

Medicaid Transformation Project Evaluation

Rapid-Cycle Report

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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's Medicaid Transformation Project (MTP) from April 1 to June 30, 2019. In this period, CHSE completed the first round of interviews with key informants from Washington State agencies. In addition, we began recruiting and conducting interviews with key informants from Washington State's accountable communities of health (ACHs), and made progress on initiating administrative data analysis and provider organization surveys. Following a summary of our accomplishments in this period, this report summarizes findings from the first round of state agency key informant interviews.

► KEY FINDINGS:

- *Previous initiatives and legislation in Washington provided a foundation for MTP and health system reform efforts.*
- *Managed care organizations are meeting value-based payment (VBP) goals but providers, especially smaller provider organizations, need more support to adopt VBP models.*
- *MTP has encouraged a coordinated approach to addressing workforce capacity in the state, and state administrators are considering various strategies to enhance training and address workforce shortages.*
- *More support is needed from the state to enhance population health management and the use of health information technology (HIT) and health information exchange (HIE). Many HIT and HIE tools exist and are being used, which poses challenges to information exchange and interoperability.*
- *Long-Term Supports and Services (LTSS) is showing promise and leverages the state's history and experience in addressing long-term needs. LTSS remains somewhat separated from the other MTP activities, and alignment with the other initiatives may support the success of this program and the state's vision.*
- *Foundational Community Services (FCS) has roots in legislative direction, and MTP provided a way to fund this work. FCS is using evidence-based models to deliver the benefits and Division of Behavioral Health and Recovery is monitoring the model fidelity. Beneficiaries are able to access FCS benefits from multiple points of access to improve reach to those who need services. Partners involved in FCS, which are generally community-serving or community-based organizations, had little experience with Medicaid and its billing structures. With no planning phase, there was a steep learning curve to deliver these benefits. Lack of available housing limits the ability to help beneficiaries find and keep housing using FCS benefits, which in turn limits the capacity to properly staff employees to provide the housing benefits.*

Accomplishments

Foundational Tasks

CHSE submitted a study amendment request to the Washington State Institutional Review Board (WSIRB) for additional administrative data needed to carry out the evaluation, and received approval for the request from WSIRB. In addition, CHSE amended its data confidentiality agreement to use the additional data with assistance from WSIRB.

Key Informant Interviews

The qualitative team completed the first round of interviews with key informants from Washington State agencies, including the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS), and began analyzing data from the interviews. In addition, the qualitative team began recruiting key informants from ACHs, and conducted initial site visits with three ACHs. Site visits enable the qualitative team to collect preliminary information about an ACH and schedule follow-up interviews with ACH staff and stakeholders. The qualitative team will continue to recruit and conduct interviews through fall 2019.

Administrative Data Analysis

Following WSIRB approval for use of additional administrative data and amendment of the confidentiality agreement, the quantitative team received the data and began organizing the data into an evaluation database. Within the next three months, the quantitative team will begin using these data to analyze trends in performance metrics for ACH regions and subgroups of Medicaid members, and to identify the target populations of ACHs' health improvement projects in order to evaluate the impact of these projects.

Primary Care Practice and Hospital Surveys

CHSE completed pilot testing of the surveys at four sites, including two primary care practices and two hospitals in Washington State. Using feedback from pilot testing, we revised the surveys and prepared web versions for final review and approval by HCA and DSHS. In addition, we received lists of Washington State primary care practices and hospitals from the Washington All Payer Claims Database that we will use to administer the surveys and began finalizing our methodology for creating the sample of primary care practices to survey. Using information from the list, we began contacting hospitals to identify staff who should receive the survey. We anticipate beginning to contact staff at primary care practices in August, after creating the practice sample. We plan to use ACHs' partnering provider rosters submitted in July to ensure that our sample contains a sufficient number of practices working with ACHs on health improvement projects.

Findings from Key Informant Interviews

Overview

This report summarizes findings from Round 1 interviews with 14 state agency key informants who have knowledge of and experience with MTP. The report will cover our qualitative methodology and provide a narrative summary that begins to address the following evaluation research aims:

- Aim 1: Assess overall Medicaid system performance
- Aim 2: Assess progress toward meeting value-based payment (VBP) targets
- Aim 3: Assess the impact of MTP on workforce capacity needed to support health system transformation
- Aim 4: Assess the impact of MTP on the adoption and use of health information technology (HIT)
- Aim 6: Assess implementation and impact of Initiative 2, Long-Term Services and Supports (LTSS)
- Aim 7: Assess implementation and impact of Initiative 3, Foundational Community Supports (FCS)

Methods

We consulted the Washington State Health Care Authority (HCA) to develop an initial list of key informants and their contact information. 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 stakeholders were conducted between January and April, 2019. Interviews were approximately one hour and were conducted using video software or over the phone. 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. The topic areas of VBP, workforce capacity, HIT, data analytics, LTSS, and FCS informed our understanding of the other aims.

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 as a group to discuss emerging findings. Then team members reviewed the collected text that was tagged with specific codes, identified patterns, and summarized the high-level findings below.

Aim 1: Assess Overall Medicaid System Performance

Through interviews, we identified initial conditions that were in place in Washington prior to the start of MTP. Previous initiatives and changes to the state's organizational structure informed the state administrators' approach to MTP, provided contextual information important for understanding the region at baseline, and will inform our understanding of performance changes over time.

Previous Initiatives: Washington Did Not Start from Scratch

Prior to MTP, Washington State enacted Healthier Washington, a statewide initiative focused on health care transformation and improving population

health. Through Healthier Washington and other

efforts (grants, legislative action, and advocacy), several organizations and state staff were already implementing changes to foster whole-person care, aging in place, and supportive employment and housing. Healthier Washington set the stage for the state's focus on health care transformation in the state. The \$65 million State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI) was especially influential, as it was used to develop the Accountable Communities of Health (ACHs), conduct the Regional Health Needs Inventory to assist data-informed decision making, and help launch alternative payment models in regions of the state. The legislative mandate to fully integrate behavioral and physical health by 2020 was also critical for signaling the state's prioritization of integrated care. Key informants described MTP as a funding source, but also as a catalyst that energized and continued existing efforts and demonstrated to the legislature that these programs were worthwhile and effective.

"[SIM] ... became the seeds for the Medicaid transformation work." (State Participant 11).

Through legislative direction, the Department of Social and Human Services (DSHS) and HCA underwent an organizational restructure. The Division of Behavioral Health and Recovery (DBHR), which was formerly under DSHS, moved to the HCA. Medicaid purchasing was previously transferred from DSHS to the HCA in 2011, consolidating the state's purchasing power. MTP required leaders across multiple departments (HCA, DSHS, and the Department of Health) to work together. The multi-agency initiative and state reorganization were foundational steps in working toward the state's vision of integrating behavioral health and providing whole-person care. State interviewees anticipate that legislative direction will continue to play a role in sustaining and supporting MTP.

Aim 2: Assess Progress Toward Meeting VBP Penetration Targets

Managed Care Organizations (MCOs) are Meeting VBP Goals

Under SIM, HCA established contractual arrangements with MCOs and began incentivizing VBP adoption through an annual withhold program that continued with MTP. Performance measures were informed by the Health Care Payment and Learning Action Network (HCP-LAN) Alternative Payment Model framework. MTP requires that 90 percent of dollars paid by MCOs to providers be paid through VBP arrangements that meet the HCP-LAN categorization of 2C (i.e., Rewards for Performance) or higher by 2021. Interviews with state-level staff revealed that MCOs were essential to VBP adoption. One interviewee reported that in 2017, MCO performance or adoption was approximately 30 percent, 10 percent higher than the anticipated target, and the adoption rate was about 50 percent, which also outpaced HCA's annual goals.

Providers Need More Support

Interviews suggest that while MCOs are exceeding targets for VBP adoption, providers, particularly smaller providers (including behavioral health providers), need more resources to assume the risks of VBP adoption (i.e., billing, contracting, and establishing VBP arrangements with MCOs). Larger providers are

“We haven’t really provided a lot [of support to providers]. We’re exploring a lot of, how could we support—what are the needs, but even if we mapped [it] out, here’s everything that’s needed, we don’t currently have the resources or capacity identified to fulfill that.” (State Participant 7)

more apt to have greater resources and greater capacity to implement change and assume risk. These providers tend to be the first ones to contract with MCOs, but they are insufficient for meeting the 90 percent goal. While the HCA has begun to develop VBP technical assistance support for providers, the support offered is limited, according to interviews. Additional VBP support may be offered through the ACHs, which we will continue to explore in our upcoming ACH site visits.

Aim 3: Assess the Impact of MTP on the Development of the Workforce Capacity Needed to Support Health System Transformation

Medicaid Transformation Elicits a Coordinated Approach to Workforce Development

Prior to SIM and MTP, the state lacked coordination around workforce issues. The SIM demonstration provided an opportunity for the state to coordinate efforts across stakeholders. HCA established the Washington Health Workforce Sentinel Network (Sentinel Network), which included HCA, the state’s Workforce Training and Education Coordinating Board, and the University of Washington Center for Health Workforce Studies.

Since MTP began, the state has formed a number of partnerships in the region, especially through the Health Workforce Council, which is comprised of people from professional associations, including the Hospital Association, the Medical Association and the Nurses Association. Through these partnerships, Washington is pursuing opportunities to address workforce shortages across the state and

“The health workforce activities here tend to be focused through an entity called the Health Workforce Council. It...develop[s] clear pathways and act[s] on priorities to address what was originally termed in the legislation as shortages, but we are trying to get it expanded to say health professions, so we can be broader in refining what people do and refining competencies.” (State Participant 8)

create opportunities for education, training and career development. We will continue to follow these efforts, as most of the state’s work has focused on convening and engaging stakeholders, and the opportunities described below are only considerations.

The State is Pursuing Various Opportunities to Enhance Training and Address Demand and Shortages

HCA aims to build workforce capacity during MTP by recruiting and retaining health professionals at various levels, from paraprofessionals to nurses and physicians. There are a number of initiatives under consideration, including loan repayment, scholarship opportunities, alternative career pathways (i.e., apprenticeships), and rural health recruitment.

The state is exploring workforce reciprocity and enhancing the role of paraprofessionals to address workforce shortages. With workforce reciprocity, the state would enter into reciprocal agreements with other states to hire health professionals with an out-of-state licensure.

“We knew there was a growth of paraprofessional roles, medical assistants, a growing demand for community health worker kinds of roles, use of peer support specialists in behavioral health, but there was no real structure to look at education training.” (State Participant 8)

Recent proposed legislation to join the Nursing

Licensure Compact failed due to concerns about the changes to time requirements for gaining state nursing licensure. Workforce reciprocity also has implications for providing telehealth services to rural and underserved communities, and this approach will likely return to future legislative sessions.

Paraprofessionals (i.e., community health workers, peer counselors) were also identified as a solution to the workforce shortages; however, these roles lack standardized education and training. Establishing standards, consistency, and a set of skills and competencies that are focused on team-based care may be needed in order to thoughtfully deploy this group of individuals into the workforce.

Aim 4: Assess the Impact of MTP on Provider Adoption and Use of Health Information Technology

The State Plays a Critical Role in Improving and Promoting Consistency in Tools for Information Exchange and Population Health Management Capacity

Providers across the state use a variety of different electronic health record (EHR) and information exchange tools, including EDIE, PreManage, CommonWell, and Carequality. However, these tools are not used consistently across regions, and more work is needed to increase their use and create alignment. The state’s investments in the Clinical Data Repository (CDR), which aims to connect disparate EHR platforms and aggregates clinical information in one location, may facilitate greater use of these data. However, at this time, the CDR is not mature enough to generate aggregate clinical data to support the ACHs with their population health management needs.

ACHs have developed plans for supporting information exchange and monitoring the health of their populations, but some may need additional support to develop greater analytic capacity and sophistication. Some analytic support is currently provided by HCA, DSHS, and Providence CORE. HCA also reviewed ACH implementation plans

“As the ACHs were maturing and creating their own data teams, we were very proactive in connecting with their data teams. We actually stepped up biweekly meetings with their data teams. We started to hear from them either direct data requests or in conversations.” (State Participant 11).

in an effort to their need around population health management and information exchange. However, interviewees suggested that the state could play a greater role in guiding the ACHs and addressing data gaps, as population health data gaps have the potential to pose risks in the ability to evaluate which efforts are effective.

Aim Six: Assess implementation and impact of Initiative 2, Long-Term Services and Supports LTSS Leverages Previous Programs and Shows Promising Improvements

Compared to other states, Washington has a long history of emphasizing home and community-based services as part of its long-term care approach. This includes the Family Caregiver Program, which began prior to MTP and had limited funding. The Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs were intended to expand the Family Caregiver Program, and through the TSOA program, target individuals who were not financially eligible for Medicaid

and prevent them from spending down their assets in order to access Medicaid-funded long-term care services. Interviewees reported that these programs are showing promising reductions in cost and emergency department utilization rates. We will evaluate change in these and other outcomes associated with LTSS as part of our quantitative evaluation of MTP.

Reaching Caregivers is Challenging

Despite high demand and referrals for services, interviewees shared challenges reaching unpaid family caregivers because these individuals often do not identify as a caregiver or may not be accustomed to seeking services and help. Interviewees believe there are more eligible caregivers who have not yet engaged and enrolled in the programs. Another unanticipated outcome is that MAC and TSOA outreach efforts have increased reach and connected the Area Agencies on Aging to individuals who may benefit from LTSS programs other than MAC and TSOA.

“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.’ [We are] helping people to see that it’s okay to accept help, and it can actually help them be healthier, be a better caregiver, and be better in that role.” (State Participant 3)

Aligning LTSS with Other MTP Initiatives May Support the State’s Broader Goals

TSOA and MAC appear separate from the other initiatives. Exclusion of dually-eligible beneficiaries from the target population for Initiative 1 may be driving this separation. Dually-eligible and Medicare beneficiaries represent a significant proportion of the LTSS-eligible population. LTSS is also paid using fee-for-service models, which may further isolate it from Initiative 1, which emphasizes value-based payment models. The growing aging population has ramifications for workforce needs, health care costs and emergency department utilization, so expanding alignment efforts across the initiatives may be beneficial and help support the state’s broader goals.

Aim Seven: Assess Implementation and Impact of Initiative 3, Foundational Community Supports

Legislation Directed the Foundational Community Supports Program

Foundational Community Supports (FCS) are a set of Medicaid benefits which aim to help individuals with complex health needs obtain and maintain housing and employment stability. Prior to MTP, the legislature directed the DBHR to begin measuring homelessness and employment among the behavioral health population. A subsequent bill directed implementation of supportive housing and supported employment services and the use of evidence-based promising practices for achieving those outcomes. While these bills provided legislative direction to implement these services, it did not include funding to pay for additional services, and DBHR applied for the 1115 waiver to implement these services.

FCS is using Evidence-Based Models and DBHR is Monitoring Fidelity

The models for supported employment and supportive housing are based on evidence-based programs that were recommended by Washington State Institute for Public Policy (WSIPP), and the state has leveraged formal toolkits for these programs that were developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). DBHR’s current role is to oversee the program and ensure quality assurance and fidelity to the evidence-based models.

Beneficiaries Can Access Services Through Multiple Pathways

Beneficiaries can enroll in FCS programs through a variety of health care and community serving providers in the region. Amerigroup, the third-party administrator, is currently contracted with over 100 agencies with more than 300 sites across the state. FCS providers are paid using a fee-for-service billing infrastructure, and all FCS providers must be credentialed Medicaid providers.

Partners Experienced a Steep Learning Curve

Several FCS provider organizations are community-serving organizations that had little experience with the health care system and had never contracted with Medicaid prior to this program. These organizations 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.

Housing Availability Impacts Enrollment and Staffing Structure

Interviewees reported that enrollment in supportive employment has been higher than supportive housing. This may be related to limited housing availability that is needed to accompany the supportive housing benefit, as FCS does not create more affordable housing or pay for housing infrastructure that is needed to successfully house an individual. Interviews described an ongoing need for partnerships, especially with the Department of Commerce, as they are critical partners in creating affordable housing that's needed to pair with the supportive housing FCS benefit.

“We can provide the services to pay for or to help somebody obtain and maintain that housing, but we still need the subsidies to be able to pay the rent. We’ve developed a strong relationship with the Department of Commerce, but they really actually need the funds to be able to pay those rents. That’s been some focus of the legislature this year.” (State Participant 2)

The lack of affordable housing availability also impacts organizations' ability to staff individuals to provide the supportive housing benefit. For example, if an organization only has two housing openings a month, and a caseload of two FCS beneficiaries, then the revenue generated from those two cases is not enough to sustain a staff member, requiring organizations to pay for those positions through philanthropic dollars or other resources.

Next Steps

The qualitative team has begun recruiting and conducting interviews with the ACHs. Each site visit to an ACH begins with an informal call with the Executive Director or Chief Executive Officer of the ACH to discuss the logistics of our visit and allow an opportunity for us to learn more about the ACH. During this call, we also cover recommendations on who we should interview to cover topics related to our research questions. We plan on conducting approximately three to six in-person interviews with each ACH and will continue to recruit and conduct interviews through the fall of 2019.