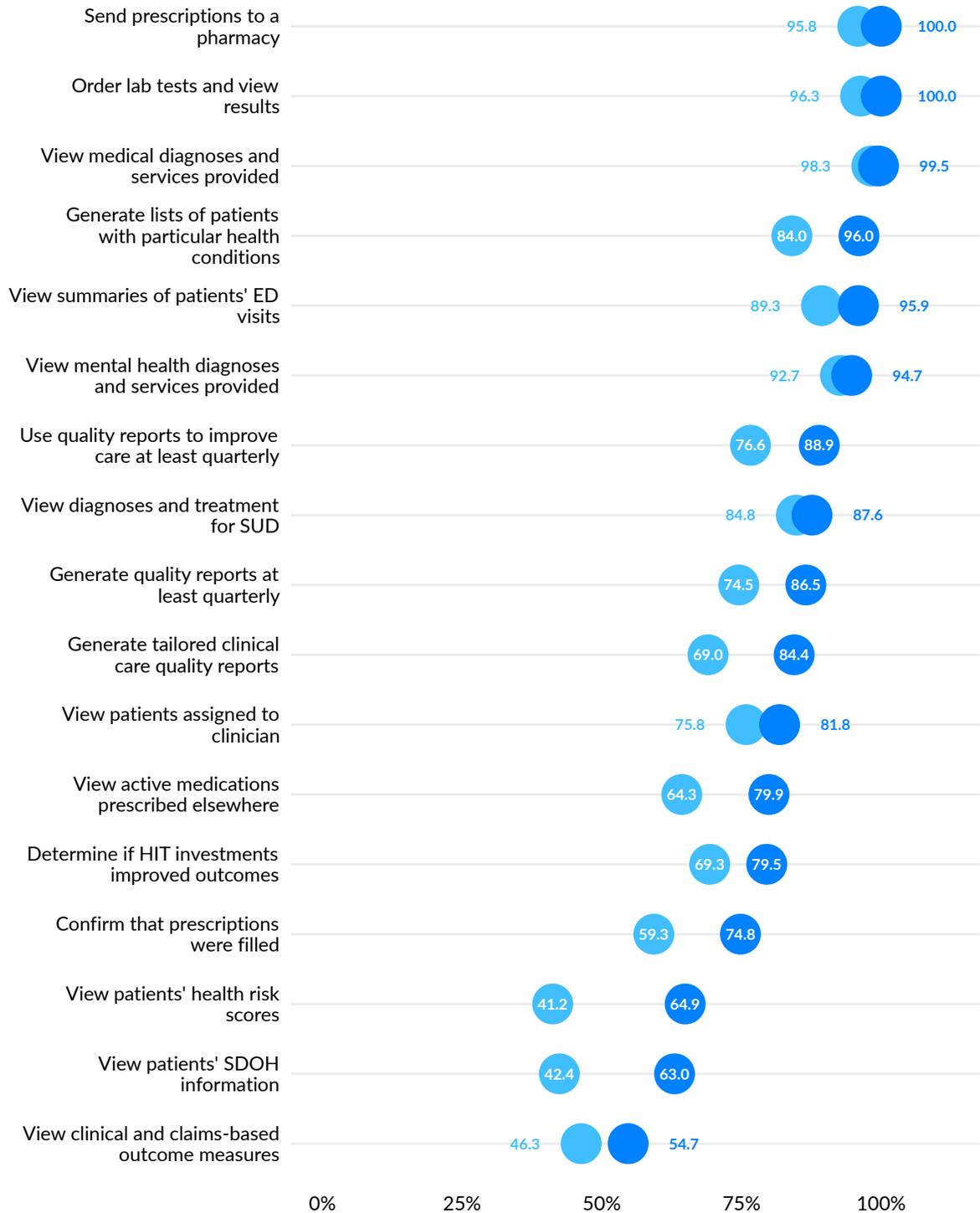
Exhibit 5.2 shows the percentage of practices where clinicians used the EHR system to exchange information with specific types of outside organizations.

- Information exchange with outpatient clinics and hospitals was widespread in 2018. Clinicians at 76 percent of practices used the EHR to exchange information with outpatient clinics outside their organization; clinicians at 74 percent of practices used the EHR to exchange information with outside hospitals.
- Clinicians at less than half of practices used the EHR to exchange information with long-term care providers. Clinicians at less than one-third of practices used EHRs to exchange information with social-service or community-based organizations.

The proportion of practices where clinicians exchanged information with outside outpatient clinics, hospitals, and behavioral health care providers increased by more than 16 percentage points from 2016 to 2018. In contrast, the proportion where clinicians exchanged information with outside long-term care providers and social-services organizations increased by fewer than 10 percentage points from 2016 to 2018.

**Exhibit 5.1. From 2016 to 2018, the percentage of primary care practices where clinicians used electronic health records (EHRs) to view emergency department (ED) visit summaries increased from 89 percent to 96 percent.**

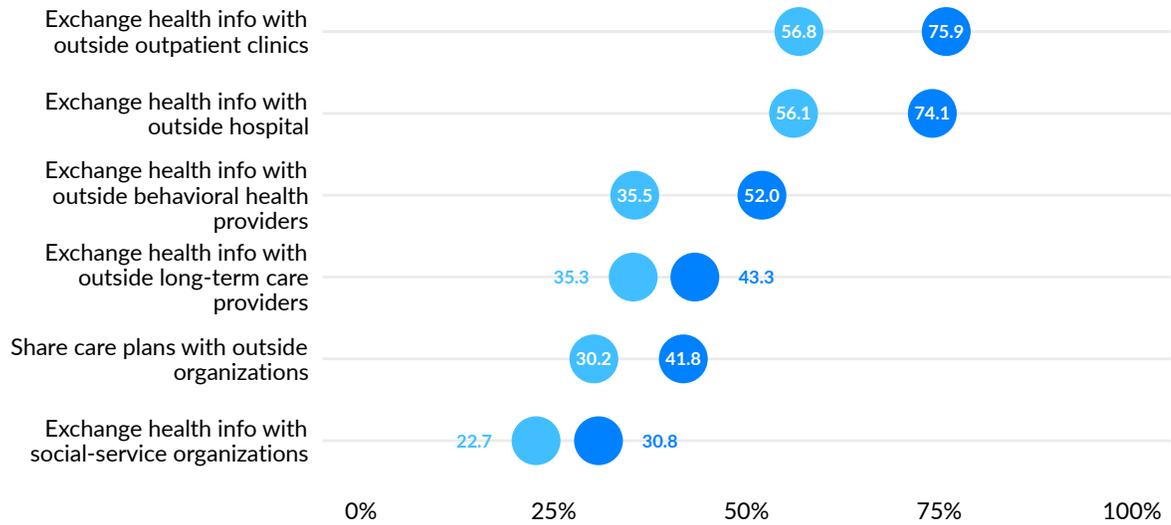
Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.



Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

**Exhibit 5.2. In 2018, clinicians at 76 percent of practices used the EHR to exchange information with outpatient clinics outside their organization.**

Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.



Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

## HIT Investment

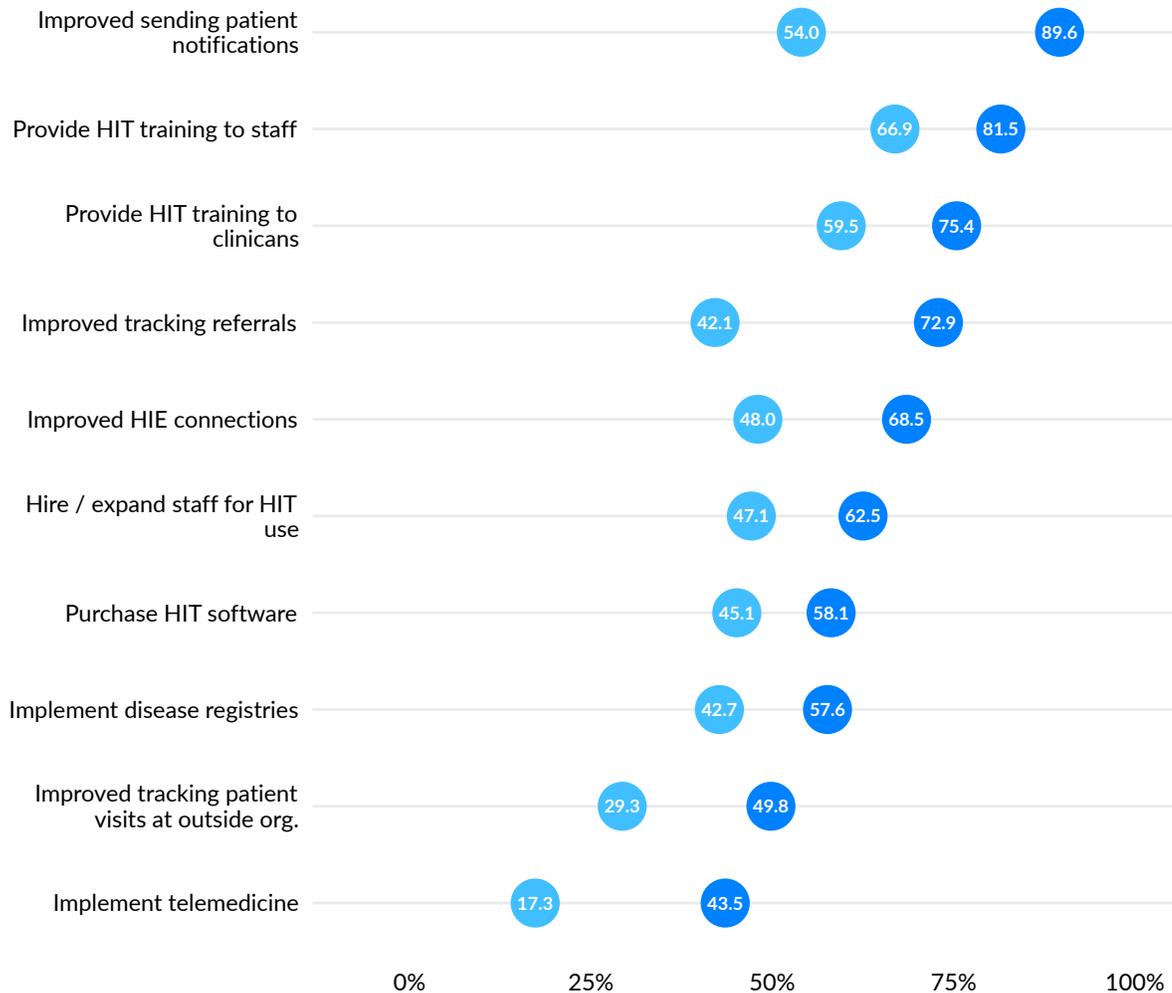
To understand HIT investment by primary care practices, we asked practices whether they made 10 specific kinds of HIT investments in 2016 and 2018. To understand ACHs' HIT investments, we interviewed State and ACH informants about HIT investments and factors influencing HIT use in support of MTP goals.

### HIT Investment by Primary Care Practices

**Overall, HIT investment was widespread among practices in 2018.** Exhibit 4.3 shows the percentage of practices that made specific financial investments in HIT in 2016 and 2018. Over half of practices invested in eight of the 10 areas listed on the survey in 2018. Moreover, the percentage of practices that invested in each area increased substantially from 2016 to 2018. This may indicate an effort to prepare for the HIT demands associated with national programs like Meaningful Use, as well as MTP and VBP requirements in MCO contracts (which began in 2017) and early adoption of integrated managed care in some regions of the state.

**Exhibit 4.3. From 2016 to 2018, the percentage of primary care practices that made financial investments in 10 areas of health information technology increased substantially.**

Light blue circles show percentages in 2016. Dark blue circles show percentages in 2018.



Source: Population estimate based on responses to CHSE's primary care practice survey. See Appendix B for survey methodology details and Data Appendix, Table 7 for number of responses and confidence intervals.

### HIT Investment by ACHs

**Generally, ACHs have invested in HIT to fill specific gaps in provider organizations' HIT capacity.**

These include gaps among behavioral health care providers and gaps in providers' ability to store and share SDOH information.

- HIT for behavioral health provider organizations:** Interviews with ACH informants and HIT assessments conducted by ACHs indicate that behavioral health care providers are less advanced in use of HIT than other types of provider organizations. ACHs have invested in EHR tools and provided technical assistance to help behavioral health care providers bill for services under integrated managed care, improve quality reporting, and participate in VBP arrangements.
- Technology to store and exchange SDOH information:** The six ACHs that selected Project 2B (Community-Based Care Coordination) invested in a regional technology platform that allows community health workers (CHWs) and care coordination agencies participating in Pathways Community HUBs to share information about patients' health care and social-service needs. In

addition, some ACHs plan to develop regional community information exchanges (CIEs) that would allow clinical and community organizations to share information. ACH informants described the inability to exchange health care and SDOH information as a barrier to coordinating clinical and social services for Medicaid members. Our practice survey indicates that relatively few practices exchanged information with social service organizations.

ACHs also invested in a variety of other HIT tools and training. For example, some invested in registries to track patients with specific health conditions, clinical decision support tools, and training on the Emergency Department Information Exchange and Collective Ambulatory tools.

## Barriers to Using HIT for MTP Goals

**While ACHs have invested in a diverse set of HIT tools, they have not made efforts to connect providers to OneHealthPort, the designated lead HIE for the state.** Informants described the following issues with OneHealthPort:

- **OneHealthPort does not connect clinical and social service organizations.** OneHealthPort only connects clinical partners authorized to collect and use health care information under the Health Insurance Portability and Accountability Act and requires participating partners to use a certified EHR. As a result, most social-service organizations cannot use OneHealthPort.
- **ACH informants reported that their partners experienced difficulties with OneHealthPort.** More data collection and analysis are needed to understand the nature of these difficulties. Generally, HIEs often experience initial data quality and validation issues that require substantial time and effort to address. Given the relationships and trust that ACHs have built with many of their partners, ACHs could play an instrumental role in working with their partners to identify data quality issues and report these issues back to the State or HIE coordinator, but they do not have the capacity to fix these issues themselves.

**ACH informants expressed a desire for a statewide approach to HIE and community information exchange (CIE).** ACHs recognize that their partners need to share clinical and social information in order to meet MTP's goals. However, ACHs cannot work toward this goal efficiently without coordination from a central authority that establishes a common approach to HIE and CIE. Some ACH informants explained that establishment of regional HIEs or CIEs by each ACH would be an inefficient use of funds: HIEs or CIEs that connect providers solely within ACH regions would not enable providers in different ACH regions to exchange information about the many patients who cross ACH boundaries. In addition, provider organizations whose clinics and hospitals span ACH regions would be unlikely to participate in multiple regional information exchanges due to the inconvenience and expense of participating in multiple systems that do not connect. Thus, a common approach to HIE and CIE across the state is needed.

## Next Steps

We will conduct a second round of provider organization surveys to collect data on HIT use and investment in 2020 and continue interviewing State and ACH informants to understand barriers to HIT use as MTP progresses. In addition, we will interview representatives from a sample of practices and hospitals about their ability to use HIT for coordinating care, improving quality, and achieving other MTP goals.

# Impacts of Health Improvement Projects

## Overview

In this chapter, we describe important variations in ACHs' approaches to their health improvement projects based on interviews with ACH informants. We then describe emerging challenges that may affect ACHs' ability to meet MTP's goals and sustain their projects after MTP ends. Chapter 1, Exhibit 1.4 summarizes the projects.

At the time this report was being prepared, ACHs were beginning to implement their health improvement projects. Future reports will assess the outcomes associated with these efforts.

*Chapter 1, Exhibit 1.4 summarizes Domain 2 and 3 health improvement projects listed in the Washington State Health Care Authority's (HCA's) Project Toolkit.*

## ► KEY FINDINGS

### Approach to Projects:

- Some ACHs prioritized contracting with partners based on their ability to implement health improvement projects and move performance metrics, while others allocated resources across a wide variety of partners.
- Some ACHs required their partners to follow change plans with activities and outcomes specified by the ACH, while others allowed their partners more flexibility to choose activities and outcomes for their projects.
- ACHs often used common approaches across multiple health improvement projects. Examples include using a common intervention or model, identifying shared target populations, and using a shared system of decision-making or common partners.

### Emerging Challenges:

- ACH informants described challenges obtaining data to assess project performance and make course corrections. This may reflect both the limitations of claims data and tension in MTP's design.
- ACHs are positioned to address social and community-level determinants of health, but MTP's design has narrowed their focus to clinical factors. Under this incentive structure, ACHs may focus their efforts in clinical areas, potentially foregoing investment in SDOH that could yield long-term gains.
- There does not appear to be a plan for sustaining health improvement projects beyond the last year of MTP.

## Approach to Health Improvement Projects

MTP requires ACHs to carry out at least two health improvement projects from Domain 2 (Care Delivery Redesign) and two projects from Domain 3 (Prevention and Health Promotion) using evidence-based approaches from HCA's *Project Toolkit*. (Chapter 1, Exhibit 1.4 summarizes the projects.) At the outset of MTP, ACHs completed regional health needs inventories to guide their project selection processes and selected between four and eight projects. Exhibit 6.1 presents the projects selected by each ACH.

**Exhibit 6.1. Domain 2 and 3 Projects Selected by ACHs**

Accountable Community of Health	Project 2A: Bi-Directional Integration of Physical and Behavioral Health Care (Required)	Project 2B: Community- Based Care Coordination	Project 2C: Transitional Care	Project 2D: Diversion Interventions	Project 3A: Addressing the Opioid Use Public Health Crisis (Required)	Project 3B: Reproductive and Maternal or Child Health	Project 3C: Access to Oral Health Services	Project 3D: Chronic Disease Prevention and Control
Better Health Together	X	X			X			X
Cascade Pacific Action Alliance	X	X	X		X	X		X
Elevate Health	X	X			X			X
Greater Columbia ACH	X		X		X			X
HealthierHere	X		X		X			X
North Central ACH	X	X	X	X	X			X
North Sound ACH	X	X	X	X	X	X	X	X
Olympic Community of Health	X			X	X	X	X	X
SWACH	X	X			X			X

Interviews with ACH informants revealed that ACHs vary on the ways in which they selected partner organizations for health improvement projects, the extent to which they established uniform requirements for the work of their partners, and the extent to which they used common approaches across health improvement projects defined in HCA's *Project Toolkit*. We will continue to track variance in the ways that ACHs approach their projects, which may help explain differences in the outcomes of projects across ACHs as the evaluation continues.

### Partner Selection

Following project selection, ACHs executed contracts with a variety of organizations to carry out work on health improvement projects. These included health care providers; community-based providers of social, educational, and employment services; local government entities; and Tribal nations. Exhibit 6.2 presents examples of partner organizations contracted by ACHs.

## Exhibit 6.2. Examples of ACH Partners

Partner Type	Example
<b>HEALTH CARE PROVIDERS</b>	<ul style="list-style-type: none"> <li>• Behavioral health care provider</li> <li>• Hospital</li> <li>• Primary care provider</li> <li>• Residential substance use disorder treatment provider</li> </ul>
<b>COMMUNITY-BASED SOCIAL, EDUCATIONAL, AND EMPLOYMENT SERVICES PROVIDERS</b>	<ul style="list-style-type: none"> <li>• 211 network (referral to social services)</li> <li>• The Arc</li> <li>• Assisted living facility</li> <li>• Catholic Charities</li> <li>• Church</li> <li>• Homelessness services provider</li> <li>• YWCA</li> </ul>
<b>LOCAL GOVERNMENT ENTITIES</b>	<ul style="list-style-type: none"> <li>• Area agency on aging</li> <li>• City fire department</li> <li>• City housing authority</li> <li>• County health department</li> <li>• County human services department</li> <li>• County sheriff</li> <li>• Educational service district</li> <li>• Emergency medical services</li> </ul>
<b>TRIBAL NATIONS</b>	<ul style="list-style-type: none"> <li>• Confederated Tribes of the Colville Reservation</li> <li>• Cowlitz Indian Tribe</li> <li>• Port Gamble Sklallam Tribe</li> <li>• Quinault Indian Nation</li> <li>• Tulalip Tribes of Washington</li> </ul>

Source: ACH partnering provider rosters submitted to Washington State Health Care Authority.

### **Some ACHs prioritized contracting with partners based on their ability to implement projects and move performance metrics, while other ACHs allocated resources across a wider variety partners.**

Some ACHs prioritized partnering with health care provider organizations that serve a large number of Medicaid members in order to maximize their ability to reach Medicaid members, improve pay-for-performance metrics, and maximize project incentive payments. Similarly, some ACHs selected partners based on their capacity to implement projects, their experience with the project area, and their willingness to invest in the projects. For example, one ACH evaluated partner applications “based on some domains that we found important like leadership, commitment, and Medicaid volume.” (ACH 9, Participant 20)

Other ACHs allocated resources and investments to a wider variety of partners. For example, one ACH informant shared that “He values that [the board was] really interested in making sure...that we were making investment across the whole system, not choosing just the high-volume providers. That was one piece that was really important.” (ACH 3, Participant 39) These ACHs prioritized inclusion and engagement of diverse partners over the ability to move performance metrics in the short run.

## Uniformity of Requirements across Projects

ACHs require partnering providers to complete a change plan, a reporting tool that describes the ways in which projects will be implemented and monitored. Change plans specify the activities, milestones, and outcomes associated with projects, allowing ACHs and their partners to monitor progress.

### **The extent to which ACHs set uniform requirements across their projects varied among ACHs.**

Some ACHs required their partners to follow change plans with activities and outcomes specified by the ACH. For example, one ACH created different change plan templates for primary care practices, behavioral health care provider organizations, hospitals, and community-based organizations. Each template included a list of activities for each project and a list of corresponding outcomes that partners were required to report twice a year. The ACH required its partners to select activities and outcomes from the list for use in implementing and monitoring their projects.

Other ACHs allowed their partners more flexibility to choose activities and outcomes for their projects in order to accommodate partner characteristics and capabilities. One ACH informant explained:

[Partners] set their own aims, and then they set their subsequent milestones. We're more interested in them working on their own aims and milestones and then tracking those....We're trying to meet providers where they're at. (ACH 3, Participant 126)

This variation extends to the ways in which ACHs select project target populations, the groups of Medicaid members they intend to serve with each project. Some ACHs provide partner organizations with broad discretion to define each project's target population. For example, one ACH gave each partner a list of possible target populations for their projects and allowed the partner to choose the population based on their assessment of where they could make the greatest impact. Other ACHs provide uniform definitions for partners to use. However, partners still have leeway to adopt somewhat different target population definitions. For example, one ACH required partners to serve "high-risk" Medicaid members, but partnering organizations could use slightly different definitions to identify high-risk members.

## Common Approaches across Projects

**ACHs often used common approaches across multiple health improvement projects.** While HCA's *Project Toolkit* defined eight different health improvement projects, ACHs used common approaches to achieve the goals of multiple projects. Examples include using a common intervention or model, identifying shared target populations, and using a shared system of decision-making or common partners across projects.

- **Common intervention or model:** One ACH chose the Patient-Centered Medical Home (PCMH) model as its overarching approach to health improvement projects. ACH decision makers believed that helping partners achieve PMCH certification would improve their ability to integrate physical and behavioral health care, coordinate care, and manage population health—capabilities needed for all projects the ACH selected. This ACH made investments to support partners seeking PCMH certification, including PCMH-related training and funding for population health management tools.
- **Shared target populations:** ACHs often defined similar target populations for different projects. For example, one ACH chose the same target populations—people with high blood pressure, asthma, or heart disease—for three projects. Another ACH chose different target populations for each project, but directed partners to focus on four high-priority groups—people experiencing homelessness, people

who had been arrested, pregnant women, and children—within the target population for each project.

- **Shared decision-making or common partners:** One ACH established a workgroup to make decisions about Project 2C (Transitional Care) and Project 2D (Diversion Interventions) and developed a standardized system for referrals between acute care providers and outpatient providers to be used for both projects. Another ACH required all partners to work on the same set of projects: Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care), Project 3A (Addressing the Opioid Use Public Health Crisis), and Project 3D (Chronic Disease Prevention and Control).

By using a common approach across different projects, ACHs aimed to reduce duplication of effort, minimize burden for partners, and maximize efficiency.

**Using a common approach was easier for some projects than for others.** For example, informants described opportunities for cohesion and alignment between Project 2A (Bi-directional Integration of Physical and Behavioral Health) and 2B (Community-Based Care Coordination). However, it was difficult to use common approaches to Project 3B (Reproductive Maternal and Child Health) and Project 3C (Access to Oral Health Services) because there was little overlap between pay-for-performance metrics for these projects.

## Emerging Challenges

Our interviews with ACH informants revealed challenges with projects that emerged in the initial years of MTP. These challenges may affect the ability of ACHs and their partners to meet MTP's goals in the short run and sustain health improvement projects after MTP ends.

### Challenges in Assessing Project Performance and Making Course Corrections

The State provides ACHs with a variety of data reports for informational and monitoring purposes, including performance metrics at the ACH, county, and zip-code levels. For metrics based on health care claims, the information in these reports tends to be nine to 12 months old, counting from the last quarter in the reporting period to the release date of the report. ACHs used these reports to help identify health needs in their regions and select projects. However, ACHs informants indicated that these data lacked the timeliness and granularity needed to closely monitor the performance of their projects and make course corrections.

The feedback from ACHs that they lack timely and granular data may reflect limitations with claims data as well as tension between the kind of data ACHs need and data the State can provide. As noted above, the State provides ACHs with reports on performance metrics at more granular levels than the ACH region. However, claims data do not include (and the state does not receive) indicators for which beneficiaries were served by specific health improvement projects. For example, claims data do not include information that identifies beneficiaries served by Project 2B (Community-Based Care Coordination), meaning that the State cannot provide information on who received such services or which providers were treating those beneficiaries. In addition, the time needed for health care claims to be processed limits the State's ability to calculate and report performance metrics quickly.

The challenges identified by ACHs may also reflect tension in MTP's design: ACHs are responsible for leading and coordinating projects, but they are located outside the delivery system. The provider organizations that partner with ACHs to implement projects—including clinics, hospitals, and social service organizations—may be able to identify and track real-time outcomes for patients within their

domains, but ACHs typically lack access to this information or to a near-current view of population health among Medicaid members in their regions.

Several ACHs are working on ways to overcome these challenges. Some ACHs are beginning to partner with MCOs to obtain regional or county-level data. This may enable ACHs to obtain data more quickly than through State reports, although MCOs (like the State) may lack data on project services that do not generate health care claims. Other ACHs are working with health care provider partners to generate “proxy measures” for claims-based performance metrics from electronic health records data. These measures may be defined or calculated slightly differently from MTP performance metrics, but informants believe they may be close enough to use for monitoring progress. One ACH became certified to use health care data under the Health Insurance Portability and Accountability Act (HIPAA), meaning it can store and use personal health information. The ACH planned to invest in building a regional data warehouse to support the exchange of clinical and community information.

Such efforts may enable ACHs to receive performance metrics data more quickly, and allow ACHs to acquire data from their partners on people served by specific projects. The ability of ACHs to carry out such innovative efforts may depend on ACH capabilities; for example, ACHs with fewer resources or less health care experience may be less able to partner with MCOs and health care providers on obtaining data and monitoring projects. Through future rounds of interviews with ACHs and health care provider organizations, we will seek to monitor and understand these efforts.

### **Focus on Clinical Determinants of Health**

**ACHs are positioned to address social and community-level determinants of health, but MTP’s design has narrowed their focus to clinical factors.** The ACH model is designed to address social and community-level determinants of health. However, multiple aspects of MTP’s design have focused ACHs on establishing partnerships with clinical providers and improving health care processes.

- Most evidence-based approaches listed in HCA’s Project Toolkit pertain to health care processes performed in clinical settings.
- Most pay-for-performance (P4P) metrics measure health care processes, such as receipt of recommended services. (Exhibit 2.1 lists P4P metrics.)
- Improving social and community-level determinants of health may require substantial time to yield improved outcomes and savings. However, MTP’s five-year timeframe has focused ACHs on working with clinical providers to improve P4P metrics and earn incentive payments in the short run.

Some ACHs are starting to focus on community-level determinants of health. However, there is a risk that ACHs will continue to prioritize clinical relationships and outcomes to move P4P metrics, potentially foregoing investment in SDOH which could yield long-term gains.

### **Sustainability**

**There does not appear to be a plan for sustaining health improvement projects when MTP ends.**

ACHs have begun to implement a variety of delivery system reforms. However, there does not appear to be a statewide strategy or explicit funding to maintain or sustain these efforts beyond the five-year demonstration project. Sustainability looms large in the mind of many ACH stakeholders, especially since delivery system reforms often require a longer time to be successful. An HCA leader reported that the agency has begun to identify sustainability activities with key partners and schedule meetings with ACHs to resume sustainability discussions.

In addition to the larger issues of long-term sustainability, informants described two examples of important components not funded by Washington State's Medicaid program or MCOs: services represented by specific current procedural terminology (CPT) codes and Pathways Community HUBs.

- **Specific CPT codes:** ACH informants reported that some CPT codes representing important services for health improvement projects are not reimbursed by Medicaid. One informant stated, "We know that these CPT codes are not being reimbursed for chronic care and transitional care.... Those are specific care codes that I wish that the Healthcare Authority would reimburse....If they're not recommended, if they're not funded, then the MCOs are not required to pay for them. And yet part of the sustainability of the project areas require these things to happen." (ACH 9, Participant 114)
- **Pathways Community HUBs:** The six ACHs that selected Project 2B (Community-Based Care Coordination) pay for services provided through Pathways Community HUBs, which coordinate health care and social services within their regions. (Exhibit 1.4 describes Project 2B.) Currently, MCOs do not reimburse HUBs for the care coordination services they provide. In October 2019, HCA stated that it would not require MCOs to fund HUBs (Washington State Health Care Authority 2019d). The State and MCOs may view HUBs as duplicating services provided by Washington State's Health Homes Program, which also provides care coordination for high-risk Medicaid members.

## Next Steps

At the time this report was being prepared, ACHs were transitioning from project planning to project implementation, and data needed to estimate the impacts of ACH projects were not yet available. Future reports will provide estimates of project impacts on a variety of outcomes, including health care access, quality, and spending, as well as selected social outcomes. To provide context and help explain project impacts, we will continue to interview State and ACH informants about project implementation, challenges, and successes. In addition, we will interview representatives from a sample of primary care practices and hospitals that partnered with ACHs on health improvement projects in order to understand implementation at the clinic and hospital level and identify the effect of projects on health care delivery.

# Implementation and Impacts of Medicaid Alternative Care and Tailored Supports for Older Adults

## Overview

In this chapter, we describe the policy context and implementation of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA). We then present Initiative 2 enrollment trends and provide an early look at TSOA implementation and outcomes based on a survey of TSOA recipients conducted by the Washington State Department of Social and Health Services (DSHS). We conclude by describing the extent of connections between Initiative 2 and other MTP initiatives.

*Chapter 1 provides background information about TSOA and MAC.*

### ► KEY FINDINGS

- *Washington State has a long history of emphasizing home and community-based services in its Medicaid program. MAC and TSOA fit with the State's emphasis on long-term care choice by introducing a lower-intensity, lower-cost option for long-term care.*
- *Area Agencies on Aging (AAA) play key roles in MAC and TSOA administration. Washingtonians can apply for MAC and TSOA benefits at AAA offices, and AAAs carry out a variety of functions for people receiving these benefits.*
- *From September 2017 to September 2019, TSOA enrollment far outpaced MAC enrollment. Informants believe there are more eligible caregivers to reach with MAC and TSOA benefits.*
- *Eighty percent of TSOA survey respondents who received services said TSOA benefits would help keep them from moving to a nursing home or adult family home. Overall, respondents reported high satisfaction with the TSOA application process and benefits.*
- *Connections between Initiative 2 and other MTP initiatives could help the State and ACHs achieve MTP goals. However, connections between Initiative 2 and other initiatives are scarce.*

## Policy Context and Program Implementation

**Washington State has a long history of emphasizing home and community-based services (HCBS) as part of Medicaid-funded long-term supports and services (LTSS).** Before MTP, the State focused on “rebalancing” LTSS by shifting financing away from nursing facility care toward HCBS, with the goal of supporting people as they “age in place.” As a result, HCBS spending accounted for 68 percent of Washington State’s Medicaid LTSS, in contrast to 57 percent for the US, in 2016 (Eiken et al. n.d.).

Prior to MAC and TSOA, the State implemented the Family Caregiver Support Program (FCSP), which funded a range of services and supports for caregivers, with the goal of enabling care recipients to remain in their homes and delaying or preventing institutional care use. However, funding for FCSP was limited. Key informants described FCSP as a successful model of care, reporting that participants delayed entering the LTSS system and experienced better quality of care and health outcomes. MAC and TSOA were designed to build upon and expand FCSP by making this type support into a Medicaid benefit.

**Informants described MAC and TSOA as “bridging the gap” with more intensive care.** Key informants described MAC and TSOA as providing a more appropriate level of care for some populations than HCBS or nursing facility care, which are more intensive and costly LTSS options. TSOA, which provides some supportive services for people who need LTSS, but who are not yet financially eligible for Medicaid, was described by one informant as “bridging the gap” between “no support” for needs associated with aging and “full intensity” of care in HCBS or a nursing facility:

People have to impoverish themselves to enter [the long-term care] system, and then once you enter our system, you get everything. Many people may not need everything, but there is no other option. It’s either you spend down to the point where you have no resources and then all these options open up to you or you continue to squeak by on whatever you can, and you have no options. We wanted to try to bridge that gap. (State Participant 99)

By introducing a lower-intensity and lower-cost care option, policymakers hope to help people who need care avoid impoverishing themselves to access services while controlling Medicaid LTSS costs to the State.

**Area Agencies on Aging (AAAs) play key roles.** Key informant interviews confirmed that Washington’s AAAs, local agencies that help plan and administer aging services across the state, play an important role in administering LTSS.

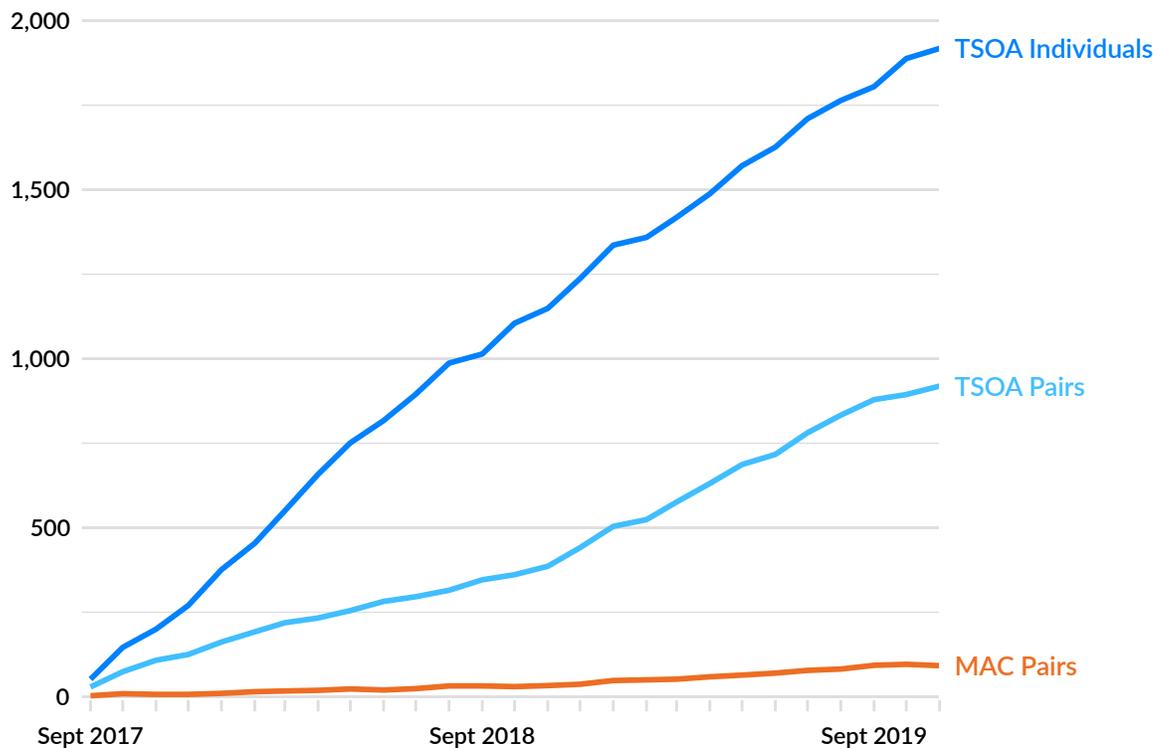
- Washingtonians can apply for MAC and TSOA directly at AAA offices. This differs from other LTSS programs, which require application directly with State departments. This approach is intended to increase access to the programs. As one informant stated, “Instead of there just being one door through the state, clients now have the ability to come in multiple doors to access services with the new initiative.” (State Participant 167) DSHS is responsible for final financial and functional eligibility approval.
- AAAs carry out a variety of functions for people receiving MAC and TSOA benefits. These include ongoing case management and coordination of services for caregivers and care recipients, such as housekeeping, errands, support groups and counseling; medical equipment and supplies; and personal care services for individuals without a caregiver. In addition, AAAs conduct home visits and assist with care planning.

## Enrollment and Service Availability

Washingtonians began enrolling in MAC and TSOA in September 2017. Exhibit 7.1 presents enrollment from September 2017 to December 2019, including enrollment of caregiver and care-recipient pairs in MAC; caregiver and care-recipient pairs in TSOA; and individuals without an unpaid family caregiver in TSOA.

**Exhibit 7.1. In each month from September 2017 to September 2019, the number of individuals enrolled in TSOA was much greater than the number of caregiver and care-recipient pairs enrolled in TSOA and MAC.**

As of December 2019, only 84 caregiver and care-recipient pairs were enrolled in MAC.



Source: Aggregated MAC and TSOA enrollment data from Washington State Department of Social and Health Services.

**TSOA enrollment far outpaced MAC enrollment.** By September 2019, nearly 2,000 individuals and nearly 1,000 pairs of caregivers and care receivers were enrolled in TSOA.

Informants believe there are more caregivers eligible for MAC and TSOA whom they have not yet engaged and enrolled. Despite high demand for TSOA services and high numbers of referrals for services, informants reported challenges reaching caregivers because many unpaid family caregivers do not identify as caregivers and may be unaccustomed to seeking services and help. One informant stated:

It's hard to help people even realize that they are a caregiver to people. They have roles. "I'm a mom." "I'm a sister." "I should be doing this." Helping people to see that it's okay to accept help, and it can actually help them to be healthier and actually be a better caregiver and be better in that role. (State Participant 167)

**Informants reported that the availability of supportive services covered by MAC and TSOA may vary across regions.** Services like evidence-based training and educational programming are available in all regions. However, availability of support groups and other services may vary by region, depending on resources available in local communities.

## An Early Look at TSOA Implementation and Outcomes

Data needed to estimate the impacts of TSOA and MAC—including person-level data on enrollment, use of supportive services, and outcomes—were unavailable at the time this report was prepared. To provide an early look at implementation and outcomes of TSOA, we analyzed responses to a survey of TSOA recipients administered by DSHS in the fall of 2018.

**A substantial portion of care recipients had significant care needs.** This indicates that the program is succeeding in targeting those who need supportive services.

- Most beneficiaries needed help with at least one activity of daily living (72 percent), such as walking (53 percent) and bathing (36 percent).
- About one-quarter (28 percent) had a fall that caused injuries, or had three or more falls within the last six months.
- Almost a third (30 percent) said they or their family had concerns about their memory, thinking, or ability to make decisions.

**Overall, care recipients expressed high satisfaction with the TSOA application process.** Care recipients also described several ways that the application process could be improved.

- About 70 percent said it was easy to apply and 80 percent said staff who helped them apply explained things clearly.
- Some care recipients said the application process was confusing or too long. Some required additional help with the process or described the process as overwhelming.
- Specific complaints about the application process were that the print size was too small and that some of the questions about finances were too invasive. This may reflect the inclusion of questions needed to determine financial eligibility for MAC or TSOA, including being “at risk” of spending down assets to qualify for Medicaid-funded LTSS.

**Overall, 84 percent of people who received services expressed satisfaction with TSOA, and 80 percent thought TSOA services would help keep them from moving to a nursing home or adult family home.** These findings are based on responses from the overwhelming majority of survey respondents (93 percent) who received some services at the time of the survey.

- Services commonly provided by TSOA include help with housekeeping (56 percent), assistance in obtaining medical care and managing health conditions (26 percent), and assistance with meal preparation and obtaining groceries (21 percent).
- While indicating overall satisfaction, respondents commented about a number of perceived shortcomings with TSOA services. These included challenges in working with their caregivers or a caregiving agency (29 percent), such as dissatisfaction with caregivers’ performance (14 percent), challenges communicating with a caregiving agency about visit times and changes to caregiving plans (nine percent), and difficulty communicating with caregivers about visits and tasks (four percent). In addition, some respondents reported that there were insufficient hours or days of services (17 percent).

DSHS conducted a final survey of MAC and TSOA participants in fall 2019. We will present results from this survey in future reports.

## Connection to Other MTP Initiatives

**Few connections exist between Initiative 2 and other MTP initiatives.** State and AAA informants described opportunities to connect Initiative 2 with other initiatives in order to help achieve MTP goals. For example, ACHs could potentially leverage AAA expertise in care transitions, opioid use disorder care, chronic disease management, advanced care planning, and dementia interventions—expertise which could help ACHs implement health improvement projects. In addition, ACHs could help raise awareness of supportive services provided by MAC and TSOA within their regions. These services could help reduce use of costly institutional care—including emergency department visits, acute hospital stays, and hospital readmissions—potentially helping ACHs improve pay-for-performance metrics in their regions.

However, several factors may inhibit greater connection between Initiative 2 and other initiatives:

- Many people eligible for MAC may also be dually eligible for Medicare and Medicaid, and people eligible for TSOA are ineligible for Medicaid. The State calculates pay-for-performance metrics based on outcomes of Medicaid members, excluding outcomes for dual-eligibles. As a result, ACHs may lack financial incentive to promote MAC and TSOA services because improved outcomes among dual-eligible and non-Medicaid populations would not result in improved pay-for-performance metrics.
- Medicaid managed care organizations (MCOs), which have formal roles in Initiative 1, are not involved in paying for MAC and TSOA benefits. As a result, MCOs may lack an incentive to advocate for ACH promotion of MAC and TSOA benefits in ACH governance.
- HCA manages Initiative 1, while the DSHS Aging and Long-Term Services Administration manages Initiative 2. This may create a barrier to coordination of State policy for the two initiatives.

## Next Steps

Data needed to estimate the impacts of MAC and TSOA were unavailable at the time this report was prepared. Future reports will provide estimates of Initiative 2's impact on a variety of outcomes, including the physical and mental health status of care receivers and caregivers and overall LTSS spending per capita across the state. Our analysis of overall LTSS spending, which includes nursing facility care, other residential care, and in-home care, will help determine whether MAC and TSOA have impacted overall LTSS spending and helped delay or avoid the need for more intensive and costly Medicaid-funded LTSS. In addition, future reports will present updated information on participant experience with MAC and TSOA based on a final round of Initiative 2 surveys conducted by DSHS in fall 2019. To provide context and help explain these findings, we will investigate Initiative 2 implementation in future rounds of interviews with State and AAA informants.

# Implementation and Impacts of Foundational Community Supports

## Overview

In this chapter, we describe Foundational Community Supports (FCS) enrollment trends and participant characteristics in the first two years of the program. We then describe early challenges with FCS implementation and the extent of connections between Initiative 3 and other MTP initiatives. Chapter 1 provides background information on Initiative 3.

*Chapter 1 provides background information about FCS.*

### ► KEY FINDINGS

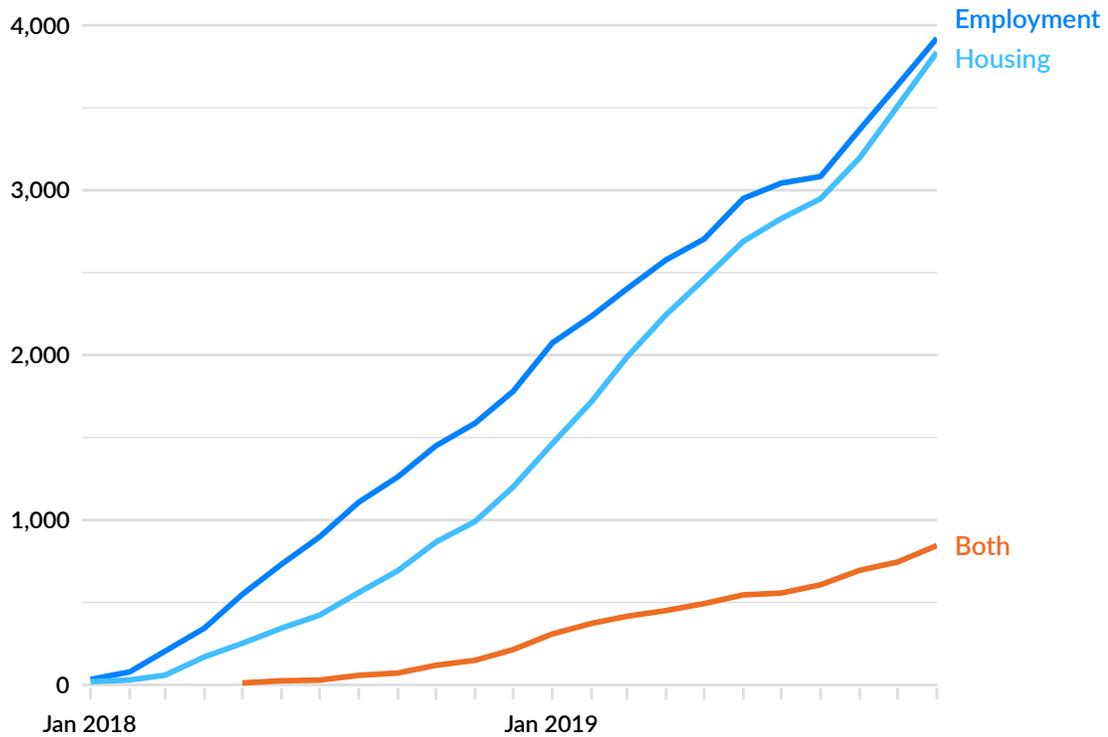
- *Enrollment in supportive housing and supportive employment increased steadily from January 2018 to November 2019.*
- *Early challenges with FCS implementation included lack of FCS service providers in rural areas, a steep learning curve for providers inexperienced with Medicaid administrative requirements and billing, and lack of affordable housing across the state.*
- *Although FCS services could potentially be used to support ACH health improvement projects, most ACHs were unaware of opportunities to connect the initiatives.*

## Enrollment and Participant Characteristics

Washingtonians began enrolling in FCS in January 2018. Exhibit 8.1 presents the number of participants enrolled in supportive housing, supported employment, and both benefits in each month from January 2018 to November 2019. Enrollment increased steadily, reaching 6,914 participants in November 2019. Data on specific types of services and hours of services participants used were unavailable at the time this report was prepared. These data will be presented in future reports.

**Exhibit 8.1. Combined enrollment in supportive housing and supported employment reached 6,914 by November 2019.**

The number of participants enrolled in both benefits reached 845 by that month.



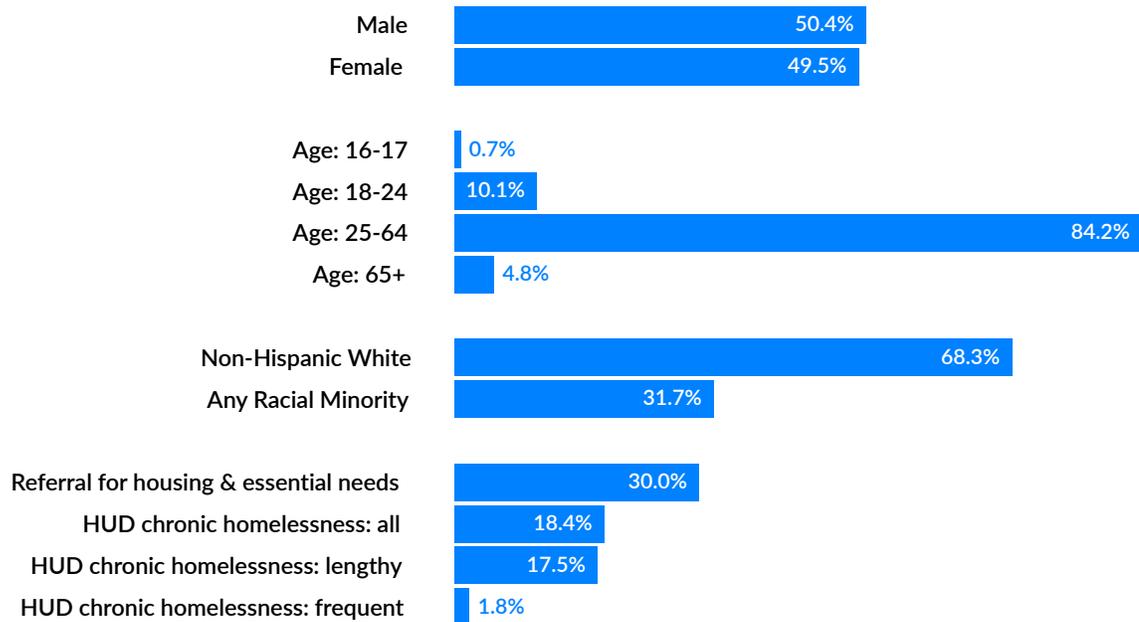
Source: Aggregated FCS enrollment data from Washington State Department of Social and Health Services.

Exhibit 8.2 presents selected characteristics of FCS participants as of November 2019. These include sex, age, race/ethnicity, and challenges with homelessness, which may be a basis for certain kinds of state or federal assistance.

- As of November 2019, a similar number of men and women participated in FCS, with more than 80 percent between 25 and 64 years old. Nearly one-fifth met the federal Department of Housing and Urban Development’s definition of chronic homelessness.
- Nearly one-third were referred to FCS from Washington State’s Housing and Essential Needs Program (HEN), which provides essential items and housing assistance to people who are unable to work due to a physical or mental disability.

**Exhibit 8.2. In November 2019, nearly one-fifth of Foundational Community Supports participants met the federal Department of Housing and Urban Development's definition of chronic homelessness.**

Nearly one-third were referred to FCS from Washington State's Housing and Essential Needs Program.



Percentage of participants by sex and age category may not sum to 100 percent due to missing or unknown information for some participants. Source: Aggregated MAC and TSOA enrollment data from Washington State Department of Social and Health Services.

Notably, the distribution of participants across these characteristics was similar for participants enrolled in supportive housing, supported employment, and both programs.

One informant described the State's effort as targeting people who were disconnected from supportive services but who were likely to have significant health and social service needs:

We're not serving people who are necessarily hearing about things and saying, "Oh, I want that service." We're doing really intensive outreach to shelters, the homelessness encampments, the people living outside, to EDs, to jails, to help us upkeep people's goals and needs, and to figure out how to connect them to services. So, we're serving a population who's not necessarily [going to] come and say, "Hey, sign me up for Medicaid," or, "Help me find a dentist". We need to be very, very assertive and proactive in our work. (State Participant 26)

Future reports will examine the characteristics of FCS participants in greater detail using person-level data.

## FCS Implementation

Key informant interviews indicated early challenges with FCS implementation:

- **Access challenges:** State interviewees described challenges related both to the limited availability of FCS service providers in rural areas and public awareness of how to connect with FCS programs. In terms of public awareness, key informants noted that outreach, particularly for those in need of housing, needs to be intentional and ongoing to reach the target populations.

- **A steep learning curve for FCS providers:** Many FCS service providers do not provide medical services; therefore, these providers lacked experience with Medicaid contracting and billing. For these organizations, offering FCS services meant transforming existing systems for client enrollment and billing in order to become Medicaid providers. They needed additional support and assistance with contracting, understanding benefit rules and regulations, and developing a fee-for-service billing infrastructure. There was little time to plan for implementation, and these community-serving organizations encountered a steep learning curve as they built the infrastructure to provide and bill for these services.
- **Impact of housing availability on provider staffing structure:** Lack of affordable housing in many areas of the state impacted FCS providers' ability to pay staff who administer supportive housing benefits. While FCS services can provide assistance to clients who are already housed—including development of independent living skills, connections to social services, establishment of credit, and meeting the obligations of tenancy—limited housing stock presents challenges to service providers working with the unhoused population. For such providers, having a caseload large enough to fund an FCS position is an uncertainty. The revenue that the organization would receive from providing services to only two beneficiaries would likely be insufficient to pay a single staff person, requiring the organization to pay the staff person using philanthropic dollars or other resources.

## Connection to Other MTP Initiatives

**Although FCS services could be used to support ACH health improvement projects, ACHs were unaware of opportunities to connect the initiatives.** FCS could potentially be used to help achieve the goals of some ACH projects in Domains 2 and 3. For example:

- Pathways Community HUBs operated under Project 2B (Community-Based Care Coordination) could be used to connect Medicaid members to supportive housing or supported employment services.
- Supportive housing services could be used to help Medicaid members successfully transition from acute care, institutions, or the criminal justice system to the community, a goal of Project 2C (Transitional Care).
- Supportive housing services could also help provide the stability needed to manage chronic conditions, a goal of Project 3D (Chronic Disease Prevention and Control).

ACH informants recognized that FCS services could be used to help achieve the goals of number of ACH projects. However, these informants were largely unaware of regional activity surrounding Initiative 3 or how they could connect to FCS services.

**Some ACHs effectively connected Initiatives 1 and 3, linking people with services provided by both initiatives.** For example, one ACH care coordinator, who was also enrolling clients into FCS for an FCS provider organization, was able to refer an individual who was ineligible for FCS to the ACH's Pathways Community HUB under Project 2B (Community-Based Care Coordination).

One of our care coordinators was doing the supported employment program under FCS and was working with a client [who] was living in her van, but for whatever reason, was not eligible for the housing part of the FCS benefit. The care coordinator couldn't help [the client] with that. When they started working in Pathways, because we don't have specific restrictions around what we can assist clients with, she was able to address that need, and then move on to the many other things that client wanted to work on. (ACH 2, Participant 34)

Another ACH community-based partner and board member described ways in which ACH incentives were used to expand their operations and capacity. FCS allowed them to bill Medicaid for housing and employment services the organization provided so it could increase the availability of these services to the community. While HCA was supportive of alignment and use of both funding opportunities, it was the ACH partner that identified this opportunity.

I was in a pretty unique spot to be able to see that, just because of my earlier work with that coalition that was working toward Medicaid supportive housing. I did my best to try to bring it up as the housing representative on the ACH board. It was all very technical. Initiative One was not something that we talked about very much, hardly at all....[FCS] was just enough outside of our area of focus that it would be hard for people to see that. (ACH 6, Participant 89)

ACH informants described the absence of connections between Initiatives 1 and 3 as a missed opportunity to improve care coordination and increase the capacity of ACHs' community-based partner organizations.

## **Next Steps**

Future reports will provide estimates of Initiative 3's impact on a variety of outcomes, including homelessness and employment, health care quality, and health care spending. To provide context and help explain these findings, we will investigate Initiative 3 implementation in future rounds of interviews with State informants and partners.

# Conclusion and Recommendations

Washington's Medicaid Transformation Project (MTP) is remarkable for its scale and novel approach to health care delivery and payment reform:

- This \$1.5 billion program aims to improve care and outcomes for a wide variety of Medicaid enrollees, including children, mothers, adults with chronic disease, individuals with mental health and substance use disorders, and people with high health and social service needs.
- MTP initiatives encompass value-based payment (VBP), workforce capacity, and health information technology (HIT), foundational and interrelated factors underlying health system performance.
- MTP funds and tests accountable communities of health (ACHs), a model with the potential to align health care and social-service sectors and address social determinants of health (SDOH).
- MTP addresses non-medical factors that affect health and health care use: It supports low-intensity services for caregivers, with the goal of bridging unsupported caregiving and traditional long-term supports and services (LTSS), and it funds housing and employment supports for the most vulnerable Medicaid members.

This report has examined the performance of Washington State's Medicaid system and the efforts of the State and ACHs to transform the system at the outset of MTP. ACHs have begun to implement health improvement projects and the state has begun to enroll Medicaid members in Medicaid Alternative Care (MAC), Tailored Supports for Older Adults (TSOA), and Foundational Community Supports (FCS). MTP's Initiative 4, the SUD Amendment, has been executed and state agencies have begun plans to implement and monitor Initiative 4.

## Strengths and Potential Challenges

This report identifies emerging strengths of Washington State's Medicaid system and MTP as well as potential challenges for achieving MTP's goals in the first two years of the program. We summarize the strengths and potential challenges below. Following our summary, Exhibit 9.1 presents a more detailed description of the strengths and potential challenges.

### **Medicaid System Performance under the Delivery System Reform Incentive Payment (DSRIP)**

**Program:** Within the first two years of MTP, Washington State's Medicaid system generally performed well in the domains of Mental Health Care, Substance Use Disorder Care, and Opioid Use and Treatment. However, Black and American Indian/Alaska Native members experienced worse outcomes across domains. ACHs lacked up-to-date, granular data on outcomes within their regions, which could help fine-tune projects and address disparities.

**Progress toward Value-Based Payment (VBP) Adoption Targets:** Participation in VBP arrangements was widespread among primary care practices in 2018, a finding consistent with reports from the State that Medicaid managed care organizations (MCOs) have met their VBP targets for MTP. However,

the overwhelming majority of practices reported less than one-fifth of their revenue from VBP. This suggests that the State's definition of VBP adoption may provide an incomplete picture of VBP progress. ACH informants described the need for greater clarity regarding the roles of ACHs and MCOs in driving VBP.

**MTP's Impact on Health Care Workforce Capacity:** Workforce shortages existed among primary care practices in 2018, with practices expressing concerns that these shortages would result in suboptimal outcomes for MTP's focus populations. Moreover, barriers exist to expanding specific workforces needed for MTP health improvement projects. As with VBP, ACHs described the need for greater clarity from the State regarding their role in meeting workforce needs.

**MTP's Impact on Health Information Technology (HIT) Use:** Use of electronic health records to accomplish key patient care tasks was widespread among primary care practices in 2018. ACHs made investments to help providers close HIT gaps. However, ACH informants described substantial barriers to health information exchange and professed a desire for coordination from a central authority to avoid a fragmented and incompatible system of disparate regional health information exchanges (HIEs) and community information exchanges (CIEs).

**Impacts of ACH Health Improvement Projects:** Key informant interviews identified three emerging challenges that may affect ACHs' ability to meet MTP's goals and sustain their projects after MTP ends. First, ACH informants described challenges obtaining data to assess project performance and make course corrections. This may reflect both the limitations of claims data and tension in MTP's design. Second, MTP's design has narrowed ACHs' focus to clinical factors, which may lead them to limit investments in SDOH that could yield long-term gains. Third, there does not appear to be a plan for sustaining health improvement projects beyond the last year of MTP.

**Implementation and Impacts of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA):** MAC and TSOA offer an innovative approach to controlling Medicaid LTSS spending, and program rollout appeared successful overall. Greater connections with other MTP initiatives could help achieve MTP goals, but few connections currently exist.

**Implementation and Impacts of Foundational Community Supports (FCS):** Enrollment in supportive housing and supported employment increased steadily. However, a lack of FCS service providers in rural areas and a lack of affordable housing across the state could limit the program's impacts. ACHs could leverage FCS to support health improvement projects, but few ACH were aware of FCS.

## Exhibit 9.1. Strengths and Potential Challenges with Washington State's Medicaid Transformation Project

### MEDICAID SYSTEM PERFORMANCE UNDER THE DSRIP PROGRAM

#### Strengths:

- Washington State's Medicaid system performed well in the domains of Mental Health Care, Substance Use Disorder Care, and Opioid Use and Treatment. Metrics in these domains generally improved or were above national benchmarks.

#### Potential Challenges:

- Performance was mixed in the domains of Prevention and Wellness; Care for People with Chronic Conditions; and Emergency Department, Hospital, and Institutional Care Use.
- Across most domains, Black and American Indian/Alaska Native Medicaid members experienced worse outcomes than the average Medicaid member.

### PROGRESS TOWARD VBP ADOPTION TARGETS

#### Strengths:

- The State of Washington established targets for VBP adoption and incentives to help meet the targets. The incentives include withhold arrangements in MCO contracting and DSRIP payments.
- Participation in VBP arrangements was widespread among primary care practices in 2018, although participation in contracts with downside risk—which create strong incentives for provider to manage care efficiently and control costs—was relatively uncommon.

#### Potential Challenges:

- Beyond MCO contracting, State efforts to promote VBP have been limited.
- The overwhelming majority of practices reported receiving less than one-fifth of Medicaid revenue from payments linked to quality in 2018.
- The State's definition of VBP adoption may provide an incomplete picture of VBP progress.
- ACH informants described lack of clarity regarding their role in promoting VBP.

### MTP'S IMPACT ON HEALTH CARE WORKFORCE CAPACITY

#### Strengths:

- ACHs pursued a variety of efforts to build workforce capacity. Common efforts included providing topical training and training community health workers.

#### Potential Challenges:

- Primary care practices reported widespread staffing shortages and concern that staffing shortages would lead to suboptimal outcomes for people with severe mental illness, co-occurring behavioral and medical conditions, and substance use disorder in 2018.
- Barriers exist to expanding specific workforces needed for health improvement projects, including behavioral health care providers, community health workers and peer counselors, and waived SUD treatment providers.
- ACH informants described that the State did not provide clear direction regarding ACH roles and responsibilities for addressing workforce gaps and needs.

## Exhibit 9.1 (continued). Strengths and Potential Challenges with Washington State's Medicaid Transformation Project

### MTP'S IMPACT ON HEALTH INFORMATION TECHNOLOGY

#### Strengths:

- Among primary care practices, electronic health record systems (EHR) were widely used to accomplish important patient care tasks and exchange information with outpatient clinics and hospitals.
- Financial investments in HIT were prevalent among practices in 2018, with the percentage of practices that made HIT investments increasing substantially from 2016 to 2018.
- ACHs focused on filling HIT gaps among behavioral health care providers and gaps in providers' ability to store and share SDOH information.

#### Potential Challenges:

- ACHs have not made extensive efforts to establish regional Health Information Exchanges (HIEs) or to connect providers to OneHealthPort, the designated lead Health Information Exchange (HIE).
- ACH informants expressed a desire for a statewide approach to HIE and community information exchange (CIE). They described concerns that establishing regional HIEs or CIEs would result in fragmentation and wasted resources.

### IMPACTS OF ACH HEALTH IMPROVEMENT PROJECTS

#### Strengths:

- ACHs have partnered with a variety of organizations to carry out work on health improvement projects.

#### Potential Challenges:

- ACH informants described challenges obtaining data to assess project performance and make course corrections. This may reflect both the limitations of claims data and tension in MTP's design.
- ACHs are positioned to address social and community-level determinants of health, but MTP's design has narrowed their focus to clinical factors.
- There does not appear to be a plan for sustaining health improvement projects when MTP ends.

### IMPLEMENTATION AND IMPACTS OF MAC AND TSOA

#### Strengths:

- MAC and TSOA are aimed at "bridging the gap" between lack of support for aging and more intensive and costly long-term services and supports (LTSS).
- Enrollment in TSOA increased steadily in the first two years of the program.
- Eighty percent of surveyed TSOA participants said the program would help keep them from moving to a nursing home or adult family home.

#### Potential Challenges:

- Greater connection between Initiatives 1 and 2 could help achieve MTP goals, but few connections between the initiatives exist.

### IMPLEMENTATION AND IMPACTS OF FCS

#### Strengths:

- Enrollment in supportive housing and supported employment increased steadily in the first two years of the program.

#### Potential Challenges:

- A lack of FCS service providers in rural areas and affordable housing across the state could limit the program's impacts.
- While ACHs could leverage supportive housing and supported employment to support health improvement projects, few ACH were aware of FCS.

## Cross-Cutting Challenges

In addition to strengths and potential challenges associated with specific evaluation aims, our evaluation of MTP has identified overarching challenges that cut across aims.

**MCO have levers to drive health care delivery and payment change, but MTP assigns responsibility to ACHs.** As payers for health care, MCOs have the ability to influence provider efforts in a variety of areas, including VBP, behavioral health integration, and workforce capacity. However, MTP assigns partial responsibility for progress in these areas to ACHs, which may lack strong “levers” to influence provider behavior. While Washington State’s Medicaid waiver requires MCOs and ACHs to collaborate, the geographical and operational overlap of MCOs and ACHs introduces complexity into MTP. As shown in Exhibit 1.3, 34 different MCO-ACH relationships must be nurtured and managed. Some ACH informants describe positive relationships between MCOs and ACHs, while others describe the potential for greater involvement in MTP by MCOs.

**ACHs may be poorly positioned to lead reform in some areas of health care delivery and payment.** ACHs bring together local organizations with knowledge of their region’s health needs for the purpose of addressing those needs. However, their local nature and focus may make ACHs poorly positioned to take action on some aspects of health care delivery and payment. For example, responding to shortages of licensed health care providers that require years to train, such as primary care doctors and psychiatrists, may require allocation and coordination of financial resources at the state level. Similarly, establishing HIEs or CIEs that enable health care and social service providers across the state to share patient information may require guidance and standard-setting at the state level in order to avoid fragmentation and wasted resources. MTP assigns partial responsibility for these areas of delivery system reform to ACHs through Domain 1 projects, but ACHs have described needs for greater guidance and standardization from the State in both areas.

**ACHs are well-positioned to address SDOH, but MTP’s pay-for-performance incentives may limit investment in this area.** Washington State’s Medicaid waiver requires integration of non-clinical partners into ACH governance structures. The local knowledge that these partners bring to the table could help ACHs address community-level determinants of health in order to help achieve MTP’s overarching goals. However, MTP’s pay-for-performance incentives emphasize health care process metrics. As a result, ACHs have focused much of their early efforts on contracting and collaborating with clinical partners. ACHs may continue to prioritize these clinical relationships and outcomes to move short-term pay-for-performance metrics, potentially under-investing in SDOH, which may yield longer-term benefits.

**Success may require a commitment to sustaining the ACH model beyond the current waiver timeframe.** Large-scale delivery system reform may take longer than the typical timeframe offered by Medicaid waivers granted by the federal Centers for Medicare & Medicaid Services. MTP is now in its fourth year, leaving fewer than two years for ACHs to earn incentive payments. Concern with sustainability after the current waiver ends looms large for ACHs. Some ACHs have taken steps to play roles in the health care system and demonstrate value beyond 2021. However, others have only begun to consider sustainability. To date, the State of Washington has not provided clarity in its commitment to ACHs after the current waiver ends. This uncertainty may create barriers for working with partners, implementing projects, and realizing the potential of the ACH model.

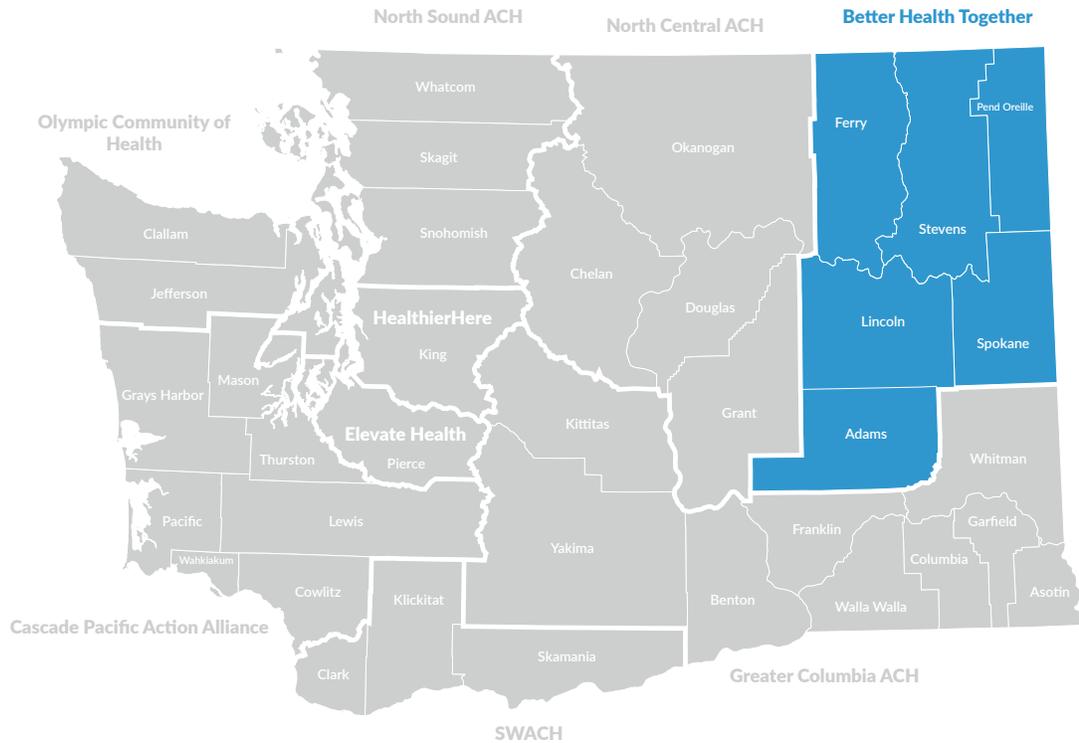
## Preliminary Recommendations for the State of Washington

Based on data and findings from the first two years of MTP, we believe the following actions may improve the potential for the State to meet its goals.

- 1 Provide clarity on sustainability and expectations for ACHs beyond 2021.** Given the short timeline to the end of Washington State's Medicaid waiver in 2021, HCA could provide more clarity on the ways ACHs will be expected to sustain themselves and their health improvement projects, either through HCA support or through contracting with MCOs. Concerns about the lack of long-term viability for ACHs may inhibit ongoing efforts. To realize the potential of the ACH model, the State may need to demonstrate commitment to the ACH model over a longer timeframe.
- 2 Provide ACHs with specific strategies and guidance on health information exchange (HIE) and community information exchange (CIE).** The ability for providers across the state to exchange information about patients' health and health-related social needs may help achieve a number of MTP goals. ACHs reported concerns about OneHealthPort, the designated lead HIE in the state, but were also reluctant to invest in regional HIEs because of concerns about fragmentation. ACHs expressed a similar concern with CIE development and a lack of consensus about the best approach. Guidance and clarity from the state, in addition to consideration of a uniform approach to HIE and CIE, may avoid unnecessary fragmentation and expenditures in the future.
- 3 Clarify the role of ACHs in meeting workforce needs.** MTP requires ACHs to address workforce capacity as part of their Domain 1 activities. However, ACH informants indicated that the State did not clearly define the role of ACHs in building workforce capacity and addressing shortages. ACHs have primarily focused on meeting MTP's workforce needs by training existing workers, but they may be poorly positioned to lead on creating new workers—especially licensed health care providers—or on addressing state-level regulations that may restrict the expansion of workforces needed for MTP. The State should clarify the intended role of ACHs in meeting workforce needs.
- 4 Evaluate ways to connect MTP's initiatives and facilitate connections.** ACHs may be able to leverage benefits provided under MTP Initiatives 2 and 3 to help achieve health improvement project and MTP goals. HCA and DSHS could evaluate the value of connecting the initiatives and potential strategies to foster greater connection. If greater connection would be valuable, the agencies could sponsor and facilitate forums for ACHs, Initiative 2 and 3 service providers, and State experts to exchange plans. Competing demands of MTP may mean ACHs lack bandwidth to work on leveraging Initiatives 2 and 3, but State leadership and facilitation may help.
- 5 Enhance VBP reporting to track dollars directly tied to quality and efficiency.** State informants and MCOs report that VBP adoption surpassed the State's VBP targets in the first two years of MTP. However, the State's definition of VBP adoption does not measure the proportion of Medicaid revenue directly tied to quality. More granular reporting may be needed to determine if provider incentives in MCO contracts are strong enough to motivate efforts to improve quality and efficiency. For example, the State could supplement current reporting to include dollars at risk based on quality, service use, or cost goals. This could include maximum bonus payments or penalties that providers would pay under a FFS contract with bonuses or penalties for quality; maximum shared savings payments that providers could earn for meeting spending targets; or the maximum amount that capitation payments could be adjusted up or down in a prospective payment system that adjusts capitation payment amounts for quality. Dollars at risk for quality,

service use, or cost could be reported as a ratio to total contract dollars in order to gauge the strength of VBP incentives.

# Better Health Together



**Backbone organization:** Private philanthropic organization

**Integrated managed care status:** Mid-adopter (2019)

**Tribal nations:** Colville Confederated Tribes, Spokane Tribe and, Kalispel Tribe

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid subgroup <sup>1</sup>	ACH	State
Total	209,166	2,029,780
Chronic condition	42.5%	38.0%
Severe mental illness	13.2%	10.8%
Rural	13.3%	17.4%
High-poverty area	28.7%	17.4%
AI/AN	4.1%	3.2%
Asian	1.4%	4.4%
Black	3.9%	7.3%
HI/PI	1.7%	2.9%
Hispanic	10.9%	21.5%
White	69.5%	49.7%
Unknown race/ethnicity	8.6%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► BETTER HEALTH TOGETHER (BHT) HIGHLIGHTS

- *BHT aims to improve the health of the entire population, not just Medicaid beneficiaries.*
- *BHT incorporates health equity and the social determinants of health (SDOH) into its health improvement projects.*
- *Financial support for the Pathways Community HUB comes from MTP and other funding sources, including a federal grant to reduce recidivism.*

## Background

The Better Health Together (BHT) region is comprised of rural, agricultural, and livestock-ranching areas in Northeastern Washington. While the region is geographically large, the population is primarily concentrated in Spokane County. Based in the city of Spokane since 2013, BHT serves as both an ACH and the Navigator Network of Eastern Washington, supporting residents with the health insurance enrollment process. In Adams County, the Hispanic and/or Latinx population is nearly five times larger than the state's proportion.

## Organizational History and Evolution

In 2013, BHT was founded as an independent non-profit organization. Throughout the history of the organization, BHT has received financial and administrative support from the Empire Health Foundation (EHF). The mission of EHF is to transform health care and advance health equity by funding capacity-building initiatives in the region. As of January 2020, BHT has ceased purchasing back-office services from EHF and moved these positions in-house. Currently, BHT does not receive financial support from EHF.

## Governance

BHT's governance structure consists of a board, technical councils, and collaboratives, which are involved in the ACH's decision-making process.

- **BHT Board:** Board members not only set the strategic vision of the ACH, but commit to promoting change within their own organizations as well. Represented groups include clinical and non-clinical sectors, community-serving organizations, managed care organizations, and tribes.
- **Technical Councils:** There are five councils, which include Community Voices Council, Community-Based Care Coordination (Hub) Council, Provider Champions Council, Tribal Partners Leadership Council, and Waiver Finance Workgroup. The Technical Councils make policy recommendations in their areas of expertise to the board, which has the ultimate decision-making authority. The Hub Council has disbanded as of 2019.
- **Collaboratives:** The Spokane Collaborative and the Rural Collaboratives (i.e., Ferry, Stevens, Pend Oreille, Lincoln, and Adams Counties) are comprised of partners that implement the selected projects and collaborate on efforts that address regional priorities. Additionally, the collaboratives share feedback on proposed policy recommendations from technical councils that are ultimately shared with the board.

BHT describes its governance structure as bi-directional, with recommendations coming from the technical councils and collaboratives to the board. The BHT executive director manages administrative operations and focuses on the ACH's strategic direction, funds flow, and policy matters (i.e., local or state governmental policies).

## Relationships and Collaboration with Tribal Nations

**BHT cultivates tribal engagement through its Tribal Partners Leadership Council and by supporting tribal health care.** Tribes are represented on the BHT board and through the Tribal Partners Leadership Council. Tribal Partners include the Spokane Tribe of Indians, Kalispel Tribe of Indians, the Confederated Tribe of the Colville Reservations, Lake Roosevelt Community Health Centers, The NATIVE Project, and the American Indian Community Center.

Initially, the BHT board did not have tribal representation, which strained relations between the ACH and the tribes and Indian Health Care Providers (IHCPs). The ACH committed to consistent engagement, collaboration, and trust-building to improve the relationships between BHT, tribes, and IHCPs. Current efforts include working with the tribes to deliver trauma-informed care training and identifying other opportunities for contracted partnerships with Tribal Partners. The Colville Confederated Tribes, Kalispel Tribe of Indians, and the American Indian Community Center have contracts with Amerigroup (the third-party administrator for Foundational Community Supports) to deliver supportive housing and employment, and BHT continues to encourage and provide support for other tribal nations to develop similar contracts.

## Accountable Community of Health Role

**BHT informants describe BHT as a convener, bringing together partners to foster community, organizational, and political change.** BHT staff described themselves as neutral conveners, but also (related to health equity) as disruptors of inequitable systems. BHT administrators, especially the Executive Director, seem particularly policy-minded and plan for more advocacy work in 2020 and 2021.

## Approach to Change

**BHT aims to improve the health of the entire population, not just Medicaid beneficiaries.** BHT selected partners through a request for proposal process. Partners included behavioral health provider organizations, federally qualified health centers, rural health centers, and health and hospital systems. BHT is contracted with 36 partner organizations, representing 92 locations or sites. All partners incorporated bi-directional integration into projects 3A (Addressing the Opioid Use Public Health Crisis) and 3D (Chronic Disease Prevention and Control). Contracted partners were required to submit plans to address all three of these project areas, supporting project alignment.

**BHT emphasized health equity and addressing the SDOH as key to improving health and creating whole-person focused systems transformation.** In addition to BHT's selected projects, they have four, board-approved priority areas: reducing unintended pregnancies, improving oral health, increasing behavioral health care access, and reducing jail recidivism. BHT collaborated with Ferry and Spokane County law enforcement to implement the Pathways Community HUB, which supports care coordination for people transitioning out of jail. BHT used funding from federal and foundation grants, the State Innovation Model grant, and MTP to support the HUB.

**BHT developed its own pay-for-achievement measures to monitor partner progress and incentivize project performance.** These metrics are used to allocate funding to partners based on their performance. Partners also develop change plans which act as a roadmap, identifying the project strategies, activities, target population, goals, timeline, and budget. Partners develop their own aims and milestones. Twice a year, they provide a narrative report and report on metrics, including a set of health equity metrics (see Approach to Health Equity).

**BHT developed learning cohorts, where partners were grouped by readiness, to prioritize contracting with partners most prepared for change first, to provide targeted technical assistance, and to facilitate peer learning.** BHT selected partners they believed were most engaged and prepared for change first. These partners were grouped in their first of two learning cohorts. The first cohort began contracting with the ACH to implement health improvement projects in January 2019. The second cohort began in August 2019. The August cohort received technical assistance from BHT before finalizing their change plans. Learning cohorts provide opportunities for partners to network (rural partners join via livestream) and receive training on topics like patient registries, team-based care, and SDOH screening tools. Training opportunities are extended to members of BHT's collaboratives and technical councils.

## Domain One: Health Systems and Community Capacity Building

**BHT trains and monitors community health workers (CHWs) to promote consistency, professionalism, and quality assurance among this workforce.** BHT meets weekly with two care coordination agencies and its CHWs to manage the implementation of the Pathways Community HUB. As a HUB, BHT trains and supports CHWs to identify risks, coordinate care, and achieve positive outcomes. BHT and the local CHW network are closely connected. By training and monitoring CHWs, BHT advances a profession well suited to connect clients to care.

**In support of value-based payment (VBP), BHT administrators see themselves as a liaison between partners and MCOs.** BHT provided training and information on VBP and contracting to their partners and have encouraged partners to set up contracts, but are unsure how else to support VBP adoption.

**BHT does not plan to invest in a regional health information exchange (HIE). Instead they have focused their efforts on supporting adoption and use of health information technology (HIT) tools to for integrated managed care (IMC) and the Pathways HUB.** BHT chose not to develop a regional HIE platform due to concerns about developing nine disparate tools across the state. BHT and some of its partners believe the state is better positioned to invest in HIT/HIE infrastructure; however, BHT partners shared dissatisfaction with the statewide HIE, OneHealthPort. BHT allocated funds to their behavioral health providers to assist them in the transition from paper to electronic health records. BHT administrators contracted with Xpio, an HIT company, to assist primarily behavioral health provider organizations with HIT/HIE adoption and IMC transition. Finally, Care Coordination Systems (CCS) technology is being used for the Pathways HUB model.

## Approach to Health Equity

**Informants describe health equity as a key component for delivery system reform.** BHT defines health equity as “when institutions support every person in achieving their individual full health potential, so that no person experiences negative health outcomes as a result of identity, environment or experiences.” The ACH regards health equity as a journey, a process of education and training. Informants stated that the region cannot achieve health care transformation without addressing structural inequities (e.g., ability, class, gender, race and ethnicity, sexual orientation).

When BHT spoke with local partners, they realized few had defined health equity for their organizations or knew how to put the concept into practice. As a result, BHT developed a curriculum for discussing health equity with partners and held presentations to foster a common language. The ACH continues to offer equity resources, including a technical assistance bank of local consultants to support its partners on areas of improvement, a learning cohort training series, and lunch-and-learns to highlight exemplars. BHT requires partners to incorporate equity into their organizational values. Additionally, partners complete an equity assessment (developed by BHT) to identify the organization's strengths and areas for improvement.

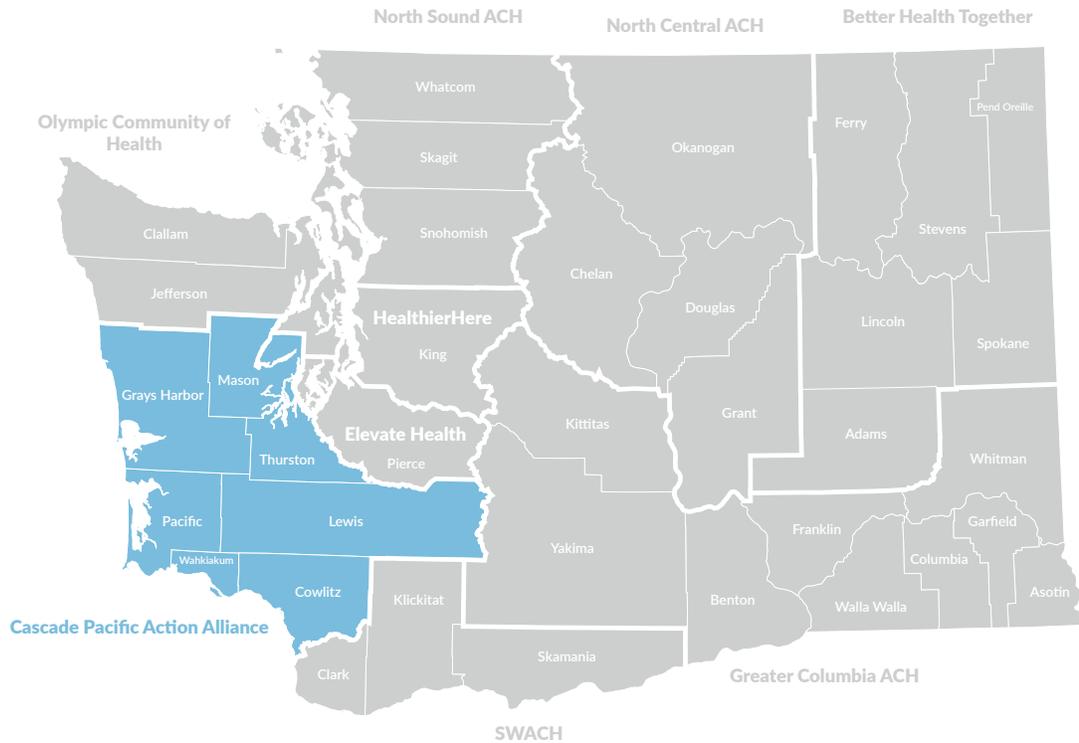
## **Integrated Managed Care (IMC)**

**BHT led the IMC transition in their region.** The Spokane Behavioral Health Organization, which served as the region's payer for behavioral health care before IMC, invited BHT to lead the region's IMC efforts. BHT facilitated IMC by developing relationships among stakeholders, including county commissioners, behavioral health care providers, and HCA. BHT also served as a neutral convener, hosting a work group for providers and managed care organizations. In addition, BHT contracted with Xpio Health to assess the HIT needs of behavioral health provider organizations and other health care providers related to the IMC transition. BHT allocated funds to their behavioral health provider organizations to assist them with the transition from paper to electronic health records.

## **Data and Analytics**

**BHT plans several efforts to make data available to the public and its partners.** BHT plans to create a public-facing ACH Community Dashboard to monitor clinical performance and assist partners in decision-making. The dashboard would present measures derived from the Washington All Payer Claims Database and measures reported by health care providers, such as patient volume and progress towards health equity. BHT contracted with Providence CORE to manage its data analytics and develop the dashboard.

# Cascade Pacific Action Alliance



**Backbone organization:** Non-profit collaborative of regional health leaders

**Integrated managed care status:** Mid-adopter (2019)

**Tribal nations:** Confederated Tribes of the Chehalis, Cowlitz Indian Tribe, Nisqually Indian Tribe, Quinalt Indian Nation, Shoalwater Bay Tribe, Skokomish Indian Tribe, Squaxin Island Tribe

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	X
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	X
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	198,873	2,029,780
Chronic condition	41.4%	38.0%
Severe mental illness	12.2%	10.8%
Rural	39.6%	17.4%
High-poverty area	22.7%	17.4%
AI/AN	4.1%	3.2%
Asian	1.9%	4.4%
Black	2.8%	7.3%
HI/PI	1.7%	2.9%
Hispanic	13.8%	21.5%
White	66.4%	49.7%
Unknown race/ethnicity	9.4%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► CASCADE PACIFIC ACTION ALLIANCE (CPAA) HIGHLIGHTS

- *All Tribal Nations in the region are actively working with CPAA on health improvement projects.*
- *CPAA leverages strong partnerships with its backbone organization and remains closely connected.*
- *CPAA is flexible with their partners in project implementation.*

## Background

The seven counties within the Cascade Pacific Action Alliance (CPAA) region are a mix of urban and frontier communities, where most are rural and frontier. Historically, CHOICE Regional Health Network (CHOICE) covered a five-county region. Through CPAA, this regional coverage extended to include Cowlitz County and Wahkiakum County.

## Organizational History and Evolution

**CPAA was established by CHOICE, a non-profit collaborative of health care leaders from hospitals, public health, and behavioral health provider organizations that was founded in 1995.** CPAA leverages CHOICE's strong partnerships to bring together organizations from a multitude of sectors. While CPAA operates as a distinct organization with its own board and budget, they are closely connected. CPAA pays CHOICE for administrative services, CPAA staff are CHOICE employees, and CPAA and CHOICE share some board members. CPAA staff have roles and responsibilities in both organizations, and many of its partners participate in CHOICE and CPAA programs. This overlap can create partner confusion when distinguishing between CHOICE and CPAA-led programs.

## Governance

**CPAA's governance structure promotes involvement and communication between the Board of Directors, CPAA staff, committees, communities, and project implementation partners.** CPAA's governance structure includes the following bodies:

- **Board of Directors:** The 19-member Board ensures alignment and avoids duplication between CHOICE and CPAA activities, approves and monitors implementation of regional and community plans, and approves budgets and partner funding. CPAA staff propose ideas to the Board for final decision. Board member representation is half clinical and half non-clinical. There is currently one seat on the Board for a tribal representative, which is occupied by one of the seven tribes in the CPAA region. The slight majority of the CPAA board members are also on the CHOICE board.
- **CPAA Council:** The 36-member Council advises the Board about regional priorities, holds local forums within counties, and elects members of the Board of Directors. The Council includes representatives of managed care organizations (MCOs), education, public health, housing, health systems, and consumers.
- **Community Advisory Committee:** The Committee advises CPAA staff on project implementation. It consists of consumers, community members, and consumer advocates.

## Relationships and Collaboration with Tribal Nations

**In the CPAA region, all of the Tribal Nations are committed to implementing health improvement projects and CPAA continues to work on building trusting relationships.** CPAA acknowledges that building trust with the seven sovereign nations in its region, after a long history of distrust, is challenging and takes time. To support this process, CPAA allows individual tribes to decide how to communicate and collaborate with CPAA. The CPAA board includes one seat for a tribal representative, with the option of rotating the position among participating tribes. CPAA has also hired a tribal liaison who serves as a trusted representative, meets one-on-one with each tribe, and facilitates regular meetings between the Tribal Health Directors and CPAA. CPAA staff are continuing efforts to build trust and collaborate with the tribal nations.

Each Tribal Nation has committed to carrying out several health improvement projects, including projects that focus on opioid response activities. The tribal liaison works directly with them on preparing change plans and meeting requests for technical assistance. As sovereign nations, tribes were not asked to respond to requests for proposals as were other kinds of organizations, but they were asked to create change plans. CPAA has also connected the Confederated Tribes of the Chehalis to the Opioid Use Reduction and Recovery (OURL) Alliance, a CHOICE program in collaboration with Pacific Mountain Workforce Council that helps people with opioid use disorder (OUD) gain employment.

## Accountable Community of Health Role

**CPAA sees itself as a neutral convener that brings together diverse organizations across its seven counties to achieve the Triple Aim, described below.** Informants also described their role as overseeing the health improvement projects at a high level to identify themes, challenges, and opportunities for support. In addition, informants described their roles as thought partners and educators. Finally, CPAA serves as the Community CarePort HUB (based on the Pathways Community HUB model) for Project 2B (Community-Based Care Coordination).

## Approach to Change

CPAA engaged partners through previous relationships established by CHOICE, outreach, and community meetings. CPAA contracted with 49 partners, including the seven tribes in the region, across 58 sites or locations to implement one or more health improvement projects.

**CPAA emphasizes improving the health system for the entire population of the region and attention to “whole-person care.”** Informants described CPAA as focused on transformation that helps the whole region, not just Medicaid beneficiaries. Two concepts drive CPAA’s approach to projects: whole-person care, which informants described as including integrated behavioral health care and services that address the social determinants of health (SDOH); and the Triple Aim, which informants defined as health care with lower cost, higher quality, and a focus on population health. CPAA has contracted with partners to implement health improvement projects that address the SDOH. For example, PeaceHealth is contracted to implement a program and screens patients for food insecurity, while another partner located near a behavioral health clinic offers laundry services, coffee, and referrals for counseling services.

**CPAA provides partners with a high level of flexibility to design and implement projects.** Partners select target populations for each of their projects, as well as milestones and metrics for tracking project implementation, from a list provided by CPAA. CPAA administrators track partners’ progress through change plans and site visits (See Chapter 6).

**CPAA aims to provide equitable access to Community CarePort across all seven counties.** CPAA serves as the HUB for Community CarePort, which is based on the Pathways Community HUB model for Project 2B (Community-Based Care Coordination). They started the Community CarePort HUB with five contracted care coordination agencies and expanded to 12 agencies, reaching patients in all seven counties. CPAA highlighted their efforts to provide equitable access to the Community CarePort within each county. In June 2019 they reported that they surpassed their initial goal of enrolling 400 people into the program, and plan to enroll about 4,000 clients by the end of the transformation.

**CPAA focuses on providing training, education, and technical assistance to its partners.** CPAA supports a learning collaborative that offers opportunities for peer partner learning, collaboration, technical assistance, and training. Overall, CPAA administrators see their partners as change agents and themselves as the convener and supporter.

## Domain One: Health Systems and Community Capacity Building

**CPAA supports workforce capacity through training, technical assistance, and community health workers (CHWs).** CPAA aims to build the region's workforce capacity by providing trainings and technical assistance. These efforts include peer learning opportunities and training new CHWs to support the Pathways Community HUB.

**CPAA invests in tools contracted partners need to implement projects and support VBP adoption.** Examples include financial support for patient care registries and electronic health record (EHR) tools to ensure timely wellness visits. To support MCO billing and reporting requirements, CPAA has provided financial support to behavioral health provider organizations to adopt new EHRs or to enhance EHRs.

**To support VBP adoption, CPAA shares information from the State to its partners and encourages participation in the State's Value-Based Purchasing Survey.** Informants expressed interest in more support and clarity from HCA regarding ACHs' roles and responsibilities for VBP.

## Approach to Health Equity

**CPAA takes a multi-pronged approach to improve health equity.** CPAA is a participant of Southwest Accountable Community of Health's Equity Collaborative, which began in April 2019. This collaborative brings partner organizations together to discuss and share learnings around equity assessments and plans. CPAA also provides trainings on implicit bias and health equity.

## Integrated Managed Care (IMC)

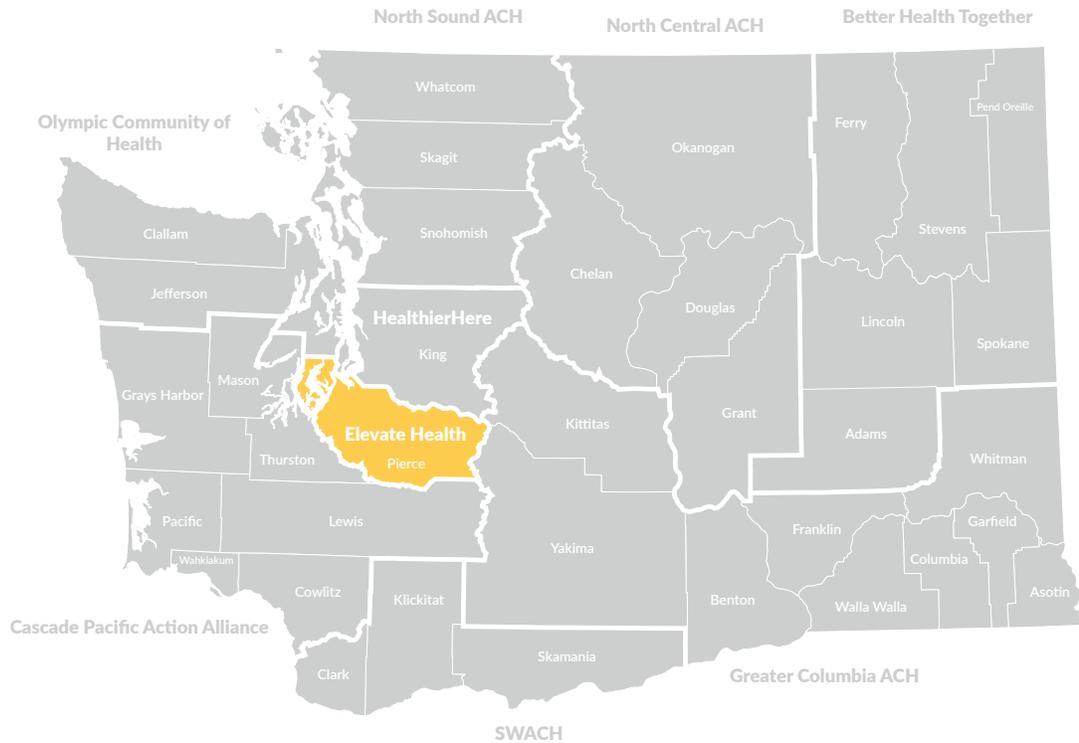
**CPAA has been engaged with and supportive of integrated managed care.** CPAA staff were engaged with the region's two behavioral health organizations as they transitioned to IMC. CPAA also contracted with Xpio, a health information technology company, to provide technical assistance to behavioral health agencies (BHAs) with adopting or enhancing EHRs, and provided financial incentives for BHAs to enhance their EHRs. In addition, CPAA staff organized training on contracting with MCOs and developed a Provider Readiness Workgroup to convene and help providers prepare for IMC.

## Data and Analytics

**CPAA reported challenges acquiring the type of data that are needed to transform care.** CPAA employs a data analyst who focuses on making data more accessible for other CPAA staff. The ACH contracted with Providence Center for Outcomes Research and Education to develop proxy metrics

that track partner project success. CPAA anticipates that these proxy measures will allow them to monitor partner work and make course corrections.

# Elevate Health



**Backbone organization:** Public health district

**Integrated managed care status:** Mid-adopter (2019)

**Tribal nations:** Nisqually Indian Tribe, Puyallup Tribe

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	248,130	2,029,780
Chronic condition	39.4	38.0
Severe mental illness	10.3	10.8
Rural	5.2	17.4
High-poverty area	20.2	17.4
AI/AN	3.0	3.2
Asian	4.5	4.4
Black	12.5	7.3
HI/PI	5.3	2.9
Hispanic	15.1	21.5
White	48.1	49.7
Unknown race/ethnicity	11.5	11.1

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► ELEVATE HEALTH HIGHLIGHTS

- *Elevate Health provider partners selected the MTP projects and strategies.*
- *Elevate Health uses a multi-pronged approach to care coordination known as the Care Continuum Network.*
- *Elevate Health has sustainability goals past the MTP timeframe.*

## Background

**Twelve percent of Washington's total population resides in Pierce County, the second most populated county in the state and the location of Elevate Health's office.** Elevate Health, formerly Pierce County Accountable Community of Health (PCACH), is one of two single-county ACHs in the Seattle-Tacoma metropolitan region. Pierce County is largely urban and suburban, although there are a number of rural areas in the southern and eastern portions of the county.

## Organizational History and Evolution

**Originally the ACH's backbone organization was the Tacoma-Pierce County Health Department (TPCHD). In late 2016, the Board decided to become a stand-alone agency.** The ACH recruited leadership, bringing in an executive director with experience in Oregon's Medicaid transformation. The ACH became a non-profit in 2017 and changed its name to Elevate Health in 2018. The ACH continues to collaborate with TPCHD for various project work, opioid leadership health equity trainings, and their county-level public health expertise.

## Governance

**The ACH convened a Provider Integration Panel (PIP), composed of primary care providers, to advise the board and incorporate clinical perspectives.** The ACH board and leadership believed that its success for MTP required engaging primary care partners first and foremost. However, Elevate Health also convened community members to act as a Community Advisory Committee (CAC) to the ACH. The two groups worked alongside the board to define outcomes, select projects, and tailor the strategies for Pierce County's transformation.

**The 19-member board began to restructure its approach to Governance at the time of our site visit.** Under a modified Carver Model, ACH leadership operationalize the means to the board's established ends, staying within the scope defined by the board's set of executive limitations, which detail actions that would require board approval. Transition to the model included the Executive Committee developing end-statements (i.e., their desired outcomes), and setting executive limitations. Elevate Health is phasing out their use of board committees in favor of all policy-related activity being managed by an organized governance structure: its 19-member ACH board of trustees.

## Relationships and Collaboration with Tribal Nations

**Elevate Health has executed contracts with the local tribal government to work on health improvement projects and the ACH has engaged with the tribes in other ways.** Elevate Health contracted with Puyallup Tribal Government in April 2019 to support the Nurse Family Partnership (NFP) program in the region, which provides maternal and child health services to the Puyallup Tribe. Elevate Health was exploring a Dental Health Assistant Training program and other opportunities to support the tribal government.

## Accountable Community of Health Role

**Informants described Elevate Health as a convener, partnership broker, consultant, and provider of technical support.** The ACH convened the PIP and CAC as the first step in their transformation to work as a “think tank” to design the approach to health improvement projects. As a partnership broker, the ACH facilitates contracts between organizations to coordinate bi-directional care and referrals for a shared population of patients. Elevate Health also supports their partners by providing direct technical support for project implementation and by facilitating peer-learning sessions that focus on capacity building.

## Approach to Change

**Elevate Health’s vision for whole-person care aims to address individuals’ behavioral, physical, and social determinants of health needs through improved service coordination.** The ACH collaborates with regional partners through its Care Continuum Network (CCN) to connect people to services like health care, education, and food. The CCN involves four components: a Community Health Action Team (CHAT), the Pathways Community HUB, Health Homes, and a respite center.

- **Community Health Action Teams (CHAT):** The CHAT serves as an entry point to the CCN. It identifies patients who need care coordination and directs them to the Pathways Community HUB, or to the Health Homes program for the highest-risk individuals, using warm handoffs. It includes a community health worker (CHW) who locates clients in acute care settings, such as hospitals and urgent care facilities, as well as a nurse and a mental health specialist.
- **Pathways Community HUB:** Elevate Health operates as the regional Pathways HUB, which coordinates primary care, behavioral health care, and social services for patients who are identified by the CHAT as needing care coordination and who do not qualify for Health Homes.
- **Health Homes:** HCA contracts with Elevate Health to serve as the lead for Washington State’s Health Homes program in Pierce County. As the regional Health Homes lead, Elevate Health helps the highest-risk patients navigate among regional Care Coordination Organizations (CCOs), including mental health, substance use, and social service providers.
- **Respite Care:** Elevate Health plans to establish a respite center to address the needs of unstably-housed clients with chronic conditions.

Elevate Health believes the CCN will improve metrics for multiple health improvement projects by improving primary care, behavioral health care, substance use disorder (SUD) care, and care for people with chronic conditions.

**Elevate Health aligns strategies and target populations across multiple projects, including projects not selected for the transformation.** The ACH selected four projects to avoid spreading themselves too thin in effort and financial investment. In retrospect, staff felt they could have selected all eight MTP projects, as their aligned approach to whole-person care would improve outcome measures associated with all Domain 2 and 3 projects. For example, Elevate Health selected a single target population (pregnant women with SUD) for three of four projects, and it uses a single strategy (the CCN) that staff believe will improve a wide variety of performance metrics, including metrics attributed to Project 3B (Reproductive and Maternal or Child Health), which was not selected by the ACH for MTP.

**Elevate Health contracted with the majority of Medicaid providers in the region as health improvement project partners.** Elevate Health partnered with 30 organizations that operate across 77 sites in Pierce County. By contracting with the health systems and provider organizations that serve the highest number of Medicaid lives in Pierce County, Elevate Health's change efforts have the potential to reach most of the region's Medicaid population. The ACH first engaged its contracted partners when it convened the PIP and the partners directed Elevate Health's project selection and planning. The ACH's contract terms and change plans are standardized with similar strategies, milestones, and metrics for all partners.

**Elevate Health supports its partners through staff advisors and learning communities.** Clinical Improvement Advisors that work in the field are assigned to each partner to assist with workflow and change implementation and monitor their progress. For further support, ACH learning communities were established, open to both partners and community stakeholders. Through the learning communities, partners and stakeholders work as teams to develop shared policies and procedures, and to report on challenges experienced as they implement practice changes or use new health information technology.

## **Domain One: Health Systems and Community Capacity Building**

**Elevate Health is leveraging partner investments in HIT and using their resources to address the need for a community information exchange.** The ACH facilitated a negotiation between its two largest Medicaid providers to commit to using the same Electronic Health Record (EHR). This transition required financial investment from both partners and required one partner to transition to the new EHR (EPIC). Elevate Health's clinical partners use HIE tools developed by Collective Medical Technologies for care coordination, although these tools are not accessible by the CHAT or some CBOs, which presents challenges to CCN care team communication. The ACH intends to develop a community information exchange (CIE) to assist with communication between the CHAT and the Pathways HUB.

**Elevate Health staff view their role as a broker and partner in value-based payment (VBP) by educating its partners on the benefits of VBP.** ACH informants also conveyed that providers in the region were ready to transition to VBP, but "implementing it was complicated," due to challenges they encountered contracting with the managed care organizations.

**In support of workforce development, Elevate Health supports Community Health Workers (CHWs) through low-cost or free trainings and advocating for livable wages.** Elevate Health seeks out opportunities to create new roles for local health workers in a changing health care system; for example, the ACH developed the CHAT as a workforce pilot project and as a new way to coordinate care delivery for organizations that previously did not have access to such staff resources.

## Approach to Health Equity

**Elevate Health requires its partners to report their progress on health equity.** Upon contracting with the ACH, all Elevate Health partners took an equity assessment, adopted from The Institute for Healthcare Improvement's Health Equity Organizational Assessment Tool, to identify where they were on "the care continuum for equity." To evaluate progress, Elevate Health considers equity in the delivery of health services by partners and equity in the regional health workforce, which included opening up health service employment opportunities to more of the population through CHW trainings. Elevate Health's CAC connects the ACH to community voices and helps identify care gaps related to health equity.

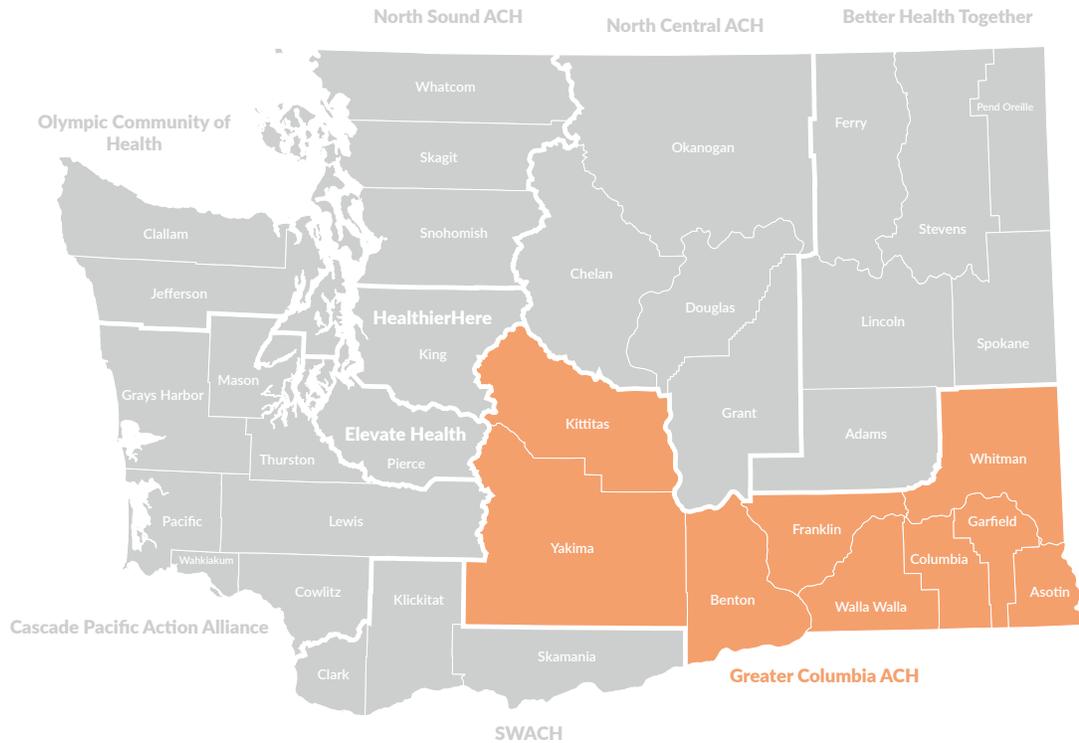
## Integrated Managed Care (IMC)

**Elevate Health provided technical assistance and support to its partners with IMC.** In preparation for IMC, Elevate Health deployed the Qualis billing and assessment toolkit to identify the needs of their behavioral health provider organizations and offered technical assistance in transitioning their billing processes. The ACH also provided funds to behavioral health partners to assist with IMC capacity and ensure partners had the staff needed to convert to the managed care organization billing processes. Following IMC adoption in 2019, the ACH convened an IMC Learning Collaborative, including behavioral health and SUD partners, to offer technical assistance and support for billing-related challenges.

## Data and Analytics

**To acquire timely data, Elevate Health planned to invest in a regional "Data Lake."** Elevate Health interviewees described lack of timely outcomes data as one of the most important barriers to its success. Modeled after other states' DSRIP programs, Elevate Health planned to develop a regional data source. This "data lake" would bring together diverse regional partner data for timely decision-making and improve efficiency and outcomes.

# Greater Columbia ACH



**Backbone organization:** Non-profit organization

**Integrated managed care status:** Mid-adopter (2019)

**Tribal nations:** Yakama Nation

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	
2C: Transitional Care	X
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	272,392	2,029,780
Chronic condition	33.6	38.0
Severe mental illness	7.3	10.8
Rural	25.5	17.4
High-poverty area	41.6	17.4
AI/AN	3.2	3.2
Asian	1.0	4.4
Black	1.7	7.3
HI/PI	0.6	2.9
Hispanic	51.1	21.5
White	34.3	49.7
Unknown race/ethnicity	8.2	11.1

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► GREATER COLUMBIA ACH (GCACH) HIGHLIGHTS

- GCACH has the most counties and covers the largest geographic area of all ACHs.
- GCACH partners are adopting the Patient Centered Medical Home (PCMH) model.
- The region's state innovation model (SIM) grant project was a Readmission Avoidance Project carried forward to inform MTP Project 2C (Transitional Care).

## Background

By land mass, the **Greater Columbia Accountable Community of Health (GCACH) region is the largest ACH in Washington State.** There are highly rural and remote areas in the region, as well as several urban centers including Yakima and the Tri-Cities (Kennewick, Pasco, and Richland). The GCACH office is located in Kennewick, Washington.

## Organizational History and Evolution

**The ACH backbone, Benton-Franklin Community Health Alliance (BFCHA), is a non-profit organization established in 1992 and the Local Health Improvement Network that convenes health and human services in the Tri-Cities area.** Prior to the State Innovation Model (SIM) grant, BFCHA leadership applied for an ACH planning grant through the HCA for Benton, Franklin, Walla Walla, Columbia, Garfield, and Asotin Counties. BFCHA established the ACH under a fiscal sponsorship agreement for the six counties, and the Executive Director of BFCHA became the GCACH Executive Director in February 2017. The ACH eventually expanded to nine counties to reflect the state's Behavioral Health Regional Service Areas. GCACH separated from BFCHA in 2017 to become an independent non-profit; however, BFCHA remains engaged with GCACH as a Local Health Improvement Network (LHIN), one of seven health alliances the ACH contracts with to advance health improvement goals.

## Governance

**GCACH staff work closely with the board, using a structured model to facilitate decision-making.** The GCACH board is comprised of 17 board directors. Board committees include finance, budgeting and funds flow, bylaws, communications, and nominations. Other GCACH-led committees include the data management and health information exchange committee and the practice transformation workgroup. All committees and workgroups report and make recommendations to the board, with the Nominating Committee being responsible for recommending board members for officer positions. Each committee has a charter regarding their role and how it relates to overall governance. GCACH staff use the Situation, Background, Assessment, Recommendation (SBAR) model and present data and information to the committees who review, reshape, and provide feedback before the final SBAR is presented to the Board of Directors.

**GCACH has a Leadership Council, open to anyone, which serves as a community forum.** The Leadership Council is a permanent advisory committee that is responsible for identifying priorities, monitoring improvement, and representing the community's voice as a community advocate. The Leadership Council acts in an advisory capacity to the board.

## Relationships and Collaboration with Tribal Nations

**GCACH has an active relationship with Yakama Nation, which is represented on the ACH board.**

Yakama Nation is the most populated reservation in the state and the second largest reservation geographically. At the time of our visit, GCACH was assisting Yakama Nation to become the seventh LHIN in the region. In addition, SWACH (formerly Southwest Washington ACH), which includes a portion of Yakama Nation, is collaborating with GCACH to support the tribe's adoption of bi-directional integration by contributing to a capacity building fund. GCACH is also working with Yakama Nation to adopt Digital Health Commons Community Information Exchange (CIE) to assist with service coordination.

## Accountable Community of Health Role

**Greater Columbia is a convener of regional health services, facilitator of practice transformation, and service provider.** As a service convener, GCACH brought together a number of sectors across a large region to improve awareness of available services and increase opportunities for collaboration. Prior to MTP, there was not an opportunity in the region for health services to work together. GCACH is facilitating practice transformation for partners through the Patient Centered Medical Home (PCMH) model and offering personalized technical assistance to ensure success in bi-directional integration, population health management, and movement towards value-based purchasing. Additionally, GCACH supports the seven LHINs and provides learning collaboratives for contracted partners.

## Approach to Change

**Staff and board members emphasized a need for whole-person care that includes improving the social determinants of health (SDOH).** GCACH partnered with the LHINs to work locally to identify the SDOH needs in their communities. LHINs are established regional health coalitions that contract with GCACH as partners. ACH partnerships with the LHINs assure fair geographic coverage across a vast region, ensuring the preferences and needs of local communities are communicated and addressed by the ACH.

**GCACH organized its partners into cohorts.** GCACH is contracted with 21 partner organizations, representing 41 locations or sites. GCACH primarily contracted with clinical partners first, in January 2019. A second cohort of behavioral health partners was added in July, and a smaller, third cohort was approved later in 2019.

**GCACH is using the PCMH model to align its selected health improvement projects.** GCACH identified similar project strategies and target populations across its selected projects. For example, care managers in PCMH practices can risk stratify and direct patients to care settings such as Health Homes, substance use disorder (SUD) services, or resources for chronic disease management. These settings are associated with three of its selected health improvement projects: Project 2C (Transitional Care), Project 3A (Addressing the Opioid Use Public Health Crisis), and Project 3D (Chronic Disease Prevention and Control). GCACH also included strategies that address MTP projects it did not select for the transformation; for example, Project 3C (Access to Oral Health Services; not selected) is addressed through PCMH best practices that promote fluoride varnishing, and Project 2D (Diversion

Interventions; not selected) is addressed through project 3D (Chronic Disease Prevention and Control and Care Transitions; selected) strategies that aim to reduce hospitalizations.

**GCACH developed their own toolkit and workbook for partners.** The GCACH toolkit has eight milestones for achievement that determine partner incentives. Partners use an electronic reporting portal to report on their progress. With the reporting portal that comes out of the toolkit, GCACH is building a data dashboard to view regional trends and partner milestone completion. This will be shared quarterly with the ACH Practice Transformation Workgroup.

**For technical assistance and training, GCACH identified exemplary practices to mentor others, and an ACH practice transformation team member visits partner sites twice monthly.** Partner education is further facilitated through monthly learning collaboratives. Partners are required to attend 12 learning sessions annually, and four Leadership Council meetings. Regional, state, and national experts lead the collaboratives, which focus on topics such as the Patient Centered Medical Home model, the intersection between care transitions and emergency medical services, and the opioid crisis.

## Domain One: Health Systems and Community Capacity Building

**GCACH invested in a community information exchange (CIE), Digital Health Commons, to facilitate care coordination in the region.** Digital Health Commons CIE was also adopted by Olympic Community of Health and HealthierHere ACHs. GCACH further supports health information technology use by providing technical assistance to its partners on population health management, disease registries, and pre-visit planning tools. They are incentivizing practices to use the Collective Medical Platform, which includes Emergency Department Information Exchange (EDIE) and PreManage, and Direct Secure Messaging (DSM).

**GCACH invested in a fund to increase regional workforce capacity.** In 2019, the Behavioral Health Internship and Preceptorship fund was developed to address the region's behavioral health workforce shortages. The fund will support interns in need of clinical experience and connect them with preceptors willing to train them. GCACH financed this through their IMC fund.

**ACH informants report that provider partners are ready and motivated to begin transitioning toward value-based payment (VBP).** However, the regional providers are largely still operating as fee-for-service due to slow contract negotiations surrounding reimbursement rates from the managed care organizations (MCOs) that had delayed the transition.

## Approach to Health Equity

**GCACH equity efforts were focused on defining and operationalizing equity at the time of our interviews.** The ACH's plans include producing an equity statement, vision, and set of values. Partnerships with the LHINs, which are better positioned to identify and address needs of local communities across the large region, are the ACH's approach to understanding which regional populations are the most affected by health disparities.

## Integrated Managed Care (IMC)

**GCACH administrators accepted the role of leading IMC for the region.** When the HCA approached the regional Behavioral Health Organization (BHO) about leading IMC for Greater Columbia, the BHO resisted the transition to IMC, as the process would impact their viability. The ACH stepped in, and was instrumental in helping regional providers navigate IMC transition through technical assistance and support offered by GCACH Practice Transformation Navigators. GCACH helped behavioral health

providers acquire and implement needed infrastructure for contracting with MCOs (e.g., certified electronic health records and reporting platforms). GCACH provided technical assistance tailored to partner needs. Contracted behavioral health partners were connected to additional funding resources, technical assistance, and tailored learning collaborative sessions. GCACH has also implemented regular bi-monthly meetings with the MCOs to address provider reimbursements and MCO claim denials.

## **Data and Analytics**

The ACH used population level data sets from the Health Care Authority for its community needs assessments and to select its health improvement projects. Having contracted with partners, GCACH is now focused on accessing provider-level data to assist with monitoring and evaluation. GCACH is using its mid-cycle assessments and partner reporting tools to build a data dashboard specific to GCACH partner milestone progress. At the time of our visit, ACH staff hoped to work with the MCOs to obtain more timely provider-level data.

# HealthierHere



**Backbone organization:** Public health/government

**Integrated managed care status:** Mid-adopter (2019)

**Tribal nations:** Muckleshoot, Snoqualmie, Cowlitz, and the Seattle Indian Health Board

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	
2C: Transitional Care	X
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

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<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ▶ HEALTHIERHERE HIGHLIGHTS

- *HealthierHere embeds health equity into its organizational design and approach.*
- *Investments include system-wide health information exchange tools for care integration and coordination.*
- *HealthierHere's Performance Measurement Dashboard presents snapshots and trends to demonstrate the progress and gaps for all nine ACHs.*

## Background

**HealthierHere, initially known as King County Accountable Community of Health, represents about one-fifth of all Washington State Medicaid recipients.** While some describe Seattle as synonymous with King County, the region is comprised of 39 cities and towns. The urban-suburban mix that has come to define King County masks the number of rural communities and health disparities in the region.

## Organizational History and Evolution

**Prior to receiving the State Innovation Model (SIM) grant in King County, community and government leaders convened a 30-member panel of local experts from the health, human services, and prevention sectors (called the Transformation Panel) to address health and human services integration.** The Health and Human Services Transformation Panel, supported by two King county departments, Public Health Seattle & King County (PHSKC) and the Department of Community and Human Services (DCHS), provided interim leadership and an administrative backbone for the ACH. This Transformation Panel eventually evolved into the ACH.

**HealthierHere's backbone organization was King County, through PHSKC and DCHS.** HealthierHere separated from county government and became a Limited Liability Company (LLC) in March 2017, doing business as HealthierHere, with a contract with King County for backbone support while they acquired staff until December 2017. After HealthierHere's separation from county government, it began operating under the fiscal sponsorship of Seattle Foundation. The Seattle Foundation is a philanthropic organization serving the Greater Seattle area. HealthierHere has its own infrastructure and staff to support the Medicaid Transformation Project work and receives some administrative support from the Seattle Foundation for human resources, payroll, and accounts payable. They contract with county departments for data analytics and evaluation as well as performance monitoring and regional health needs inventory data.

## Governance

**The HealthierHere 27-member multi-sector governing board includes seats for the tribes, providers, payers, government, community-based organizations, consumers, and philanthropy.** The board makes ACH strategic decisions, while the Executive Director manages daily ACH programmatic work and operations. For decision-making, proposed plans are worked through and reviewed by the committees before going to the governing board. Board committees include an Executive Committee, Community and Consumer Voice Committee, Performance Measurement and Data

Committee, Transformation Committee, Finance Committee, and an Incentive Funds Flow Workgroup, a subcommittee of the Finance Committee that provides input and expertise specifically for financial modeling and decision-making processes. Other workgroups form to address specific project work as needed (i.e., Shared Care Plan).

## Relationships and Collaboration with Tribal Nations

**HealthierHere employs a Tribal Engagement Manager and developed a new governance committee to address Native priorities.** The Tribal Engagement Manager is dedicated to building and maintaining relationships with the three federally recognized tribes and works directly with the urban Indian health board and several Native-led or Native-serving community-based organizations. HealthierHere's tribal outreach efforts led to the development of a tribal engagement plan and a new governance committee, the Indigenous Nations Committee, dedicated to embedding the voice of Native people in HealthierHere's MTP efforts and addressing health disparities experienced by urban and rural Native people in King County.

**The HealthierHere Governing Board allocated eight percent of earned project incentive funds to its tribal partners.** HealthierHere encouraged regional Native-serving organizations to consider submitting Innovation Plans detailing how they would like to be involved with the ACH and their needed resources. The Cowlitz Indian Tribe has a 10-county service delivery area that includes King County; however, the Cowlitz Reservation is not located in the county. At the time of our visit, Seattle Indian Health Board and Cowlitz Behavioral Health were health improvement project partners; however, Muckleshoot and Snoqualmie Tribes had not submitted Innovation Plans to the ACH.

## Accountable Community of Health Role

**ACH staff regard HealthierHere as a convener, facilitator, and catalyzer.** As a convener, the ACH engages in building and strengthening multi-sector partnerships, aspiring to promote change at the local, state, and federal levels. As a facilitator, HealthierHere directed their practice partners to training, technical assistance, and coaching through contracted vendors. Finally, the ACH sees itself as a catalyzer by providing seed funding for community pilot projects through its innovation fund. Potential pilot projects include jail re-entry care transitions, community-based access to medication assisted treatment, and emergency department diversions through community paramedicine.

## Approach to Change

**HealthierHere engages and convenes a variety of health and social services providers to work together to promote a regional care system.** This includes primary care providers, behavioral health provider organizations, Tribal healthcare providers, community-based organizations, substance use disorder treatment services, housing assistance, and transportation services. HealthierHere currently partners with 67 organizations across over 100 service sites in the region.

HealthierHere identified the following essential qualities of an improved care system:

- Culturally competent care teams are representative of the community.
- Health and community information exchange systems support community-clinical partnerships.
- Consumer voices drive decisions.
- Payment models reward improvement of health outcomes.

**HealthierHere selected projects based on regional need and ability to improve the associated outcome measures.** HealthierHere's project selection accounted for health equity and regional need, and the ACH facilitated community-clinical partner linkages to incorporate multiple perspectives into project work. HealthierHere's project selection also accounted for the potential to move the MTP metrics, as each of their chosen projects share metrics with one or more of the other selected projects.

**HealthierHere contracted with clinical partners first, followed by community-based partners and tribes.** Clinical partners—including hospital systems, federally qualified health centers (FQHCs), and behavioral health provider organizations—were convened first, as the ACH perceived those partners were more readily identifiable. This allowed the ACH to determine organizational readiness and capacity to improve the MTP metrics and begin implementing changes. The ACH then engaged community-based organizations (CBOs) and tribal partners as project partners and project advisors on its Community and Consumer Voice Committee. Community-based and tribal partners were selected based on alignment of mission, services provided to address social determinants of health, communities reached, organizational readiness, and capacity to improve the MTP metrics.

**Partner change plans with the ACH are standardized, and partners must meet ACH-specified deliverables to receive incentive payments.** HealthierHere's partners receive incentive payments based on clinical, population health, value-based payment, and equity deliverables. Equity progress is a partner requirement, and the ACH did not contract with organizations for MTP that could not commit to health equity deliverables in their change plans.

**HealthierHere contracted with local experts to provide training, technical assistance, and practice coaching to its partners.** The University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center is HealthierHere's vendor for project implementation support and technical assistance, which is optional for ACH partners. The AIMS Center services are primarily used by behavioral health and FQHC partners. Comagine Health is another training vendor with two contracts with the ACH: one for technical assistance on Collective Ambulatory Health Information Technology tool implementation and optimization, and another for value-based payment (VBP) training, offered through VBP Transformation Academy curriculum developed by the National Council for Behavioral Health. The ACH further facilitates monthly learning collaboratives and webinars for partners focused on the health improvement projects.

## **Domain One: Health Systems and Community Capacity Building**

**In 2019, HealthierHere began focusing on foundational infrastructure and capacity building to improve health information technology and exchange, including the implementation of a Community Information Exchange (CIE).** HealthierHere sees a clear relationship between integrated purchasing (i.e., integrated managed care) and integrated care delivery (i.e., bi-directional integration of physical and behavioral health). The ACH purchased training, technical assistance, and practice coaching for partners to enhance their use of Collective Ambulatory for primary care and behavioral health provider organizations. They are also investing in a CIE and other tools to strengthen connections between clinical and community-based partners. The CIE will include an electronic resource directory and will support shared care planning and closed loop referrals for addressing SDOH.

**HealthierHere funded VBP Transformation Academy training for behavioral health providers.** The academy offers VBP adoption technical assistance and onsite practice coaching. To assess provider progress, the ACH employed the Value Transformation Assessment, a tool adapted from the Maine

Health Access Foundation (MeHAF) Site Self-Assessment that evaluates physical and behavioral health integration progress.

**Workforce strategies are still under development.** HealthierHere has invested resources in ensuring providers have the skills they need to deliver integrated care through training, technical assistance, and practice coaching. HealthierHere has sponsored a number of webinars to advance best practices. HealthierHere also links its equity efforts to Domain One activities by developing strategies it believes will improve cultural competence, relevance, and community voice in the regional health workforce. They are also considering ways to promote the use of Community Health Workers (CHWs) and peer support specialists to increase access to care.

## Approach to Equity

**HealthierHere embedded health equity into its organizational vision and values.** HealthierHere considers equity a core value and applies an equity lens to all its work. The Community and Consumer Voice Committee was instrumental in developing a working definition of equity for the ACH, which states every community member should “receive the type of care that they deserve—with respect and without stigma—to address their unique and individual needs.” Equity was embedded in the ACH project selection process and its approach to convening partners, and equity considerations influenced ways of incorporating community voices into ACH decision-making.

HealthierHere requires contracted partners to complete an equity action plan and survey, which identifies three partner-selected health equity goals to be monitored on an annual basis. Service providers who could not commit to health equity progress were not accepted as ACH partners. HealthierHere used an equity assessment as a baseline measure and further developed a set of equity measures. The board was planning to review these measures at the time of our interviews. If approved, the ACH will develop a dashboard that incorporates the selected equity measures for monitoring regional health equity progress.

## Integrated Managed Care (IMC)

**HealthierHere focused on building behavioral health provider organization capacity for IMC.**

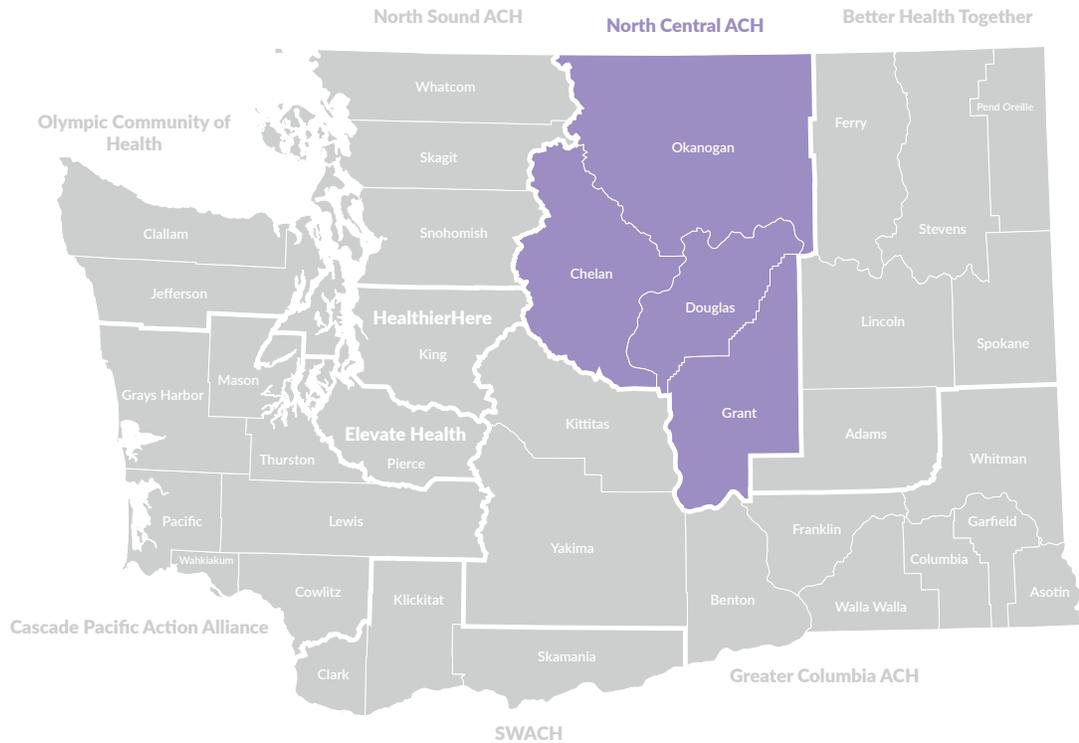
King County’s behavioral health organization (BHO), King County Behavioral Health and Recovery Division, maintains a presence in IMC, which is unique to the region. King County Behavioral Health and Recovery Division (BHRD) proposed a funding structure under the King County Integrated Care Network (ICN), which included an Independent Provider Association (IPA) network. As a part of the IPA network, behavioral health provider organizations receive technical assistance and IT support. The IPA negotiates contracts and payment mechanisms with the MCOs and provides quality assurance and compliance processes on their behalf.

HealthierHere provided initial funding to behavioral health provider organizations to support the transition to IMC. They further supported these partners in their transition to IMC by offering VBP Academy trainings and brokering training, technical assistance, and practice coaching for partner organizations interested in additional support. The ACH supports behavioral health, FQHC, and primary care partners through its contract with the University of Washington AIMS Center, which offers training and practice coaching on the Collaborative Care model.

## Data and Analytics

**The Performance Measurement and Data committee (PMD) has been integral to HealthierHere's data-related efforts.** In 2015, the ACH created a Performance Measurement Workgroup, led by PHSKC's chief of Assessment, Policy Development and Evaluation (APDE). This group, later known as the PMD, offered an "approach for meeting [the ACH's] data, information, and evaluation needs." APDE and HealthierHere's data capacity is due in part to the ACH participating in the Data Across Sectors for Health (DASH) Mentor Program, funded by the Robert Wood Johnson Foundation. DASH promotes the sharing and use of multi-sector data to improve community health. Since its involvement in DASH, HealthierHere has produced a number of data dashboards illustrating their impact on key performance indicators. Further, in its Performance Measurement Dashboard, HealthierHere presents snapshots and trends of its own regional data, as well as other regions, to demonstrate the performance measures and gaps for all nine ACHs.

# North Central ACH



**Backbone organization:** Public health district

**Integrated managed care status:** 2018 in Chelan, Douglas, and Grant Counties; 2019 in Okanogan County

**Tribal nations:** Confederated Tribes of the Colville Reservation

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	X
2D: Diversion Interventions	X
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	99,518	2,029,780
Chronic condition	36.6%	38.0%
Severe mental illness	9.2%	10.8%
Rural	60.7%	17.4%
High-poverty area	17.9%	17.4%
AI/AN	3.6%	3.2%
Asian	0.5%	4.4%
Black	0.8%	7.3%
HI/PI	0.4%	2.9%
Hispanic	46.7%	21.5%
White	39.5%	49.7%
Unknown race/ethnicity	8.6%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► NORTH CENTRAL ACCOUNTABLE COMMUNITY OF HEALTH (NCACH) HIGHLIGHTS

- *The North Central region is nearly one-fifth the size of the state and largely rural.*
- *The Latinx population is higher than the state average.*
- *There are regional shortages in most health worker positions.*

### Background

**The North Central region is overwhelmingly rural and has low population density in many areas.**

For example, the total population of Okanogan County is less than the Wenatchee metropolitan area. North Central Accountable Community of Health (NCACH) is housed in the offices of the Chelan-Douglas Health District (CDHD), the ACH's backbone organization, located in East Wenatchee. NCACH has a higher Latinx population than the state average, and the region contains expansive farmland that draws a migrant population for seasonal work.

### Organizational History and Evolution

The following organizations play important roles in NCACH governance, with each occupying a seat on the governing board:

- **Chelan-Douglas Health District (CDHD):** CDHD serves as NCACH's backbone organization and maintains a relationship with the ACH through a hosting services agreement, which includes the use of CDHD administrative staff and office space.
- **Coalitions for Health Improvement (CHIs):** These local organizations represent the three regional public health jurisdictions: Chelan-Douglas, Grant, and Okanogan. The CHIs initially formed in response to the State Innovation Model (SIM) grant while NCACH was created. CHIs have close relationships with NCACH and integrate the community voice into board activity and project implementation.
- **Whole Person Care Collaborative (WPCC):** Prior to MTP, NCACH convened primary care providers, behavioral health providers, and hospitals to develop and implement integrated care. The WPCC continues to play a significant role in NCACH's project implementation.

### Governance

**The early incarnation of the NCACH board was predominantly represented by clinical organizations.**

When the Washington State Health Care Authority (HCA) executed the Medicaid waiver and released the Project Toolkit, NCACH realized they needed to achieve broader board membership. In response, they added more community-based organizations (CBOs), increasing the board size to 20 seats, which includes the Executive Committee (the Board Chair, Vice Chair, Treasurer, and Secretary). NCACH also designated board seats to represent the three CHIs, with each CHI allotted reporting time during board meetings. Decision-making processes are informed by community input through the CHIs and the ACH project workgroups, who submit information, recommendations, and funding proposals to

the board. The board uses a flowchart developed by NCACH to guide their decision-making processes related to funding distribution.

## Relationships and Collaboration with Tribal Nations

**NCACH made ongoing efforts to engage the Colville Confederated Tribes by gaining their participation in health improvement projects.** The Colville Reservation is the largest in the state, partially situated in the NCACH service region and extending into Better Health Together (BHT). In 2017, the NCACH board produced a Tribal Communication and Collaboration policy and designated a board seat for the Confederated Tribes of the Colville Reservation. NCACH initially attempted to engage the tribes by convening a Tribal Leadership Council, also supported by the CHIs, but the response was not immediately successful. NCACH later engaged the Colville Tribes directly (through ongoing consultation with the tribal Business Council, its Health and Human Services Committee, and its Health & Human Services Director) in health improvement work. To promote opioid overdose prevention, NCACH organized Naloxone training and distribution and an Opioid Response Conference on the reservation. NCACH entered into a memorandum of understanding (MOU) with the Tribes to receive funding for overdose response efforts in June 2019.

## Accountable Community of Health Role

**Leadership and staff described NCACH as a convener of regional health services.** Informants emphasized facilitator, consultant, and provider of technical assistance as the primary roles NCACH fills in the region. Their role as a convener is particularly crucial in the North Central region, as distance between service providers has traditionally been a barrier to establishing working connections across organizations.

## Approach to Change

**The Whole Person Care Collaborative (WPCC) is NCACH's primary approach for engaging partners to implement their health improvement projects.** The WPCC, which started during SIM, convenes regional primary care and behavioral health providers. The collaborative initially directed NCACH's Bi-directional Integration of Physical and Behavioral Health project work for MTP and has evolved into the "WPCC Learning Community." This group is comprised of 17 contracted partners that join together to receive technical assistance and training necessary to implement their change plans and form connections with other partners to learn from each other. WPCC partners also receive support from practice facilitators who work with partners to monitor partner progress, assist with self-assessments, and offer technical assistance. The WPCC extends its resources and learning opportunities to other NCACH regional partners. NCACH change plans are structured, with prescribed topics for their partners to work on, although partners choose their own metrics and tactics for transformation.

NCACH works with 25 unique partners operating in 49 sites across the region. Most NCACH partners have a contract or MOU with the ACH that outlines the responsibilities and obligations committed to by signing parties. Progress made by contracted partners is monitored through their change plans, progress reports, and partner presentations on process improvement efforts or results. There is some flexibility in change plan design to allow for variation in partner organization variety, size, and capacity for change.

**NCACH aligns projects by using a single strategy or intervention to address goals of multiple health improvement projects.** For example, Projects 2C (Transitional Care) and 2D (Diversion Interventions) have a single workgroup that makes decisions about the tactics and target populations for both projects. In addition, NCACH uses a Pathways Community HUB, the evidence-based approach for Project 2B (Community Based Care Coordination) to coordinate care for the target populations that also support the goals of Project 3A (Addressing the Opioid Use Public Health Crisis) and Project 2D. Some project strategies also support the goals and objectives of Toolkit projects not selected by NCACH.

**NCACH's projects are focused on changing the clinical delivery system, and they have created a separate funding allotment for CHIs to address the social determinants of health.** NCACH is addressing the social determinants of health (SDOH) with community partners through grants that are separate from partner projects. To address regional SDOH, NCACH invested in the "CHI Initiative," a fund managed with oversight by the local CHIs. The CHIs invited community partners to apply for funds that address county-level needs, and then actively participated in application review and scoring, and selected finalists based on developed criteria. At the time of our interviews, the CHIs were reviewing community proposals for one-time projects to be funded by the CHI Community Initiatives investment process.

## Domain One: Health Systems and Community Capacity Building

**Due to shortages in most health care positions in the region, NCACH's workforce capacity building strategy is to train current health care workers with new skills.** NCACH expanded educational opportunities in the region for existing health care professionals. For example, an ACH survey of its regional partners identified a need for more chemical dependency professionals (CDPs). NCACH contracted with the Washington Association for Community Health and RtR Workforce Solutions to implement a CDP apprenticeship program.

**For Health Information Technology and Exchange, NCACH is working with Collective Medical Technology to provide training to providers in primary care and emergency settings.** ACH staff offer onboarding and technical assistance to partners to effectively incorporate these tools into workflows.

**At the time of our interviews, NCACH informants expressed that partners did not have a clear picture of how to move towards value-based payment (VBP) contracting or what was expected of them by managed care organizations.** NCACH was supporting partner movement towards VBP through facilitation of training surrounding practice transformation, including empanelment and ways to use their electronic health record (EHR) data reports for quality improvement.

## Approach to Health Equity

**At the time of our site visit, NCACH's approach for health equity was still under development.** NCACH facilitated educational activities to raise awareness, improve understanding, and communicate the importance of equity to their partners. NCACH used regional health disparity data from the Public Health Seattle & King County to determine priority geographic areas to conduct health improvement projects and identify "hot spots" by zip code. For example, to roll out the Pathways Community HUB, the ACH first chose the target population of three or more emergency department visits in the past 12 months, and then launched the Pathways Community HUB in a specific zip code in Moses Lake. The CHI regional assessments also helped the ACH to identify SDOH disparities related to health care access, including barriers to care access based on rural population mobility, such as travel distance required to reach services.

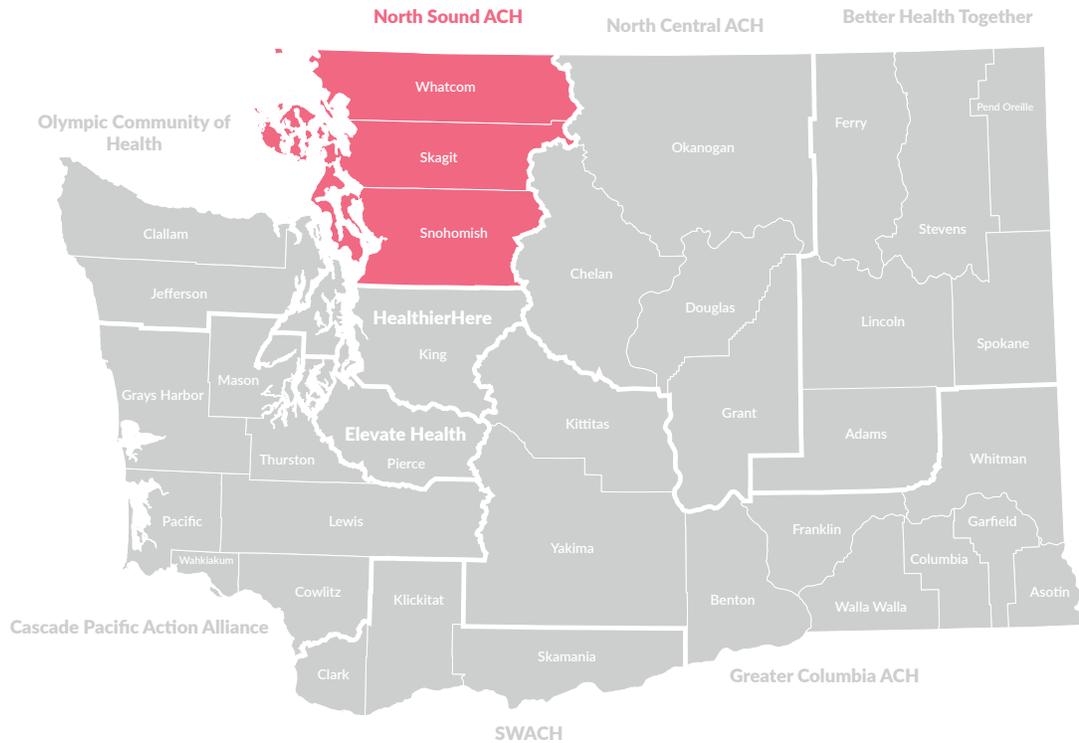
## Integrated Managed Care (IMC)

**Overlapping geographical boundaries between NCACH and the Okanogan behavioral health Regional Service Areas (RSAs) delayed the IMC transition in Okanogan County.** Chelan, Douglas, and Grant Counties were fully integrated by January 2018. Okanogan County had one contracted provider organization in the Spokane Regional Service Area, which shares an ACH service boundary with the Better Health Together (BHT) ACH. This provider organization did not contract with MCOs until BHT's transition to IMC, which occurred in January 2019. However, the counties that transitioned in 2018 provided support for Okanogan County through collaborative efforts and peer-learning. NCACH helped its partners navigate IMC transition by convening an IMC Advisory Committee to identify problems and provide technical assistance, further supported by IMC related workgroups.

## Data and Analytics

**NCACH used several approaches to obtain timely, granular data to monitor projects.** The ACH contracted with Seattle King County Public Health to access Medicaid claims and encounter data with a shorter turnaround time than the HCA. In addition, NCACH negotiated with MCOs to obtain performance metrics data for specific providers in its region.

# North Sound ACH



**Backbone organization:** Non-profit organization focused on access to affordable health care

**Integrated managed care status:** Delayed mid-adopter (2019)

**Tribal nations:** Lummi Nation, Nooksack Tribe, Samish Indian Nation, Sauk-Suiattle Indian Tribe, Stillaguamish Tribe of Indians, Swinomish Indian Tribal Community, Tulalip Tribes, Upper Skagit Tribe

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	X
2D: Diversion Interventions	X
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	X
3C: Access to Oral Health Services	X
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	303,989	2,029,780
Chronic condition	38.5%	38.0%
Severe mental illness	11.5%	10.8%
Rural	13.8%	17.4%
High-poverty area	5.6%	17.4%
AI/AN	3.8%	3.2%
Asian	4.7%	4.4%
Black	4.4%	7.3%
HI/PI	2.3%	2.9%
Hispanic	18.7%	21.5%
White	54.9%	49.7%
Unknown race/ethnicity	11.2%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► NORTH SOUND ACCOUNTABLE COMMUNITY OF HEALTH (NORTH SOUND ACH) HIGHLIGHTS

- *North Sound ACH selected all eight health improvement projects.*
- *North Sound ACH has a board seat for each tribe.*
- *North Sound ACH was one of two inaugural pilot ACHs.*

### Background

The North Sound Accountable Community of Health (North Sound ACH) office is located in Bellingham, Washington. North Sound ACH is a five-county region that includes eight Tribal Nations. It is a mix of rural and urban areas, with some rural areas only accessible by ferry or plane.

### Organizational History

**Local clinical and community organizations have a history of collaboration, and North Sound ACH inherited many preexisting partnerships.** North Sound ACH's backbone organization, the Whatcom Alliance for Health Advancement, was a non-profit focused on access to affordable health care. They led patient navigator and community health worker training programs, convened partners, supported the implementation of health programs, and coordinated their region's Medicaid enrollment and assistance program. They initially focused on Whatcom County and expanded their reach to five counties when the State Innovation Model (SIM) grant work began. North Sound ACH formed in 2016 and was one of two inaugural pilot ACHs. North Sound ACH became an independent organization in 2016, and its backbone organization permanently closed in 2019 due to challenges securing funding.

### Governance

**North Sound ACH governance committees provide opportunities for direct input from tribes, non-clinical partners, and Medicaid members.** North Sound ACH has an 18-member board with a board seat for each of the eight Tribal Nations in the region. Their board has a mix of health system, clinic, and community sector representation with slightly more representation from non-clinical organizations. In 2019, the board adopted portions of the Carver Model to create role boundaries between the North Sound ACH board and ACH operations under the CEO. Under the agreed upon model, the board sets the ACH's goals and priorities, called "the ends," and the CEO is responsible for "the means" for achieving the board's priorities, as long as they do not violate pre-defined standards, policies, or ethics. North Sound ACH's governance structure includes Finance and Governance Committees, comprised of Board and non-board members, and a Regional Voice Council, comprised of community-based organization (CBO) representatives and Medicaid beneficiaries or caregivers. The committees and council all report and make recommendations to the board.

## Relationships and Collaboration with Tribal Nations

**North Sound ACH informants described positive relationships with tribes, but noted opportunities for progress.** They often spoke about health equity and tribal engagement simultaneously, indicating that these efforts are aligned (See Approach to Health Equity). North Sound ACH staff also specify improving the health of the Native American and Alaska Native populations in their ACH's overall vision. The inclusion of all tribes in their governance structure reflects an understanding that one tribe cannot speak for another. North Sound ACH informants reported they are still learning and working to understand how best to engage the eight sovereign Tribal Nations. North Sound ACH staff asked each Tribal Nation how it would like to be engaged, and they continue to make efforts to understand and educate ACH staff and partners about tribal sovereignty.

## Accountable Community of Health Role

**Informants describe themselves as inclusive conveners and capacity builders who strengthen the region by identifying gaps and investing in contracted partners.** North Sound ACH connects partners to resources and is responsible for accelerating the adoption of best practices and models that support transformation.

## Approach to Change

**North Sound ACH selected all eight health improvement projects, leveraging the impact their efforts might have on metrics that apply across projects.** They felt all potential project areas were important to their community. By choosing all eight, they anticipated greater potential to improve outcome measures that were associated with multiple health improvement projects (e.g., outpatient emergency department visits had the potential to improve due to efforts in multiple project areas). North Sound ACH saw overlap in its selected target populations and implementation strategies, and they developed four overarching domains to create efficiency and demonstrate alignment across projects:

Domain	Projects
<b>CARE COORDINATION</b>	<ul style="list-style-type: none"><li>• Project 2B: Community-Based Care Coordination</li><li>• Project 2C: Transitional Care</li><li>• Project 2D: Diversions Interventions</li></ul>
<b>CARE TRANSFORMATION</b>	<ul style="list-style-type: none"><li>• Project 3A: Addressing the Opioid Use Public Health Crisis</li><li>• Project 3C: Access to Oral Health Services</li><li>• Project 3D: Chronic Disease Prevention and Control</li></ul>
<b>CARE INTEGRATION</b>	<ul style="list-style-type: none"><li>• Project 2A: Bi-Directional Integration of Physical and Behavioral Health</li><li>• Project 3A: Addressing the Opioid Use Public Health Crisis</li><li>• Project 3B: Reproductive and Maternal and Child Health</li></ul>
<b>CAPACITY BUILDING</b>	<ul style="list-style-type: none"><li>• Financial Sustainability through Value-Based Payment, Workforce, and Systems for Population Health Management</li></ul>

**North Sound ACH uses a standardized change plan with their partners.** North Sound ACH primarily uses change plans (see Chapter 6) to guide and monitor partner work. They developed a change plan template in collaboration with Olympic Community of Health, which uses a similar format. They identified desired goals and outcomes, set standardized metrics and milestones for partners, and provided a list of strategies partners could choose to reach those goals.

### **North Sound ACH uses Targeted Universalism as a framework that guides partner project work.**

The Targeted Universalism framework identifies a set of shared goals and outcomes and selects interventions that address the foundational barriers faced by different populations. Partners applied for project funding through an application process, which included submission of the Change Plan. In 2019 North Sound ACH contracted with 49 partners representing 133 locations or sites, including both clinical and community-based organizations. North Sound ACH uses its biannual reporting and site visits to determine partners' needs for technical assistance.

## **Domain One: Health Systems and Community Capacity Building**

### **Domain One activities are supported primarily through training, peer learning, and resource sharing.**

North Sound ACH has not yet invested in information exchange infrastructure. Instead, they have advocated for a uniform, statewide strategy for community information exchange due to the costs of sustaining that infrastructure after MTP ends. North Sound ACH administrators are addressing workforce capacity primarily through training and peer learning, and they would like to become more involved in workforce policy. Administrators have provided training and resources to partners on value-based payment contracting.

## **Approach to Health Equity**

**Partners are required to address health equity in their health improvement projects.** To promote health equity, North Sound ACH's contracted partners were required to complete an equity readiness assessment, describe how their projects address health equity in their change plans, and work with Tribal Nations on their health improvement projects. Targeted Universalism is also embedded in their change plan template, which incorporates an equity approach by encouraging partners to consider how their efforts will reach vulnerable populations. North Sound ACH is hosting an Equity and Tribal Sovereignty learning series to educate partners, North Sound ACH staff, and board members about the Tribal Nations, sovereignty, and how to address equity.

## **Integrated Managed Care (IMC)**

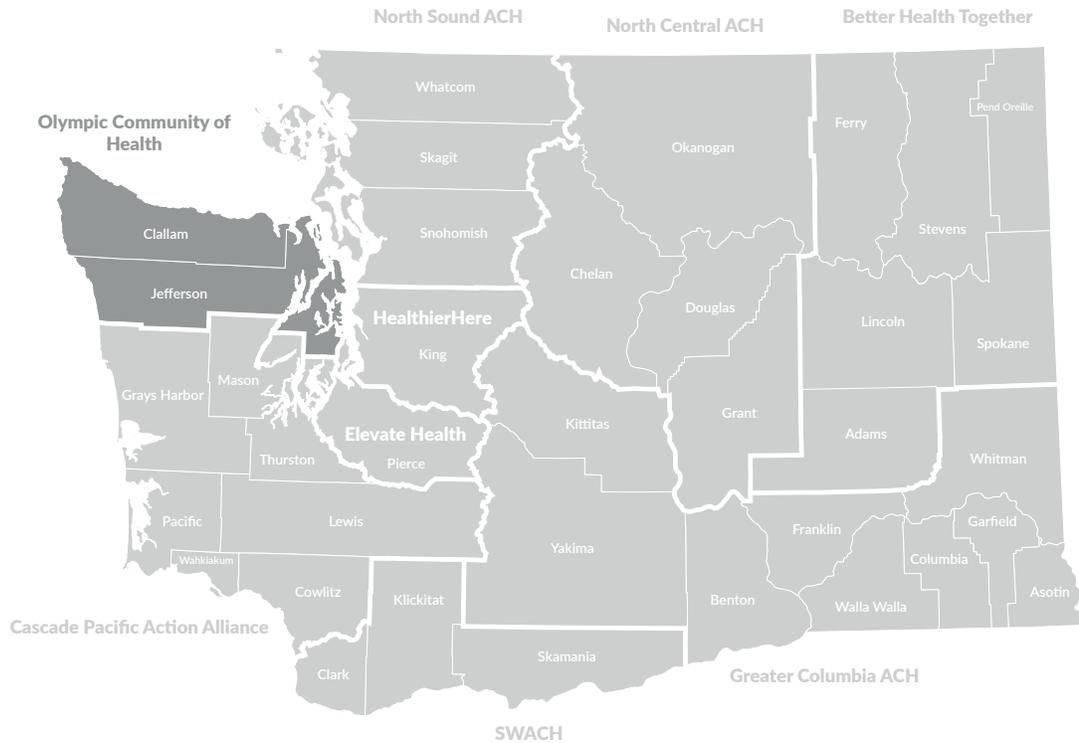
**North Sound ACH assumed a proactive role in preparing providers for IMC, but experienced delays in implementation.** The North Sound ACH region planned to implement IMC by January 2019, but needed a six-month extension due to an unsuccessful attempt by the region's behavioral health organization, which was operated collectively by the five counties, to negotiate contracts with the five Medicaid managed care organizations (MCOs). They reportedly achieved IMC in July 2019. North Sound ACH supported the region's behavioral health providers with the transition to IMC by contracting with Xpio, a health information technology company focused on behavioral health and integration, to identify behavioral health provider needs. They helped fund electronic health record systems and reporting technology necessary for behavioral health care providers to contract with and report to MCOs.

## **Data and Analytics**

**Although North Sound ACH has data analytic capacity through internal staff and contracts with King County Public Health, they seek additional data sources and more timely data.** North Sound ACH contracted with King County Public Health to help with data analytics, as they have access to the Washington All Payer Claims Database with a shorter lag time (about six months). They anticipate these data might better allow North Sound ACH to monitor, evaluate, and make course corrections. North Sound ACH has internal data analytics staff that use other data sources, such as county health

department and community assessment data. They are also interested in social determinants of health data, as there is not currently a tool that collects these data in electronic health records.

# Olympic Community of Health



**Backbone organization:** Public health district  
**Integrated managed care status:** On-time adopter (2020)  
**Tribal nations:** Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, Suquamish

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	
2C: Transitional Care	
2D: Diversion Interventions	X
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	X
3C: Access to Oral Health Services	X
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	89,913	2,029,780
Chronic condition	42.1%	38.0%
Severe mental illness	14.3%	10.8%
Rural	34.1%	17.4%
High-poverty area	4.6%	17.4%
AI/AN	6.3%	3.2%
Asian	1.5%	4.4%
Black	4.0%	7.3%
HI/PI	3.8%	2.9%
Hispanic	9.9%	21.5%
White	65.8%	49.7%
Unknown race/ethnicity	8.8%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ▶ OLYMPIC COMMUNITY OF HEALTH (OCH) HIGHLIGHTS

- *The OCH region is large and rural, with limited resources.*
- *There is a higher American Indian/Alaska Native population than the state average.*
- *Clallam County in OCH was the last in the state with voluntary managed care.*

### Background

**Olympic Community Health (OCH) has the smallest Medicaid population of any ACH, spread across a large geographic area.** The OCH region is comprised primarily of rural or frontier areas, with a few suburban areas in Kitsap and eastern Clallam County. Parts of the region are designated by the Health Research & Services Administration as primary care, mental health, and oral health shortage areas, and much of the specialty care is outsourced to the Seattle-metro area. OCH staff live and work across the three-county region, but they regularly come together and meet in-person.

### Organizational History and Evolution

**Kitsap Public Health District (KPHD) was the backbone organization for OCH.** KPHD completed the regional health needs inventory and managed the State Innovation Model (SIM) grant used to start OCH. Initially, all OCH staff were KPHD employees. In 2016, OCH separated from KPHD and became a non-profit organization. OCH continues to contract with KPHD for data analysis and regional assessment work.

### Governance

**OCH's governance structure expands upon the MTP requirements and provides a voting seat for each tribe.** The 22-seat Board of Directors is comprised of leaders from tribal nations in the region and representatives from local primary care, public health, and social service sectors. The board has three primary committees: Executive, Financial, and Performance Measurement and Evaluation. Each committee is responsible for reviewing topics and proposing ACH actions that fall within its area of focus. Committee information and recommendations are then reviewed by the full board for a final decision. The Executive Committee meets between board meetings. If a quick decision is needed, the Executive Director brings it to the Executive Committee, which evaluates if a rapid decision can be made, or if proposed actions will require full board review. OCH has a number of taskforces, subcommittees, and workgroups with specific focus areas that report to the OCH Board of Directors.

### Relationships and Collaboration with Tribal Nations

**OCH engaged tribes in its region early on and allowed them to set their own terms for participating in MTP.** Tribes requested in-person meetings with the support of tribal advocates to better understand costs and benefits of MTP participation. Three of the tribes were implementing health improvement projects with the ACH at the time of our site visit.

## Accountable Community of Health Role

**Unlike other ACH regions where collaborative organizations existed prior to MTP, the OCH region did not have an organization to convene health or community services, and OCH fills that role.** OCH interviewees describe their role as connectors and conveners, bringing together provider partners and creating opportunities for communication and collaboration. However, because a health alliance did not previously exist, OCH created a new connection opportunity for regional partners.

## Approach to Change

**OCH began the transformation by taking a clinically focused approach to health improvement projects.** OCH contracted with all the high-volume clinical providers in the region, but also contracted with providers who serve fewer Medicaid beneficiaries. This initial effort was followed with efforts to engage community-based organizations and address social determinants of health. The OCH funds-flow model linked partner organization payments to the number of Medicaid members the organization serves. As a result, key informants suggested this may have affected the number of non-clinical partners that are working on projects with OCH.

**OCH chose six projects from HCA's Project Toolkit and reconfigured their work into four domains.** To streamline the work of their contracted partners and maximize efficiency, OCH identified strategies in the project toolkit that could be used across multiple project areas and presented them in the following domains.

Domain	Projects
<b>CARE COORDINATION</b>	<ul style="list-style-type: none"><li>• Project 2D: Diversion Interventions</li></ul>
<b>CARE INTEGRATION</b>	<ul style="list-style-type: none"><li>• Project 2A: Bi-Directional Integration of Physical and Behavioral Health Care</li><li>• Project 2C: Access to Oral Health Services</li></ul>
<b>CARE TRANSFORMATION</b>	<ul style="list-style-type: none"><li>• Project 3A: Addressing the Opioid Use Public Health Crisis</li><li>• Project 3B: Reproductive and Maternal and Child Health</li><li>• Project 3D: Chronic Disease Prevention and Control</li></ul>
<b>CARE INFRASTRUCTURE</b>	<ul style="list-style-type: none"><li>• Domain 1: Health Systems and Community Capacity Building</li></ul>

**OCH requires partners to meet specific expectations and requirements for projects through the use of change plans.** The ACH is partnered with 37 organizations, operating across 59 sites in the region. OCH designed separate change plan templates for primary care practices, behavioral health provider organizations, hospitals, and community-based organizations (CBOs). Each template includes a list of strategies for project implementation and corresponding outcome metrics to track per project. Partners are able to select from the proposed strategies according to their organization's capabilities and can change their strategies annually if needed. Primary care and behavioral health partners must select strategies and metrics for all four project domains; hospitals must select among three domains (Care Coordination, Care Transformation, and Care Infrastructure), and CBOs are responsible for two (Care Coordination and Care Infrastructure). OCH staff visit contracted partners twice annually and receive bi-annual reports to monitor their progress and offer technical assistance.

**OCH uses Natural Communities of Care (NCCs) to engage partners and communicate about MTP activities.** NCCs formed in each county as a part of MTP, enabling OCH to connect with widely dispersed partners within its sparsely populated region. Although NCCs are not involved in decision-

making, they host forums where OCH representatives gather preferences, input, and feedback from the community and pass along updates from OCH to the community. Once a year, OCH hosts individual NCC convenings and a regional convening where representatives meet and exchange information. OCH hosts Regional Convenings where NCC representatives meet and exchange information about the regions. In addition, OCH staff attend existing county-wide convenings and community meetings to connect with community partners.

## Domain One: Health Systems and Community Capacity Building

**Digital Health Commons, a Community Information Exchange (CIE), is being developed to support coordination between ACH partners inclusive of community-based organizations.** OCH contracted with Quad Aim Partners to develop the Digital Health Commons, a CIE that enables clinical and community partners to exchange patient information. At the time of our visit, OCH still needed to establish an owner for Commons that is a HIPAA-covered entity, and was working with Clallam County Public Health to help implement the CIE in the region. Greater Columbia ACH and HealthierHere also use the Digital Health Commons platform.

**OCH converted the proposed Domain One strategies into the change plans outcomes and tactics.** For example, “Implement VBP arrangements with MCOs” is a suggested tactic under the sustainability outcome: “Transformation is sustained beyond MTP.” OCH contract requirements support its partners in moving towards value-based payment (VBP) by implementing workflows and processes in support of value-based care.

**OCH requires some partners to carry out activities related to health information technology (HIT) through the change plans.** OCH requires primary care and behavioral health providers to track HIT outcomes, such as establishing a notification system when a patient is hospitalized or using population management tools to systematically identify and track subpopulations.

**OCH change plans describe workforce activities as “highly recommended.”** Workforce tactics included establishing residency training programs, partnering with community colleges to recruit health professionals after graduation, and incorporation of telehealth into practices. ACH informants revealed that workforce was a topic of importance to their partners, but limited action had been taken at the time of our visit. The use of ACH “bonus pool” funds was being considered to address regional challenges related to workforce capacity.

## Approach to Equity

**OCH is planning to focus more on equity in the next phase of its work.** At the time of our visit, OCH conducted a health equity assessment with contracted partners and facilitated conversations with the NCCs to identify marginalized populations and solutions for increasing equity. OCH change plans include offering training in health equity, which is not required of partners. The ACH was focused on meeting the deadline for adopting integrated managed care; working on approaches to equity would come in the next phase of implementation with its partners.

## Integrated Managed Care (IMC)

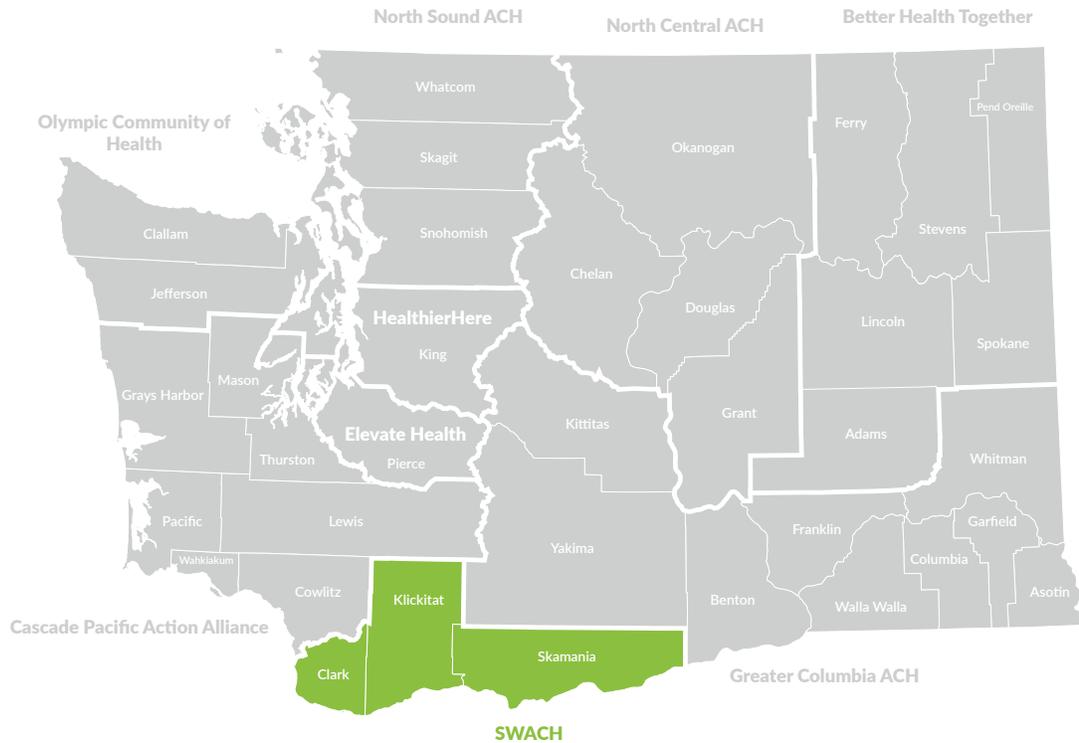
**IMC was a time-consuming transition for both OCH partners and ACH staff; informants found it distracting and reported that IMC impacted their capacity for MTP.** OCH was an on-time adopter in January 2020 and the ACH played an active role in assisting with the regional transition. Clallam County was the last county in the state to have voluntary managed care, and prior to that had not established relationships with most of the state managed care organizations (MCOs). As such, the

county's shift to IMC was challenging, as it involved hospitals, primary care providers, and behavioral health providers. CBOs also participated in the IMC transition by supporting beneficiaries to change their MCO if needed and sharing their questions and concerns with other involved partners. The IMC deadline was frequently cited in 2019 interviews as when OCH planned to address MTP focus areas that were delayed by IMC.

## Data and Analytics

**OCH has obtained diverse data on the health needs of its region through a set of unique partnerships.** During OCH's planning phase, Kitsap Public Health District (KPHD) provided OCH with public health surveillance and population health data and assisted with the regional health needs inventory and community needs assessment. Currently, OCH contracts with KPHD for data analysis to support project design and implementation. In addition, OCH has contracted with Public Health Seattle & King County (PHSKC) to access data from the Washington State All Payer Claims Database. They further use support from PHSKC for their statewide ACH dashboards and dashboard-related technical assistance. Notably, MCOs in the OCH region have also agreed to share performance measures for the region and assist OCH in tracking progress towards shared benchmarks.

# SWACH



**Backbone organization:** Non-profit organization

**Integrated managed care status:** Clark and Skamania Counties, pilot adopters (2016); Klickitat County, mid-adopter (2019)

**Tribal nations:** Confederated Tribes and Bands of the Yakama Nation, Cowlitz Indian Tribe

Selected Projects	
2A: Bi-Directional Integration (Required)	X
2B: Community-Based Care Coordination	X
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing Opioid Use (Required)	X
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	X

Medicaid Population <sup>1</sup>	ACH	State
Total	144,070	2,029,780
Chronic condition	34.7%	38.0%
Severe mental illness	9.1%	10.8%
Rural	7.7%	17.4%
High-poverty area	2.9%	17.4%
AI/AN	1.6%	3.2%
Asian	2.5%	4.4%
Black	3.7%	7.3%
HI/PI	2.6%	2.9%
Hispanic	15.4%	21.5%
White	63.2%	49.7%
Unknown race/ethnicity	11.1%	11.1%

<sup>1</sup>CHSE analysis of Medicaid enrollment and claims/encounters data. Includes members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid. Chapter 2, Exhibit 2.2 and Appendix A describe the Medicaid population and subgroups in detail.

## ► SOUTHWEST WASHINGTON ACH (SWACH) HIGHLIGHTS

- *SWACH leverages a partnership with Healthy Living Collaborative, a Vancouver community-based organization, to engage regional partners and community voices.*
- *The ACH was the first to transition to Integrated Managed Care.*
- *ACH leadership changed in 2018.*

## Background

**Most of the Southwest Washington ACH (SWACH) Medicaid population resides in Clark County.** Clark County includes Vancouver, the state's fourth most populous city and location of the SWACH office. Significant portions of Klickitat and Skamania Counties are rural with low population density.

## Organizational History and Evolution

**SWACH emerged from the Southwest Washington Regional Health Alliance (RHA), a collaborative venture formed by clinical, community, and county leaders, with a community footprint before MTP.** RHA piloted the ACH in Clark and Skamania counties under the State Innovation Model (SIM) grant in 2015. Klickitat County was added to the SWACH region in 2016. The RHA non-profit does not provide or coordinate regional services separate from the ACH. Healthy Living Collaborative (HLC), a grassroots organization that serves Clark, Skamania, Wahkiakum, and Cowlitz Counties, integrated with SWACH when it became an ACH in 2017. While there is geographical overlap, HLC and SWACH have different service regions, with SWACH serving Clark, Klickitat, and Skamania Counties.

## Governance

**In 2018, the governing board changed the leadership.** With new leadership came greater board involvement and advocacy of SWACH efforts. During the transition, SWACH contracted with Elevate Health for IT and financial service support along with other contracted support from Uncommon Solutions and Providence CORE, among others. The 13-member governing board currently includes representation from large health systems, community organizations, public health, and local schools.

**SWACH's Regional Health Improvement Plan (RHIP) Council is comprised of community members and stakeholders and acts as an advisory committee to the board and SWACH leadership.** SWACH has an executive committee, which conducts business in-between board meetings, and a finance committee that reviews financial transactions. Board decision processes begin with the Executive Director's submission of ideas to the executive committee. The executive committee (the board chair, vice chair, secretary, and treasurer) then operates as a work group that reviews ACH leadership proposals, refines plans, and submits them to the full board for approval.

## Relationships and Collaboration with Tribal Nations

**SWACH has established partnerships with both sovereign nations in the region, although they have a longer relationship with the Cowlitz Indian Tribe.** The ACH began meeting with the Cowlitz Tribe in preparation for MTP and allowed the tribe to determine if and how they wanted to engage with the ACH. The Cowlitz Tribe expressed interest in being involved as project partners and the tribe currently has two contracts with SWACH related to Project 2A (Bi-Directional Integration of Physical and Behavioral Health Care). Yakama Nation did not have a relationship with SWACH prior to MTP. The ACH leveraged neighboring Greater Columbia ACH (GCACH), which Yakama Nation extends into, to help to engage the tribe. At the time of our site visits, GCACH and SWACH were committed to providing financial assistance to Yakama Nation to address capacity challenges related to care coordination between physical and behavioral health services.

## Accountable Community of Health Role

**SWACH staff described the ACH as a neutral convener, “dot-connector,” and advocate.** SWACH supports a regional HUB known as Pathways Health Connect for Project 2B (Community-Based Care Coordination). The HUB acts as care traffic control in partnership with local Care Coordination Agencies (CCAs) to help service providers communicate and connect clients to care (see Exhibit 1.4 for a description of Project 2B.) SWACH also engages in local and state policy and advocacy work through the HLC’s policy advocacy efforts.

## Approach to Change

**SWACH’s projects focus on promoting “whole-person care” through care coordination and integration of behavioral and physical health care.** SWACH’s approach to their health improvement efforts focuses on transforming care in health service delivery settings, including primary care, behavioral health, emergency services, and substance use disorder (SUD) services. SWACH emphasizes the importance of forming clinical and community linkages and collaboration regardless of the specific project topic. The integration of HLC into SWACH helps them stay well connected to regional organizations, initiatives, and community voices.

**SWACH transformation projects are aligned in both theory and implementation rather than separate projects.** SWACH used specific strategies that bring clinical and community partners together to collaborate for all projects. For example, Projects 2A (Bi-directional Integration of Physical and Behavioral Health Care), 3A (Addressing the Opioid Use Public Health Crisis), and 3D (Chronic Disease Management and Control) all use warm handoffs to connect primary care and social service organizations.

**Improving pay-for-performance metrics was not SWACH’s top priority when choosing their MTP project strategies.** SWACH’s approach to the health improvement projects was not driven by the potential to meet what they described as “very primary care-focused” metrics. At the time of our visit, SWACH staff noted that the topic of meeting pay-for-performance metrics and understanding incentive payments was newly emerging in conversations. Prior to our visit, they were largely focused on strategies that change how clinical and community partners work together, working toward integrated care, to address the needs of the community.

**SWACH staggered partner contracting, soliciting requests from regional health care organizations and providers that serve a large number of Medicaid members first.** SWACH recognized that its transformation needed to start by contracting with primary care and behavioral health provider organizations. This contracting occurred in late 2018, with CBO contracting planned for late 2019.

SWACH is currently partnered with 27 organizations operating across 50 service sites in the region. The ACH has four categories of partners: Clinical Transformation Partners, Community Organization Partners, SWACH Regional Service Partners (i.e., the Pathways Community HUB Care Coordination Agencies), and Partners for Shared Learning and Regional Impact (i.e., education and capacity building partners that are uncontracted).

**SWACH monitors and evaluates individual partner progress through change plans that are focused on aims, selected target populations, and milestones.** SWACH collaborated with its partners to develop a change plan for each of their projects. Contracted partners submit evidence of progress on deliverables and key activities quarterly. The ACH is open to adjusting a partner's contract to revise their scope of work if they are experiencing unexpected challenges. SWACH set a broad target population for its projects: all Medicaid beneficiaries. In doing so, partnering providers were able to decide what populations were important to them and who they wanted to target. SWACH reported that partner needs for technical assistance and support are addressed during site visits and through a developing learning collaborative that will offer partners quality improvement training.

## Domain One: Health Systems and Community Capacity Building

**SWACH has introduced community health workers (CHWs) into care coordination services.** Prior to MTP, HLC had established programs using CHWs and community health advocates in neighborhoods and school settings.

**SWACH has made focused investments in health information technology and exchange through HealthConnect.** Informants expressed that available ACH funding for implementing new technologies was not sufficient to make a real impact on health information exchange capacity in the region. So far, SWACH has focused on optimizing use of Collective Medical technologies for behavioral health provider organizations by providing technical assistance and support. SWACH has made focused investments in the HealthConnect infrastructure for partners to support their Pathways Community HUB.

**At the time of our visit, ACH staff were beginning to work with partners to determine what kind of support was needed to assist them in moving towards value-based payment (VBP).** SWACH is working to convene its partners and the managed care organizations to facilitate the adoption of VBP arrangements.

## Approach to Health Equity

**In 2019, SWACH convened the Equity Collaborative, a cohort of partners committed to advancing health and racial equity in their organizations.** As SWACH contracted with partners, the concept of the equity collaborative was introduced to them to determine general interest and capacity for involvement. The SWACH Manager of Equity Initiatives worked with interested organizations to evaluate their commitment and motivation and selected 14 partner organizations for participation in the Equity Collaborative. Cascade Pacific Action Alliance ACH is also a partner in the SWACH Equity Collaborative. At the time of our interviews, the Equity Collaborative partners were working on equity assessments, to be followed by developing a health equity plan for their organization.

**SWACH's approach to equity draws on the work of the HLC.** SWACH defines equity as "equal access to a healthy community, a healthy environment, and healthy relationships with the local institutions and service providers." SWACH offers regional equity trainings in collaboration with other community-based organizations. In the future, the ACH plans to further expand and improve trainings through a

restructured approach that offers equity education as an ongoing educational series. The HLC's CHW programs also contribute to health equity by supporting CHWs in underserved communities.

## **Integrated Managed Care (IMC)**

**SWACH helped Klickitat County transition to IMC in 2019.** HCA piloted IMC in Clark and Skamania Counties in 2016. However, Klickitat was not a pilot county and implemented IMC in 2019. To aid Klickitat County's transition, SWACH helped partnering providers understand regulations pertaining to IMC, such as rules for billing an integrated MCO, and invested in administrative support. Currently, SWACH is assisting partners with understanding how to effectively integrate services on the ground through change plans, peer-learning strategies, and its Integration Learning Collaborative.

## **Data and Analytics**

**SWACH contracts with Providence Center for Outcomes Research & Education (CORE) to meet its data needs.** Providence CORE provides SWACH with assessments and surveys, and has a system to allow partners to track their progress. Providence CORE also facilitates the Data Workgroup, which assisted SWACH with their Regional Health Needs Inventory to assess health disparities. SWACH worked with Providence CORE to access data from the Vancouver Housing Authority, data from Vancouver Public Schools, and claims data.

# Analysis of Performance Metrics

## Overview

In this appendix, we describe the performance metrics presented in this report, the data sources we used to calculate metrics, and the Medicaid population and subgroups whose data we used.

## Metric Selection

We selected 45 metrics from two sets:

- **Pay for Performance (P4P) Metrics:** Metrics used by the Washington Health Care Authority (HCA) to award ACHs and their partners for improving outcomes, listed in HCA's *Project Toolkit* (Washington State Health Care Authority 2019b).
- **Metrics from the State's Evaluation Design:** Metrics listed in Appendix 1 of Washington State's *Evaluation Design* for use evaluating each Domain 2 and 3 health improvement project and Initiative 3 ("Medicaid Transformation Project Demonstration Evaluation Design" 2019).

The Data Appendix, Table 2 lists the expert organization that developed the specifications for each metric and whether the metric is associated with a specific health improvement project, as listed in the *Project Toolkit* and *Evaluation Design*.

## Data Sources

The metrics we used were calculated by the State of Washington. We received records showing whether each Medicaid member met the criteria for each metric (e.g., whether a person had a primary care visit or a recommended test or screening) in each month from April 2016 through December 2018. In addition, we received Medicaid enrollment records that included information about each person's demographics, and Medicaid claims/encounters records that identify diagnoses and services each person received. This information enabled us to identify subgroups of Medicaid members and present performance metrics for Accountable Community of Health (ACH) regions and subgroups as described below.

To help understand performance of Washington State's Medicaid system, we included 2017 US rates for 20 metrics available from the National Centers for Quality Assurance (National Center for Quality Assurance, n.d.) in our presentation of results.

## Medicaid Populations and Subgroups

To calculate P4P metrics, Washington State includes outcomes for only those Medicaid members with comprehensive physical and behavioral health care benefits and excludes members who are dually eligible for Medicare and Medicaid or have primary insurance other than Medicaid (Washington State Health Care Authority 2019a, 55). We used inclusion flags in the performance metrics data we received to restrict metrics to this population, hereinafter called MTP Medicaid members.

To report metrics for members in each ACH region, we used inclusion flags provided in the data we received to identify MTP Medicaid members who resided in each ACH in each month. Importantly, we did not include or exclude members in reporting metrics for ACH regions based on the number of months they resided in the regions and qualified for Medicaid. When reporting statewide metrics, we included or excluded members based on the number of months they resided in the state and qualified for Medicaid. The State of Washington includes a member's outcomes in calculating most metrics if the member resided in an ACH region for 11 of 12 months of the measurement year. The State included a member's outcomes in calculating some metrics if the member resided in the region for only 7 of 12 months, allowing a less residentially stable population to count in the metric.

We identified MTP Medicaid members in subgroups using the following methods:

- **Medicaid enrollment data:** We used information from Medicaid claims/encounters records to identify members by race/ethnicity group, age group, sex, rural or urban geography of residence (identified using the University of Washington's Rural-Urban Commuting Area designations, a crosswalk applied at the zip code level), and residence in high-poverty or non-high-poverty areas (defined as zip codes in which the median income was in the bottom quintile of Washington State's income distribution according to the American Community Survey in 2017).
- **Medicaid claims/encounters data:** We used information on diagnoses and services from Medicaid claims/encounters data to identify members with chronic conditions, severe mental illness (SMI), and substance use disorder (SUD).
  - » **Chronic condition:** We identified a person as having a chronic condition in a given month if he or she received at least one diagnosis for a chronic condition, as defined by the Center for Medicare & Medicaid Services Chronic Conditions Warehouse (CCW), within a designated lookback period. We used claims from any place of service (i.e., inpatient, outpatient, or professional setting) to identify chronic conditions.
  - » **Severe mental illness (SMI):** We identified a person as having SMI in a given month if he or she received at least one of the following diagnoses within the last year: schizophrenia, bipolar disorder, major depression, cyclothymic disorder, post-traumatic stress disorder (PTSD), or obsessive-compulsive disorder (OCD). For schizophrenia, bipolar disorder, depression, and PTSD, we used diagnosis codes from the CCW. For cyclothymic disorder and OCD, we translated ICD-9 codes used to identify people with SMI for CHSE's Oregon Medicaid waiver evaluation into ICD-10 codes, as shown in Table A.1.
  - » **Substance use disorder (SUD):** We identified a person as having SUD in a given month if he or she received at least one diagnosis for alcohol or drug use within the last year using the Alcohol Use Disorders and Drug Use Disorders categories from the CCW algorithm.

**Exhibit A.1. Diagnosis Codes Used to Identify People with Severe Mental Illness (SMI)**

Diagnosis	ICD Code Name	ICD-9	ICD-10
Cyclothymic disorder	Cyclothymic disorder	301.13	F34.0
	Schizotypal personality disorder	301.22	F21
	Other specific personality disorders	301.11	F60.89
	Borderline personality disorder	301.83	F60.3
Obsessive-compulsive disorder	Mixed obsessional thoughts and acts	300.3	F42.2
	Hoarding disorder	300.3	F42.3
	Other obsessive-compulsive disorder	300.3	F42.8
	Obsessive-compulsive disorder, unspecified	300.3	F42.9

# Provider Organization Surveys

In this appendix, we describe our primary care practice and hospital surveys. We begin by describing survey development and our strategy for selecting practices and hospitals to survey. We then describe survey administration and our method for creating sample weights that we applied to practice survey responses in order to estimate responses for the populations of primary care practices and hospitals. We conclude by describing the extent to which responses can be used to draw conclusions about these populations.

The Data Appendix, Tables 7 and 8, present population estimates for each item on the practice and hospital surveys with 95 percent confidence intervals.

## Survey Development and Testing

We selected survey items that would allow us to construct quantitative indicators of health care transformation across the state, with a focus on (VBP) adoption, workforce capacity, and health information technology (HIT) use. Responses to these items were used to estimate statewide change in VBP adoption, workforce capacity, and HIT use. Later in the evaluation, they will be used to help us target practices and hospitals for key informant interviews. The interviews will capture information about qualitative factors that help explain changes in quantitative indicators from the survey, and explore the impact of VBP adoption, workforce capacity-building, and HIT efforts among practices and hospitals.

To identify survey items, we met with State of Washington experts to learn about the State's objectives for the survey and explore potential survey domains. We reviewed key documents, including Washington State's Medicaid waiver and the State's CMS-approved Evaluation Design, to understand the State's VBP, workforce, and HIT goals. In addition, we reviewed items from a number of existing surveys covering VBP adoption, workforce capacity, and HIT use. These include large national or international surveys with validated items, such as the National Electronic Health Records Survey sponsored by the federal Centers for Medicare & Medicaid Services and the Commonwealth Fund's International Survey of Primary Care Doctors; surveys conducted in Washington State, including the Washington State Health Care Authority's Value-Based Purchasing survey and the Washington Health Workforce Sentinel Network survey; and several surveys conducted by Washington State's Accountable Communities of Health (ACHs).

In spring 2019, we conducted cognitive testing of draft survey instruments with a small group of staff at two practices and two hospitals in Washington State. We asked staff to complete the draft survey and describe their experience completing the survey, including their understanding of the items, points at which they were confused or had difficulty answering questions, points when they might be inclined to discontinue before completion, and time needed to complete the survey. After each session, we used this information to revise the draft surveys before retesting on new subjects.

## Sampling Strategy

Our goal was to survey a sample of 275 primary care practices and all hospitals in Washington State. This section describes the lists of practices and hospitals we used to administer the surveys and the procedures we used to select practices and hospitals from the lists.

### Primary Care Practice and Hospital Lists

We selected practices and hospitals to survey from a roster provided by Washington State's All-Payer Health Care Claims Database (WA-APCD). We chose to obtain practice and hospital information from the WA-APCD because it provides both physical address information and claims-based information on payer mix and size, which we needed to execute our sampling strategy and evaluate the representativeness of our sample.

The WA-APCD roster included 469 practices and 86 hospitals. Onpoint Health Data (Onpoint), the contractor that administers the WA-APCD, used this roster to create Washington HealthCareCompare, a website that presents information on the quality of health care providers and the price of health care procedures to consumers, for the Washington State Office of Fiscal Management (OFM). Onpoint worked with LexisNexis, a provider of business and legal information, to create the roster using national provider identifiers (NPIs) from claims data submitted to the WA-APCD by health care payers, including commercial insurance carriers and Medicaid managed care organizations.

Onpoint focused its outreach and data validation effort on large practices, since these were the focus of public reporting on Washington HealthCareCompare. However, the roster was developed from all NPIs that payers submitted to the WA-APCD, and Onpoint did not actively make efforts to exclude small practices or rural practices from the list. As a result, we expect the roster to sufficiently represent practices across Washington State.

To help us create a representative sample of primary care practices and analyze the survey data, Onpoint computed two supplemental variables for each practice and hospital on the roster: Medicaid Panel Mix, defined as the percentage of unique attributed patients (for practices) or discharges (for hospitals) in 2017 covered by Medicaid, among patients or discharges covered by all payer types; and Total Panel Count, defined as the total count of unique attributed patients (for practices) or discharges (for hospitals) in 2017 across all payer types.

### Primary Care Practice Sample

We sampled practices using over-sampling and stratified sampling to ensure our sample included a sufficient number of practices in each ACH region, practices in rural and urban zip codes, and practices actively partnering with ACHs on health improvement projects. Our procedure was based on the expectation that a simple random sample would fail to capture a sufficient number of responses from practices in each of these categories. We used the following steps:

**Step 1: Select practices with Medicaid Panel Mix of at least 20 percent.** MTP is intended to transform Washington State's Medicaid delivery system. To focus the survey on practices most likely to respond to MTP (i.e., practices that serve a substantial number of Medicaid patients), we sampled exclusively from practices with a Medicaid Panel Mix of at least 20 percent, excluding 89 practices from the roster that failed to meet the threshold. After this step, there were no selected practices, and 380 practices to choose from in the next step.

**Step 2: Survey all 35 practices in rural zip codes from the remaining practices.** After this step, there were 35 practices that had been selected, and 345 to choose from in the next step.

**Step 3: Stratify by ACH.** We drew up to 25 urban practices from each of the nine ACH regions. After Steps 1 and 2, there were four ACH regions with fewer than 25 practices remaining to be sampled. In these regions, we included all remaining practices in the sample. After this step, there were 221 practices that had been selected, and 159 to choose from in the next step.

**Step 4: Create an ACH partner oversample.** We drew a random sample of 25 practices from the remaining practices listed on ACHs' July 2019 provider rosters as "Actively Implementing in Support of at Least One Project Area." The provider rosters, which HCA requires ACHs to submit as a deliverable, offer the best available list of practices actively partnering with ACHs on health improvement projects. After this step, there were 246 practices that had been selected, and 134 to choose from in the next step.

**Step 5: Sample remaining practices with a simple random sample.** We drew additional practices from the remaining population using a simple random sample in order to create a sample of 275 total practices. After this step, there were 275 practices that had been selected and 105 that were not selected during the process.

## Hospital Sample

Our goal was to survey all hospitals on the WA-APCD roster with physical addresses in Washington State. The list included 16 hospitals in Idaho and Oregon, which we excluded, leaving 70 hospitals to survey.

## Survey Administration and Data Cleaning

We administered practice and hospital surveys from September 2019 through January 2020. Using publicly available phone numbers from practice and hospital website searches, we attempted to contact each practice in the selected sample and all hospitals in Washington State to identify the person best able to answer the survey questions, along with their e-mail address. Once identified, we sent this person a link to a web-based version of the survey by email. If the recipient clicked the opt-out button, we noted this and ceased following up. For those who did not complete the survey, we followed up weekly (up to seven times) with emails and called at least three times to request they complete the survey. Additionally, we continued to pursue identities of the persons best able to answer survey questions for the practices and hospitals we were unable to connect with during previous phone call attempts. Recipients who completed the survey received a \$50 gift card. Those who did not complete the survey after the above follow-up steps were considered non-respondents.

We closed the survey to additional responses on January 31, 2020. After closure, we reviewed all completed survey responses and removed any if the respondent opened the survey, did not opt out, and submitted the survey, but did not complete any of the survey, or if the respondent answered "yes" or "no" to every question with no comments, indicating that they did not consider the questions.

## Sample Weighting

Because some clinics were more likely to be selected and surveyed than others, we needed to develop survey weights. The goal of using weights was to make the sample mirror the underlying population and allow us to calculate approximately representative estimates of survey responses for the population of practices and hospitals. The weights accounted for the fact that our sampling strategy

oversampled rural practices and ACH partners and stratified by ACH region, which may have resulted in overrepresentation of these types of practice among total survey responses. In addition, the weights accounted for incomplete responses among some kinds of practices relative to the proportion on the WA-APCD roster.

We created survey weights using three steps:

### **Step 1: Calculate weights to account for oversampling and stratification**

We selected a stratified sample of 275 practices from the WA-APCD roster, which contained 380 practices. Since we oversampled on some of the characteristics, we developed a set of weights that, when applied, would make the results reflect the composition of the 380 practices.

To account for the differences in characteristics between the WA-APCD roster and the sample, we calculated weights to adjust for differences in three categories: rural status, ACH region, and ACH partner status. Specifically, we defined 36 unique groups based on all possible combinations of these three categories (e.g., rural practices in the Southwest Washington ACH region that are non-ACH partners) and then calculated weights for each group such that the weighted number of practices in a group that was selected for our sample equaled the number of practices in that group from the WA-APCD roster:

$$w_{1,g} = \frac{N_g(\text{sample})}{N_g(\text{APCD list})}$$

Where  $g$  is one of the 36 groups.

For example, 5.8 percent of practices in the WA-APCD roster are in the Cascade Pacific Action Alliance (CPAA) region. We oversampled so that 8.0 percent of practices in the sample are in the CPAA region. After the weights are applied, CPAA represents 5.8 percent of all practices again.

### Exhibit B.1. Results from Step 1 of Practice Survey Weighting (WA-APCD Roster to Sample)

	Practices with Medicaid Payer Mix $\geq$ 20 Percent from WA-APCD List (N=380)	Practices Selected for Sample, Unweighted (N=275)	Practices Selected for Sample, Weighted (N=275)
Average Panel Size	3279.3	3424.5	3332.9
Average Medicaid Payer Mix	55.4	58.1	56.2
Percent Rural	15.3	19.3	15.0
Percent ACH Partner	45.0	52.0	45.1
Percent Better Health Together	10.5	12.7	10.6
Percent Cascade Pacific Action Alliance	5.8	8.0	5.8
Percent Elevate Health	11.6	10.9	11.6
Percent Greater Columbia ACH	10.3	13.1	10.3
Percent HealthierHere	31.8	21.5	31.9
Percent North Central ACH	4.5	6.2	4.5
Percent North Sound ACH	14.7	12.7	14.5
Percent Olympic Community of Health	5.5	7.6	5.5
Percent Southwest Washington ACH	5.3	7.3	5.3

### Step 2: Calculate weights to account for incomplete survey responses

To account for nonresponses, we repeated the weight calculation from Step 1, this time matching the 275 practice sample with the 89 responses we received from the sample. As a result, the weighted number for each group that responded to our survey equaled the number of practices in that group from our sample of 275 practices:

$$w_{2,g} = \frac{N_g(\text{responses})}{N_g(\text{sample})}$$

Where  $g$  is one of the 36 groups.

For example, 6.2 percent of practices in the APCD list were in the North Central ACH (NCACH) region. We oversampled so that 6.7 percent of practices in the sample were in the NCACH region. After the weights were applied, NCACH represented 6.2 percent of all practices again.

## Exhibit B.2. Results from Step 2 of Practice Survey Weighting (Sample to Survey Respondents)

	Practices Selected for Sample, Unweighted (N=275)	Survey Respondents, Unweighted (N=89)	Survey Respondents, Weighted (N=89)
Average Panel Size	3424.5	3813.7	3658.9
Average Medicaid Payer Mix	58.1	59.7	57.8
Percent Rural	19.3	23.6	20.2
Percent ACH Partner	52.0	60.7	58.8
Percent Better Health Together	12.7	12.4	14.4
Percent Cascade Pacific Action Alliance	8.0	10.1	6.2
Percent Elevate Health	10.9	1.1	3.3
Percent Greater Columbia ACH	13.1	14.6	14.8
Percent HealthierHere	21.5	20.2	24.3
Percent North Central ACH	6.2	6.7	6.2
Percent North Sound ACH	12.7	12.4	14.4
Percent Olympic Community of Health	7.6	9.0	8.2
Percent Southwest Washington ACH	7.3	13.5	8.2

### Step 3: Calculate final survey weights

We obtained final survey weights by multiplying weights from step 1 and 2 and then normalizing them so that the final survey weights summed up to 1:

$$w_i = \frac{w_{1,i} * w_{2,i}}{\sum w_{1,i} * w_{2,i}}$$

Where  $i$  is a practice.

For hospitals, we calculated weights using a similar method but eliminated the first step because no sampling was involved. We also did not receive any hospital responses from the Elevate Health ACH region and therefore were unable to calculate weights for that region.

### Exhibit B.3. Results from Hospital Survey Weighting

	All hospitals on the WA-APCD List (N=86)	Survey Respondents, Unweighted (N=26)	Survey Respondents, Weighted (N=26)
Average Panel Size	2887.9	2235.8	3585.0
Average Medicaid Payer Mix	39.5	38.9	37.8
Percent Rural	44.2	76.9	57.6
Percent Better Health Together	12.8	11.5	7.6
Percent Cascade Pacific Action Alliance	12.8	23.1	16.7
Percent Elevate Health	6.9	0.0	0.0
Percent Greater Columbia ACH	17.4	11.5	13.6
Percent HealthierHere	18.6	11.5	24.2
Percent North Central ACH	10.5	15.4	12.1
Percent North Sound ACH	11.6	11.5	15.2
Percent Olympic Community of Health	4.7	7.7	4.5
Percent Southwest Washington ACH	4.7	7.7	6.1

### Representativeness of Survey Responses

This section describes the extent to which the survey responses we received from practices and hospitals can be considered representative of the total population of practices and hospitals across Washington State. Weighted responses to the practice survey, presented in Chapters 3, 4, and 5 of this report, can be considered approximate estimates of responses for the population. However, the numbers of rural practices, ACH partnering practices, and practices from smaller ACH regions that responded to the survey were not large enough to represent the population of practices from these strata. In addition, the number of hospitals that responded was insufficiently large to represent the population of hospitals across Washington State.

### Practice Responses Overall

Exhibit B.4 compares the characteristics of the 89 practices that responded to the survey without weights, the characteristics of the 89 respondents with weights applied, and the characteristics of the population of 380 practices with Medicaid Payer Mix of at least 20 percent from the WA-APCD list.

### Exhibit B.4. Characteristics of Primary Care Practice Survey Respondents

	Practices with Medicaid Payer Mix ≥ 20 Percent from WA-APCD List (N=380)	Survey Respondents, Unweighted (N=89)	Survey Respondents, Weighted (N=89)
Average Panel Size	3279.3	3813.7	3427.7
Average Medicaid Payer Mix	55.4	59.7	54.9
Percent Rural	15.3	23.6	15.3
Percent ACH Partner	45.0	60.7	51.4
Percent Better Health Together	10.5	12.4	12.0
Percent Cascade Pacific Action Alliance	5.8	10.1	4.5
Percent Elevate Health	11.6	1.1	2.4
Percent Greater Columbia ACH	10.3	14.6	11.7
Percent HealthierHere	31.8	20.2	36.3
Percent North Central ACH	4.5	6.7	4.5
Percent North Sound ACH	14.7	12.4	16.5
Percent Olympic Community of Health	5.5	9.0	6.0
Percent Southwest Washington ACH	5.3	13.5	6.0

Overall, the characteristics of the weighted sample match the characteristics of the WA-APCD list, especially with respect to panel size, Medicaid payer mix, and percent rural.

On a few characteristics, the weighted sample does not represent the WA-APCD population well. For example, practices from the Elevate Health ACH region were underrepresented because we received only one response from this region. Weighting increased representation of this response, but could not account entirely for nonresponse. It should be noted that this practice represents multiple practices in the region.

### Hospital Responses

As with practices from specific strata, we received an insufficient number of hospital responses to make generalizations about the population of hospitals across the state. Therefore, we did not include survey response for hospitals in the main part of the report. Table 8 in the Data Appendix presents survey responses for hospitals and confidence intervals.

# Key Informant Interviews

In this appendix, we describe our methods for conducting key informant interviews with State of Washington and Accountable Community of Health (ACH) representatives and analyzing data from the interviews.

## Document Analysis

The qualitative team began learning about the Medicaid Transformation Project (MTP) by reviewing relevant publicly available materials and conducting informal discussions with Washington State Health Care Authority (HCA) staff and leadership. Publicly available materials included ACH implementation plans, project plans, and semi-annual reports. The qualitative team reviewed these documents and began to populate a “matrix.” The matrix is a strategy to categorize and group information extracted from the reports, including topics such as ACH target populations for improvement, project selection, governance structure, Domain 1 activities, and project partners. This allowed our team to compare ACH infrastructure and activities. Categories were refined as our review progressed, and we began to distill key differences, similarities, and unique factors among the ACHs.

## Qualitative Data Collection and Analysis

The qualitative team consulted HCA to develop an initial list of key informants at the State. We aimed to select people across diverse departments and with a range of perspectives. As part of each interview, we asked interviewees to recommend other experts we should talk with for a deeper understanding of issues or a different perspective. We used an iterative sampling strategy to achieve a maximum-variation sample. Our team moved between selecting some key informants for interviews, conducting interviews and analyzing the data, and then using insights from interviews to inform subsequent sample selection. The process of moving between selection, data collection, and analysis helped ensure that a full range of ideas and perspectives surfaced.

Semi-structured interviews with 14 key informants at the State were conducted between January and April, 2019. Interviews lasted approximately one hour and were conducted using video software or over the phone. Interview guides were tailored for each interviewee based on their area of expertise. During the interviews, participants shared their perspectives on State priorities and MTP efforts. We explored influential state policy, contextual history, and vision for MTP, which provided context for Aim 1. Topic areas such as value-based payment (VBP), workforce capacity, health information technology (HIT), data analytics, long-term supports and services (LTSS), and Foundational Community Supports (FCS) informed our understanding of the other aims.

Following data collection with State key informants, qualitative team members traveled to all nine ACHs to better understand ACHs’ experience with MTP. We conducted hour-long in-person interviews; however, some interviews were done remotely using video conferencing software to accommodate ACH scheduling needs. Prior to each site visit, the team thoroughly reviewed publicly available ACH materials (e.g., project plans, semi-annual reports, and the ACH website). The team used this information to refine and tailor the interview guides and prepare for a planning call with ACH leaders. Typically, the team completed five to nine interviews at each site visit, with the exact number of interviews based on the ACH’s size, number of selected health improvement projects,

and organizational structure. The qualitative team worked directly with each ACH to identify key participants to interview. From May to November of 2019, the qualitative team conducted 60 semi-structured ACH-level interviews.

Interviews were professionally transcribed, and transcripts were de-identified and entered into Atlas.ti (Version 8, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management and analysis. Data were analyzed using an immersion-crystallization approach. The qualitative team reviewed the data together and built a code list. Team members listened to the audio recordings, read the transcripts, and met weekly to discuss emerging findings. Team members then reviewed the collected text that was tagged with specific codes, identified patterns, and summarized high-level findings. The qualitative team held regular analysis meetings to thoroughly discuss, examine, and interpret the interview data. The qualitative team also maintains “case” summaries of that describe each ACH’s characteristics, efforts, and achievements based on review of publicly available materials and interview transcripts. These analytic summaries provide the opportunity to coalesce information from documents and interview data to develop a clearer and more holistic understanding of each ACH. These summaries facilitate the analysis process and create content to facilitate cross-case comparison.

The qualitative team periodically shares findings with a key stakeholder from each ACH, as a form of “member checking,” a qualitative research verification step that is accomplished by asking key informants to confirm that study findings are reasonable. The team then considers the feedback and shares proposed revisions, where applicable, back to the stakeholder to improve data reliability.

Finally, the evaluation team has conducted periodic mixed-methods meetings. During these meetings, both the quantitative and qualitative teams come together to discuss research data and findings. Usually, meetings center on qualitative or quantitative data presentations by analysts, who then facilitate a discussion on what the data mean, what questions arise, and how the quantitative and qualitative data might inform the other. These meetings allow for research analysts to leverage the team’s data to have a deeper understanding of transformation and their teammates’ data, pivot based on new information, allow different perspectives for richer analysis, and create alignment.

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