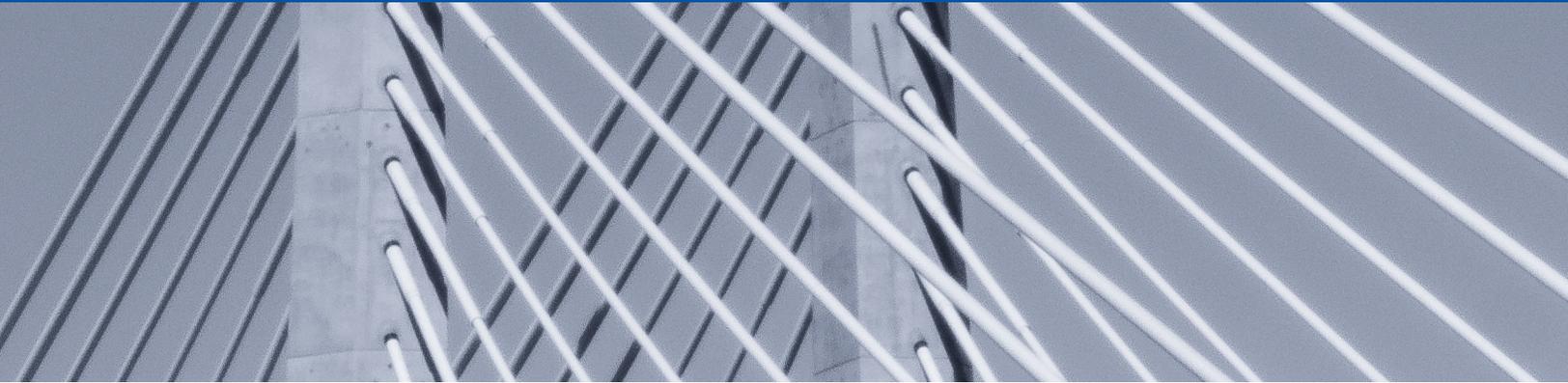


Medicaid Transformation Project Evaluation

Rapid-Cycle Report

December 31, 2019 (Revised April 13, 2020)

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS



Prepared for:

Washington State Health Care Authority



Medicaid Transformation Project Rapid-Cycle Report

Overview

This report covers activities from CHSE's evaluation of Washington State's Medicaid Transformation Project (MTP) from October 1 to December 31, 2019. By the end of this period, CHSE had completed site visits and key informant interviews with all Washington State accountable communities of health (ACHs). Also in this period, we began analyzing performance metrics data from the Washington State Health Care Authority (HCA) and the Department of Social and Health Services (DSHS), as well as data from our surveys of hospitals and primary care practices, and we held three mixed-methods analysis meetings to begin synthesizing these data with qualitative data from interviews.

Following a summary of our accomplishments in this period, this report compares the first three ACHs where we conducted interviews and site visits on six dimensions. This comparison reveals noteworthy differences in ACHs' approaches to health care transformation and indicates additional areas for future inquiry and data collection.

Accomplishments

In this reporting period, we began synthesizing qualitative and quantitative findings for the March 2020 Baseline Report, which will describe the capabilities of Washington State's Medicaid system and the work of ACHs through 2018. In addition, we continued outreach to collect hospital and primary care practice surveys, and we held calls with ACHs about their project target populations to inform quantitative analysis for future reports.

Foundational Tasks

We held three mixed-methods analysis meetings to bring together qualitative findings from the first six ACHs we visited in 2019 and quantitative findings from performance metrics data and provider organization surveys. At each meeting, analysts presented qualitative or quantitative findings to the combined evaluation team and facilitated a discussion about further questions, mixed methods interpretations, and conclusions drawn from the data. These meetings enabled each team to acquire an in-depth understanding of each other's analytic processes, adjust data collection and interpretation based on new information, hear different perspectives that informed future analyses, and align findings across teams.

Key Informant Interviews

From May to November of 2019, the qualitative team conducted 60 interviews with ACH stakeholders and completed site visits with all nine ACHs. Most interviews were conducted in person at each ACH location, with the remainder conducted by videoconference or phone. In this reporting period, qualitative analysts continued to code data from interviews and site visits and prepare analytic or "case" summaries for each ACH. (See the September 2019 rapid-cycle report for details about the data

collection and analysis process.) The summaries include one-page abstracts that succinctly describe each ACH followed by longer 10 to 15 page summaries that capture structured details about each ACH on a set of dimensions. To prepare the summaries, a single analyst reviewed transcripts and publicly available documents, drafted the summary, and met with other analysts to review and discuss the materials. These analysis meetings allowed for debate and rich discussions where individuals shared their varying perspectives about the data. The analyst revised the materials and circulated them to the larger evaluation team for review. Case summaries have been used to facilitate mixed-methods meetings (as described above) and compare and contrast ACHs on different dimensions (as described in the next section of this report).

The qualitative team met regularly to refine the qualitative codebook and coding strategies used to organize and tag qualitative data with thematic codes. This allowed the team to identify emerging themes, refine code definitions, and identify knowledge gaps that will inform Round 2 key informant interviews, scheduled for February to July, 2020.

Within the next three months, we will hold an additional mixed-methods analysis meeting to review findings from the last three ACHs we visited and incorporate findings from Round 1 interviews into the March 2020 Baseline Report. In addition, we will prepare interview guides and begin scheduling Round 2 interviews with the State and ACH stakeholders.

Administrative Data Analysis

In this reporting period, we used detailed administrative from HCA and DSHS, covering Q2 2016 through Q3 2018, to create descriptive plots of performance metrics for state as a whole, each ACH region, and key subgroups (e.g., Medicaid members by race/ethnicity). This effort included determining how to appropriately apply criteria for including or excluding certain Medicaid populations in each metric; standardizing and formatting metrics data; creating and updating code books and lookup tables for the data; and creating plots. At our first mixed-methods meeting, we reviewed metrics data and interview findings for the first three ACHs where we conducted interviews and site visits.

Using input from mixed-methods meetings, we began designing data displays for the March 2020 Baseline Report and developing R code to automate these displays. In addition, we developed R code to flag subgroups not already identified in enrollment files. For example, we developed code to identify people with chronic conditions using Centers for Medicare & Medicaid Services Chronic Conditions Warehouse (CCW), and we began developing code to identify people with severe mental illness based on the CCW.

In addition to preparing data for the Baseline Report, we facilitated calls with seven ACHs to inform quantitative analysis for the Interim and Final Evaluation Reports. On these calls, we asked ACH leadership and data teams to describe their approaches to defining target populations for each of their health improvement projects, including any changes to approaches documented in their 2018 semi-annual reports; and to provide feedback about our proposed method for identifying their target populations in administrative data. This information will help us define “treatment” and “comparison” cohorts for analyzing the impacts of health improvement projects.

Within the next three months, we will finalize code to identify subgroups and create data displays for the Baseline Report. A key step will be using an address table provided by HCA to stratify results by rural/urban areas and high-poverty areas. We will stage data from the November data refresh, which includes data through Q4 2018 and additional performance metric results, and use these data for the

report. In addition, we will continue coding subgroups needed to identify ACHs' target populations, leveraging contextual information from calls with ACHs.

Hospital and Primary Care Practice Surveys

In this reporting period, we continued contacting hospitals and primary care practices in the survey sample we created based on lists from the Washington State All-Payer Claims Database. The lists did not include contact information for hospital and practice personnel. As a result, we have needed to “cold call” hospitals and practices using phone numbers on public websites and speak with multiple personnel to identify the right person to receive the survey at each site. We used the following steps to boost survey response rates:

- On a weekly Transformation Alignment Call, we presented an evaluation update and asked ACHs to remind their hospital and practice partners about the surveys.
- We worked with HCA to add update about the evaluation and surveys to HCA's October 23 Healthier Washington newsletter.
- From late September through the end of October, we brought on temporary staff to help with outreach.
- We obtained permission from the Washington State Institutional Review Board to ask ACHs for assistance with reaching contact people at partnering hospitals and practices.
- We extended the deadline for closing the survey from November 2019 to January 2020.

While continuing survey outreach, we carried out preliminary analysis of survey responses received through early October. This effort included developing code to “weight” practice survey responses in order to account for oversampling in our sample design and compute population estimates for the state as a whole and tabulate responses. We reviewed the preliminary survey responses at our December mixed-methods meeting and began developing code to present the results in an engaging meaningful way for the Baseline Report. While additional survey responses may shift our population estimates, the process of carrying out preliminary analysis and presenting results will enable us to efficiently analyze the updated responses.

Within the next three months, we will focus on increasing survey response rates. Using responses as of January 31, we will produce population estimates for Baseline Report. These estimates will be important for understanding levels of value-based payment adoption, health workforce capacity, and health information technology use at the outset of ACHs' health improvement projects.

Comparison of Three ACHs Across Dimensions

Our September rapid-cycle report focused on early findings from interviews with ACH key informants. This report focuses on findings from the first three ACHs where we conducted interviews and site visits: Southwest Washington ACH (SWACH), Cascade Pacific Action Alliance (CPAA), and Olympic Community of Health (OCH). Leveraging our updated case summaries, we compare these ACHs on six dimensions: organizational history; involvement with integrated managed care (IMC), approach to change and health improvement projects; approach to addressing social determinants of health (SDOH); relationships with tribes; and relationships with MCOs.

ACHs can be compared on many dimensions. The comparisons in this report highlight noteworthy differences among ACHs and indicate additional areas for future inquiry and data collection.

► KEY FINDINGS:

- **Organizational history:** SWACH and CPAA were established by regional health care stakeholder organizations that existed before the establishment of ACHs. In contrast, OCH was established by a public health district, and appears to meet a previously-unmet need for bringing partners together.
- **Involvement with Integrated Managed Care (IMC):** The organization that established SWACH supported early implementation of IMC in the SWACH region. Regional Behavioral Health Organizations (BHOs) lead the IMC transition in the CPAA region, where CPAA played an important role in supporting the transition. OCH actively supports implementation of IMC, but key informants consider it a “distraction” and a barrier to addressing other areas of focus for MTP.
- **Approach to Change and Health Improvement Projects:** SWACH and CPAA provide partners with a high level of flexibility to design and implement projects. In contrast, OCH uses a more prescriptive approach that requires partners to select from a list of pre-specified tactics and outcomes.
- **Approach to Addressing Social Determinants of Health (SDOH):** SWACH and CPAA serve as Pathways Community HUBs, with the goal of coordinating health care and social services for Medicaid members with complex needs. OCH appears more clinically focused and has relatively few non-clinical partners.
- **Relationship with Tribes:** CPAA informants explain that building trusted relationships with tribes takes time; tribes in their region participate in health improvement projects, and CPAA tailors its communication efforts to individual tribe preferences. OCH appears to have exceptionally positive relationships with seven tribes in its region. SWACH used help from HCA and another ACH to engage one of the tribes in its region.
- **Relationship with managed care organization (MCOs):** CPAA informants recognize MCOs as critical partners for strategic decision-making and project implementation, hoping to work toward alignment and shared ownership. SWACH and CPAA informants described the potential for even greater involvement in MTP from MCOs. OCH informants described a positive relationship with MCOs in the region, which may have resulted from cooperation on implementing IMC.

Organizational History

ACHs were established between 2015 and 2016 using funding from a State Innovation Model grant (Center for Community Health and Evaluation 2019, 5). Across the state, different kinds of local organizations helped establish ACHs and serve as ACH “backbone” organizations, providing ACHs with operational support. The organizational history of ACHs, and ACHs’ relationship to their backbone organizations, may shape ACHs’ capabilities, approaches to change, and successes on specific projects.

SWACH

SWACH was established by the Regional Health Alliance (RHA), a collaborative of clinical, community, and county leaders that existed before MTP. Following its establishment as an ACH, SWACH integrated with Healthy Living Collaborative (HLC), a grassroots organization focused on care coordination across Southwest Washington. Collaboration with HLC, a community-based advocacy organization with a longstanding “footprint” in Southwest Washington, may explain SWACH’s emphasis on sourcing ideas from the community. In addition, the integration of SWACH and HLC, and a subsequent SWACH leadership transition, appears to have focused the ACH on community-based care coordination (described below).

CPAA

CPAA was established by the CHOICE Regional Health Network (CHOICE), a non-profit collaborative of health care leaders from hospitals, health systems, 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 a separate board and budget from CHOICE, CPAA staff are CHOICE employees, and CPAA shares some of the same board members as CHOICE. CPAA staff have roles and responsibilities in both organizations, and many of its partners are the same. Given this overlap, CPAA staff report partner confusion when distinguishing between CHOICE and CPAA led programs.

OCH

In contrast with other ACH regions, the OCH region did not have a collaborative organization that brought health care leaders and organizations together before the establishment of ACHs. As a result, OCH appears to meet a previously-unmet need for bringing partners together in the region. OCH was established by Kitsap Public Health District and currently operates as a separate entity. OCH continues to contract with the Kitsap Public Health District for data analytics and assessment work.

Involvement with Integrated Managed Care (IMC)

Integrated managed care (IMC) means that a single Medicaid managed care organization (MCO) covers both physical and behavioral health care for its members. In 2014, the Washington State Legislature required county authorities in all regions of the state to implement IMC by January 2020. MTP provides incentive payments to ACHs in regions that chose to implement IMC before the deadline (Washington State Health Care Authority, n.d.).

SWACH

Two of three counties in the SWACH region implemented IMC before ACHs were established, and SWACH serves as an IMC resource for some other ACHs. Prior to the establishment of SWACH, the Regional Health Alliance (RHA) supported IMC in Clark and Skamania Counties, the first two counties

in Washington State to implement IMC. Klickitat County joined the SWACH region after the ACH was established, and the county implemented IMC in 2019.

CPAA

Counties in the CPAA region will implement IMC in 2020. County authorities decided that the two BHOs—managed care plans that administered behavioral health care services before the transition to IMC—should lead the transition to IMC. While CPAA is not the lead entity for the IMC, CPAA has supported the transition in multiple important ways. CPAA developed a Provider Readiness Workgroup to convene and help providers prepare for IMC. To support behavioral health provider organizations with the transition, they organized a training on MCO contracting, provided financial support to adopt new or enhance their existing electronic health records (EHRs), and contracted with Xpio deliver technical assistance on EHR use and implementation.

OCH

OCH key informants describe IMC as a “distraction.” All three counties in the OCH region will adopt IMC by the 2020 deadline. One county has no prior experience with Medicaid managed care, making the transition to IMC more challenging. OCH is actively involved in the transition to IMC. For example, OCH meets monthly with MCOs, the BHO in its region, and HCA to track contracting status and discuss processes and workforce needs for IMC. Key informants described lack of capacity to work on IMC implementation and MTP projects simultaneously. They plan to address multiple areas of focus for MTP—including health equity and health system capacity—after IMC implementation.

Approach to Change and Health Improvement Projects

MTP requires each ACH to implement one required project and at least one other project each in two domains:

- Domain 2: Care Delivery Redesign
- Domain 3: Prevention and Health Promotion

The following table shows projects selected by SWACH, CPAA, and OCH.

Projects Selected by CPAA, OCH, and SWACH

ACH	2A Bi-Directional Integration (Required)	2B Care Coordination	2C Transitional Care	2D Diversion Interventions	3A Addressing the Opioid Use Crisis (Required)	3B Reproductive and Maternal or Child Health	3C Access to Oral Health Services	3D Chronic Disease Prevention and Control
CPAA	✓	✓	✓		✓	✓		✓
OCH	✓			✓	✓	✓	✓	✓
SWACH	✓	✓			✓			✓

Source: July 2019 partnering provider rosters

For each project in Domain 2 and 3, ACHs must use one or more “evidence-based approaches” identified by HCA or a similar approach subject to HCA approval. The Project Toolkit, a document published by HCA, specifies the evidence-based approaches for each project, along with a broadly defined target population that each project must serve, milestones that an ACH must achieve to earn payments for project implementation, and metrics that must improve among Medicaid members in the

ACH's region for the ACH to earn payments for performance (Washington State Health Care Authority 2019a). HCA required ACHs to define specific target populations they intend to serve with each project.

SWACH

Staff describe SWACH as a convener, facilitator, and “dot connector” that brings multiple voices and perspectives to the table for planning and implementing projects. SWACH grants its partner organizations substantial flexibility with projects, such as flexibility to select target populations. SWACH views its four projects as related and interdependent. For example, SWACH's proposed project to address opioid misuse incorporates bi-directional integration (the focus of Project 2A), community-based care coordination (the focus of Project 2B), and chronic disease prevention and control (the focus of Project 3D). SWACH appears less focused on pay-for-performance metrics than some other ACHs.

CPAA

CPAA staff describe the ACH as a neutral convener and educator. This role includes communicating information from HCA and providing training or technical assistance through learning collaboratives. CPAA conceptualizes all projects as using the principles of “whole-person care,” rather than specific models from the Project Toolkit. Overall, CPAA's approach allows for partner flexibility in project implementation, as each partner selects the target populations, milestones, and metrics used to track implementation of its projects.

OCH

OCH used a relatively prescriptive approach to set the direction for health improvement projects. It reorganized the projects into four domains and created a change plan template for each partner organization type: primary care practices, behavioral health provider organizations (community mental health organizations and SUD providers), hospitals, and community-based organizations. Each template included a list of transformation options for partners to choose and corresponding outcomes for partners to report twice a year. Partners were required to carry out options and report outcomes across multiple project areas, meaning providers must work on multiple projects areas simultaneously. However, OCH allows partners to select the target populations for their projects.

CBOs may have been dis-incentivized from participating in contracts initially as the funds flow model was based on Medicaid volume, and these organizations typically don't have the reporting capacity to determine Medicaid volume. As a result, key informants suggested this may have affected the number of non-clinical partners working on projects with OCH (described below).

Approach to Addressing Social Determinants of Health (SDOH)

Social determinants of health are the conditions in which people are born, grow, live, work, and age (Artiga and Hinton 2018). They include factors like housing, employment, and community environments. Together, these factors exert a powerful influence on health outcomes.

Several aspects of MTP are intended to address SDOH. ACH decision-making bodies must include community partners that provide services to address SDOH within ACH regions. Project Toolkit models for several health improvement projects incorporate interventions to address SDOH. For example, Project 2B addresses health and social service needs of people with complex health care needs using the Pathways Community HUB model. Under this model, 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 (Pathways Community HUB Institute, Community Care Coordination Learning Network 2016).

SWACH

SWACH views health care transformation as contingent upon building a bridge between clinical and community partners. SWACH's emphasis on clinical-community linkages fits with its approach to Project 2B. SWACH itself serves as the Pathways Community HUB for the project, meaning that it coordinates the work of community health workers from four care coordinating agencies and serves as the payer for their services.

The integration of the Healthy Living Collaborative into SWACH, and a subsequent SWACH leadership transition, appears to have focused the ACH on community-based care coordination (described above). Prior to integrating with SWACH, HLC “launched three neighborhood-level CHW programs, a school-based CHW program, and supported a network of community health workers and advocates.”

CPAA

CPAA addresses the SDOH through trainings, food security, and the Pathways HUB Model. Like SWACH, CPAA serves as the Pathways Community HUB for Project 2B, which they refer to as Community CarePort. CPAA staff see themselves as “air traffic controllers,” connecting partners among different service delivery systems. They started the HUB with five contracted care coordination agencies and expanded to 12 agencies, reaching patients in all seven counties. CPAA uses technology platforms called Care Coordination Systems and HealthBridge to support its Pathways Community HUB.

In addition to its HUB work, CPAA provides trainings on topics such as the SDOH, trauma-informed care, implicit bias, and health equity, among others. 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.

OCH

OCH's approach to change appears clinically focused. It has relatively few non-clinical partner organizations and places less emphasis on SDOH than some other ACHs. Its funds-flow model (described above) may have dis-incentivized small community-based organizations from participating in projects because it links funding to the number of Medicaid members served by partners, and some CBOs cannot calculate how many Medicaid members they serve. OCH's involvement in the transition to IMC (described above) may also account for its current limited emphasis on SDOH, and stakeholders expressed a desire to focus more on SDOH following the transition.

OCH is contracting with Quad Aim Partners to implement a community information exchange (CIE) that will enable community-based organizations to access data on the clinical and social needs of Medicaid members. OCH is not a HIPAA covered entity, meaning it cannot be the owner of the CIE. As a result, OCH intends to identify a HIPAA-covered partner, such as a public health district, to serve as the CIE owner.

Relationship with Tribes

All ACH regions include tribal reservations and tribal clinics. Washington State's Medicaid waiver requires ACHs to include representatives from the tribes, Indian Health Services facilities, or urban Indian health providers in ACH governance. In addition, the waiver requires ACHs to adopt a policy for communicating and collaborating with tribes and Indian health care providers, and to receive training on the needs of tribal and urban Indian populations in their regions (Centers for Medicare & Medicaid Services 2018, 14–16).

SWACH

SWACH established partnerships with two sovereign nations: the Cowlitz Indian Tribes and the Confederated Tribes and Bands of the Yakima Nation. The ACH has a longer relationship with Cowlitz Tribe and works with the Tribe as a stakeholder and contracted clinical partner. SWACH used help from HCA and Greater Columbia ACH, whose boundaries also include the Yakama Nation, to engage the Tribe. In addition, SWACH and Greater Columbia ACH committed funds to help Yakama Nation with behavioral health care integration.

CPAA

There are seven tribes in the CPAA region, and CPAA acknowledges that building trust with seven different sovereign nations, after a long history of distrust, is challenging and takes time. To support this process CPAA suggests the 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. They have also hired a tribal liaison who serves as a trusted representative, meets one-on-one with each tribe, and facilitates regular meetings between of the Tribal Health Directors and CPAA. Tribes are committed to several health improvement projects, including efforts that focus on opioid response activities, and the liaison works directly with them on change plans and requests for technical assistance.

OCH

OCH appears to have exceptionally positive relationships with most of the tribes in its area. OCH's Opioid Response Project Director worked closely with six of the tribes for several decades, and the OCH includes one seat for each tribe on its 22-seat governing board. OCH engaged the tribes early by asking them how they wanted to work with OCH. The tribes requested in-person meetings to learn about MTP, as well as information about the benefits and the costs of involvement with OCH.

Relationship with MCOs

Washington State uses managed care to provide health coverage for most Medicaid members. Under managed care, the State makes per capita payment to Medicaid managed care organizations (MCOs) for each person enrolled in coverage. MCOs, in turn, use funds from these payments to pay health care providers for care rendered to Medicaid members. Currently, five MCOs provide coverage for enrollees in different regions of the state (Washington State Health Care Authority 2019b). Washington State's Medicaid waiver requires MCOs to “serve in a leadership or supportive capacity in every ACH,” participate in design and implementation of health improvement projects, and implement value-based payment arrangements (Centers for Medicare & Medicaid Services 2018, 19–20).

SWACH

MCOs that provide coverage in the SWACH region attend meetings with the ACH but vary in terms of their engagement and involvement with health care transformation. For example, one MCO expressed interest in engaging with the ACH, while another wanted to limit involvement with the ACH to exchanging information about the MCO's and ACH's activities.

CPAA

CPAA staff view MCOs as critical transformation partners. MCOs are engaged with CPAA through representation on CPAA's board and council. They also participated in contracting training and Q&A sessions for the region's behavioral health care providers. CPAA key informants described the potential for even greater involvement from MCOs, such as having MCOs pay for the Pathways Community HUB, and they desire closer collaboration and strategic planning to sustain partner health improvement projects after MTP ends.

OCH

In contrast to other ACHs, OCH key informants describe a close and communicative relationship with MCOs in OCH's region. One OCH informant described MCO leadership and staff as responsive, and described good communication between her and the MCOs. Cooperation on implementing IMC in the region may help explain this relationship.

Next Steps

We will conduct Round 2 interviews with MTP key informants from February to July, 2020. Comparison of ACHs in this report indicates additional areas for inquiry and data collection in Round 2:

- Washington State's Medicaid waiver defines a role for MCOs in supporting ACHs, health improvement projects, and VBP. Key informants from two ACHs described the potential for greater involvement in MTP from MCOs. A limitation of our Round 1 interviews is that they did not include MCO key informants. We anticipate interviewing MCO representatives as part of Round 2 interviews in order to capture their perspective on, and involvement with, MTP.
- Key informants from OCH described plans to address additional areas of focus for MTP after IMC implementation. We anticipate following up with OCH informants as part of Round 2 interviews to capture their efforts following the IMC transition.
- Our Round 1 interviews underscore that ACHs are quickly evolving and dynamic organizations. As a result, updating information on ACH dimensions described in this report through future interview rounds will be critical for understanding MTP and explaining the program's impacts.

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