

Medicaid Transformation Project Evaluation

OHSU CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

RAPID-CYCLE REPORT

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MEDICAID TRANSFORMATION PROJECT

Rapid-Cycle Report

This report covers activities and findings from CHSE's evaluation of Washington's Medicaid Transformation Project (MTP) from July 1 to September 28, 2018. In this period, CHSE focused on laying groundwork for the evaluation. We submitted an application for to Washington State Institutional Review Board (WSIRB), delivered presentations to State agency and accountable community of health (ACH) partners, and gained background knowledge of MTP through meetings with State subject matter experts. We also analyzed documents to understand differences, similarities, and unique characteristics among ACHs.

KEY TAKEAWAYS

- *Through document analysis, we learned that ACHs vary on important dimensions, such as governance structures, approaches to engaging partners, and the number and type of models chosen to guide their health improvement projects. For example, some ACHs have sub-regional groups that serve their boards, and some have especially well-defined mechanisms for engaging partners.*
- *ACH activities around value-based payment (VBP), workforce transformation, and health information technology (HIT) are in a development phase, with progress and specificity of planned activities varying across the ACHs. Notably, ACH documents lack detailed or concrete plans for VBP, and ACHs generally seem unsure of how to approach VBP. ACHs described common challenges related to expanded use of community health workers (CHWs) and electronic health records (EHRs).*
- *Across ACHs, there is variation in the type and number of models chosen for health improvement projects in a given area, while within ACHs there are common elements or cohesiveness across different kinds of projects.*
- *Long-Term Supports and Services (LTSS) and Foundational Community Supports (FCS) initiatives are largely separate from the ACH work.*

Foundational activities in this period will help us launch data collection and analysis next quarter. With data from document analysis, we will refine our key informant interview guide and launch key informant interviews with State leaders, ACHs, and other stakeholders. We will also meet with HCA and DSHS to identify the full set of quantitative data needed for the evaluation and refine our provider organization survey questionnaire to assess the impact of MTP among primary care clinics and hospitals.

EVALUATION PROGRESS REPORT

Accomplishments

- We submitted an application for Washington State Institutional Review Board (WSIRB) review of the evaluation on July 12. The submission described our planned data collection and analysis activities for all evaluation aims, and included outreach materials and an interview guide for key informant interviews with State officials, ACH leaders, and partner organizations; we plan to add outreach materials and data collection instruments for provider organization surveys and interviews to the WSIRB submission by amendment. We also worked with HCA and DSHS to specify an initial set of quantitative data elements for the evaluation, which HCA submitted to WSIRB as application Appendix G on September 12.
- We delivered presentations about our plans for the evaluation to State agency staff and ACH leaders on July 16 and August 27, respectively. We believe these presentations will help build foundation for cooperation with agency staff and ACHs throughout the evaluation.
- In August, we met with State subject matter experts in the areas of VBP, HIT, workforce transformation, LTSS, and FCS to learn about these components of MTP. These meetings have helped us refine questions for key informant interviews, select metrics for quantitative analysis of LTSS and FCS, and select items for provider organization surveys.
- Led by our qualitative team, we analyzed ACHs' project plans and first round of semi-annual reports and used these documents to create an ACH "matrix" that captures key variables about ACHs and their projects. The matrix has helped us understand similarities and differences across ACHs (see Section Waiver Progress below), and will help us formulate questions for key informant interviews. In addition, our quantitative team analyzed the semi-annual reports in order to begin identifying the target population for each ACH's projects, which has helped us document additional quantitative data needed for the evaluation (see Key Decisions and Actions below).
- We delivered a draft provider organization survey questionnaire to HCA and DSHS on September 10. The questionnaire included 15 potential items tailored to evaluating progress on MTP's VBP, HIT and workforce transformation goals.

Key Decisions and Actions

- Our quantitative team will meet with HCA and DSHS on October 12 to discuss additional quantitative data needed for the evaluation. Our goal is to agree on a comprehensive list of data elements that can be used to amend the WSIRB submission.
- We will meet with State subject matter experts on October 22 to collect feedback on the draft provider organization survey questionnaire. We plan to discuss options for the provider organization list that we will use to create the survey sample in November.
- Representatives of our team will attend the ACH Learning Symposium on Oct 24 and, meet with DSHS staff to learn about eligibility and enrollment process for MAC and TSOA benefits on Oct 25.

WAIVER PROGRESS

We analyzed project plans and semi-annual reports from each ACH, and used this information to populate a “matrix” that captures differences, similarities, and unique characteristics within and across the ACHs.

KEY FINDINGS

- *ACHs vary on important dimensions, such as governance and partnerships.*
 - »*All ACHs have a board, staff, workgroups, and committees. Several ACHs also have sub-regional groups that serve on the board.*
 - »*ACHs vary in their approach to engaging partners and in the strength of their partnerships. A few ACHs have especially well-defined mechanisms for engaging partners.*
- *Domain 1 activities are in a development phase, with progress and specificity of planned activities varying across the ACHs.*
 - »*ACH documents lack detailed or concrete plans for VBP, and ACHs generally seem unsure of how to approach VBP. The primary plan cited by most ACHs is to train and educate providers on VBP.*
 - »*A common theme among ACHs is incorporating community health workers and peer support specialists into the healthcare workforce. ACHs note challenges or needs related to defining roles, training, and paying for CHWs through Medicaid.*
 - »*Some ACH regions may have more HIT expertise than others. Common HIT challenges noted by ACHs include variation in EHR platforms and interoperability of Washington’s Prescription Drug Monitoring Program with EHRs.*
- *Across ACHs, there is variation in the type and number of models chosen for Domain 2 and 3 projects in a given area. Within most ACHs, there are common elements or cohesiveness across different kinds of projects.*
- *LTSS and FCS initiatives are largely separate from the ACH work. Available documents provide less detail on these initiatives than on the DSRIP work.*

IMPLICATIONS FOR EVALUATION AND IMPLEMENTATION

- *Document analysis and informal discussions with State agency staff have helped us identify stakeholders for semi-structured interviews and refine our interview guide. Interviews will include questions on how ACHs engage partners and work with partners to make decisions; redefinition and refinement of target populations as plans evolve; and implementation of LTSS and FCS, where less detail was available from documents.*
- *Given overlap in models or approaches used by ACHs, there might be opportunities to provide technical assistance to multiple ACHs, as well as opportunities to foster peer-to-peer sharing and learning.*

Overview

Washington's MTP is complex and has multiple components to track and synthesize. These include Accountable Communities of Health (ACH), Long-Term Services and Supports (LTSS), and Foundational Community Supports (FCS). Reviewing the available literature has provided the evaluation team with critical background and orientation to the MTP work. Beyond this, evaluation staff have identified key points of interest, particularly regarding the ACH work. This report discusses our work to date on document analysis and shares our general impressions and insights.

Methods

The qualitative work for the MTP evaluation has, to date, focused on document analysis, which has been complemented by informal discussions with HCA and DSHS staff. We analyzed documents provided by HCA and DSHS, as well as publically available documents from state agency websites. We analyzed project plans and semi-annual reports from each ACH, and used this information to populate a "matrix." This matrix is a strategy to categorize information into groupings that are extracted from the reports and project plans, including topics such as ACH target populations for health improvement projects, project selection, ACH governance structure, Domain 1 activities, and project partners. We used this to compare ACH activities and structures across all nine ACHs. Categories were refined as our review progressed in order to distill key differences, similarities, and unique factors within and across the ACHs. We share key findings below.

Findings

There are nine ACHs in the state of Washington participating in the Delivery System Reform Incentive Program (DSRIP). Each has a unique beneficiary population, array of partners, set of Medicaid managed care organizations (MCOs) and behavioral health organizations (BHOs), and geography. Table 1 presents a brief snapshot of some ACH characteristics.

Accountable communities of health vary on important dimensions.

As show in Table 1, ACHs vary in the number of beneficiaries they serve, with the OCH serving the smallest population to HH serving the largest. There are similar MCOs serving ACH regions, with Molina present in each region, and NCACH having only two MCOs in their region; most regions have one BHO serving Medicaid beneficiaries, with the exception being CAAA, that has multiple BHOs. In addition, there is evidence of some transitions in BHO regional presence. These are all baseline characteristics that we will continue to monitor to see how these partnerships evolve and to assess how they might influence outcomes ACHs achieve.

TABLE 1. SNAPSHOT OF ACCOUNTABLE COMMUNITIES OF HEALTH

ACH*	Beneficiaries (% of total population in ACH region)	MCOs in Region [†]	BHOs in Region
BHT	196,000 (33%)	Molina, CHPW, UHC, Amerigroup, CC	Spokane County Regional Behavioral Health Organization (SCRBHO)
CPAA	180,000 (30%)	Molina, CHPW, UHC, Amerigroup, CC	Behavioral Health Resources, Great Rivers BHO, Sea Mar, Thurston-Mason BHO, Cowlitz Family Health Center, Valley View
GC	259,762 (13%)	Molina, CHPW, UHC, Amerigroup, CC	Greater Columbia BHO
HH	412,836 (20%)	Molina, CHPW, UHC, Amerigroup, CC	King County BHO
NCACH	94,000 (37%)	Molina, Amerigroup, CC	North Central Washington Behavioral Health
NSACH	286,760 (24%)	Molina, CHPW, UHC, Amerigroup, CC	North Sound BHO
OCH	84,000 (23%)	Molina, CHPW, UHC, Amerigroup, CC	Salish
PCACH	228,000 (27%)	Molina, CHPW, UHC, Amerigroup, CC	Optum (transitioning out in 2019)
SWACH	133,000 (26%)	Molina, CHPW, Amerigroup	Fully-integrated managed care + BH-ASO [‡]

*BHT – Better Health Together; CPAA – Cascade Pacific Action Alliance; GC – Greater Columbia Accountable Community of Health; HH – Healthier Here; NCACH – North Central Accountable Community of Health; NSACH – North Sound Accountable Community of Health; OCH – Olympic Community of Health; PCACH – Pierce County Accountable Community of Health; SWACH – Southwest Accountable Community of Health. [†]CHPW – Community Health Plan of Washington; UHC – UnitedHealthcare; CC – Coordinated Care. [‡]As of April 2016, MCOs in Clark and Skamania Counties covered physical health, mental health, and substance use disorder services. Some behavioral health services, such as mental health crisis services, were provided by a behavioral health administrative services organization (BH-ASO).

GOVERNANCE

While there is variation, all ACHs have a board, staff, workgroups, and committees that collaborate. Typically, the board holds the ultimate decision making power, especially for matters regarding finances and distribution of DSRIP funds. However, in the case of NSACH, the Executive Committee has the authority of the board between board meetings for all matters except article of incorporation and bylaw amendments.

Another notable difference between ACHs is the use of “sub-organizations.” OCH, BHT, and NCACH have sub-regional groups that serve the board. OCH has Natural Communities of Care (NCC), entities that are considered partners in care delivery for Medicaid beneficiaries based on geographical proximity, referral patterns, and service agreements (i.e., county). BHT has several groups, referred to as the Spokane and Rural Collaboratives. Each collaborative has a unique charter, governance structure, and decision making process. Each of these organizations has been tasked with developing a transformation plan, including a framework for individual partner plans. NCACH has Coalitions for Health Improvements (CHIs) located in Chelan-Douglas, Grant, and Okanogan counties. CHIs engage regional partners on behalf of NCACH and inform the board. Each CHI has a voting representative on the board.

ENGAGEMENT AND PARTNERSHIP EFFORTS

The project plans and semi-annual reports contain descriptions of partners from sectors

including social services, clinical and medical, hospital, behavioral health, housing, transportation, governmental, criminal justice, and many others. ACHs vary in their approaches to engaging partners and the strength of their partnerships at the baseline. For instance, a few ACHs have more defined mechanisms for engaging partners than others. One example is OCH's Natural Communities of Care (NCC), which was described earlier. Each of the participating providers in the NCC will develop a change plan describing expected workflow and how clinics may be reconfigured to support this work. HH's Community/Consumer Voice Committee (CCV) is a good example of consumer and community engagement. The CCV is where community members and beneficiaries have a seat at the table and work closely with the governing board and project teams to provide input.

The evaluation team would like to learn more about how each ACH engages partners through interviews. Since MTP is emphasizing community engagement and ground-up changes to

Value-Based Payment, Workforce Transformation, and Population Health Management are in a development phase.

improve health, it is important to track where communities start in terms of their partnerships, how they work to engage partners, and how they operate to make decisions and implement change (i.e., how they get things done).

Regarding Domain 1 activities, ACHs are still in an early phase of this work. Progress and the specificity of planned activities vary across the ACHs for value-based payment (VBP), workforce transformation, and population health management (HIT/HIE). Additionally, all ACHs have participated in distributing surveys for each of the Domain 1 activities, including involvement with the HCA survey. These surveys and other collaboration between ACHs and their partners provide evidence of initial conditions (strengths, challenges, and needs) with regard to VBP, workforce, and HIT/HIE. Most ACHs have dedicated workgroups or task forces to address each of the Domain 1 categories.

VALUE-BASED PAYMENT

The project plans or semi-annual reports do not contain detailed or concrete plans on VBP. Most ACHs are working with payers and MCOs in their region to establish thinking and collaboration on VBP models. ACH leaders are also working with partners on how to define value, and how to assign risk from small providers to MCOs. The primary plan cited by most ACHs is to train and educate providers on VBP, although ACHs generally seem unsure of how to approach VBP.

WORKFORCE TRANSFORMATION

A common theme among ACHs is incorporating community health workers (CHWs) and peer support specialists into the healthcare workforce. This may be in part due to the adoption of the Pathways HUB model, which emphasizes the potential of CHWs and peer support in care delivery and access. However, a couple of ACHs noted that there are challenges with defining a CHW's role and what appropriate training would look like. Relatedly, ACH leaders noted that there are professional licensure and certification barriers that may be preventing some of the workforce—including CHWs and behavioral health providers—from being involved to their full potential. This is noted especially where there are gaps in the workforce, such as with. Most ACHs noted the need or desire to have more CHWs, including ideas for CHW training and working toward making it possible to pay CHWs through Medicaid.

POPULATION HEALTH/HEALTH INFORMATION TECHNOLOGY OR EXCHANGE

About half of the ACHs have mentioned using EDIE, the Emergency Department Information

Exchange platform. The EDIE allows tracking of emergency department visits, highlighting those who visit the emergency department frequently. High frequency utilizers of emergency departments are a target population of several project categories used by several ACHs. ACH leaders have surveyed their regions on their use of and resources for HIT/HIE to better understand existing efforts, gaps, and variation within their regions.

Some regions may have more HIT and HIE expertise than others. For instance, Olympic Community of Health has piloted an information technology tool called “The Commons,” which connects health information of shared patients between a primary care provider and a substance use disorder provider. Developing this kind of tool requires developing the trusting partnership on which data sharing must necessarily be based. Regions that have developed such partnerships may be better positioned to implement HIT/HIE plans.

There are a number of challenges related to HIT/HIE noted in these ACH documents. While many providers and health system administrators reported that they use an electronic health record (EHR), there is typically variation in which platform they use. Several ACH leaders noted in their project plans or semi-annual reports that this variation creates barriers to exchanging health information. North Central ACH leaders noted a lack of interoperability of the prescription monitoring program (PMP) with EHRs. Having a PMP that functions with EHR platforms may be useful to ACH projects.

PROJECT SELECTION AND IMPLEMENTATION STRATEGIES

Guiding principles for this work, such as health equity, access to care, and quality of care, are embedded in the projects and requirements of the ACH work. However, a couple of ACHs have unique plans in this area. North Sound ACH is using the guiding principle of “Targeted Universalism.” This is described as identifying a common or “universal” goal, then identifying any barriers to this goal experienced by specific groups. The ACH tasks themselves with tailoring goals for these specific groups to achieve or reach the purported goal. Pierce County ACH is planning to develop a “playbook” with a list of guidelines, policies, procedures, protocols, and compilation of evidence-based practices that will assist and guide partners during the waiver period.

Table 2 presents details on project selection and prior or current experience in project areas by ACH. The number of projects selected by each ACH ranged from four to eight, with five ACHs selecting four projects, three selecting six projects, and one selecting all eight projects. Of note is that all ACHs selected project 3D: Chronic Disease Prevention and Control, a non-required project. NSACH, which has committed to all eight projects, is taking a holistic approach, where projects are not discreet activities, but are addressed through four initiatives: Care Coordination, Care Transformation, Care Integration, and Capacity Building. PCACH also organizes their project by a system of change rather than viewing them as separate initiatives. OCH, SWACH, BHT, and HH have some aspects of cohesiveness between projects that they have explicitly discussed.

As Table 2 shows, all ACHs are planning work on behavioral health, addressing the opioid crisis and better management of chronic care. In most areas selected, ACHs have prior experience and are leveraging this for experience in their MTP work. We have reviewed the project plans to identify what the ACHs describe that they propose to do. We understand that what actually happens can be quite different, and for good reason, and we will be monitoring this evolution.

TABLE 2. PROJECT SELECTION BY ACCOUNTABLE COMMUNITY OF HEALTH

ACH*	2A Behavioral Health Integration	2B Care Coordination	2C Transitional Care	2D Diversion Intervention	3A Addressing the Opioid Crisis	3B Reproductive, Maternal, and Child Health	3C Oral Health Access	3D Chronic Disease
BHT	X	X			X			X
CPAA	X	X	X		X	X		X
GC	X		X		X			X
HH	X		X		X			X
NCACH	X	X	X	X	X			X
NSACH	X	X	X	X	X	X	X	X
OCH	X		X		X	X	X	X
PCACH	X	X			X			X
SWACH	X	X			X			X

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In addition, for each of the selected projects, ACHs listed the models or approaches they plan to use. Across ACHs, there was variation in model choice, including the type and number of models chosen to frame and direct their efforts. Some ACHs have selected models for project partners, while others are giving project partners more choice and flexibility in the model or approach that guides their work. Some ACHs have yet to identify specific guiding models. Table 3 presents common models selected by the ACHs.

TABLE 3. COMMON MODELS SELECTED BY ACHS (BY PROJECT)

Project	Common Models
2A: Bi-Directional Integration of Physical and Behavioral Health	Bree Collaborative, Collaborative Care Model
2B: Community-Based Care Coordination	Pathways Community HUB Model
2C: Transitional Care	Care Transitions Intervention Model, Peer Bridger Program, Interventions to Reduce Acute Care Transfers
2D: Diversions Interventions	ER is for Emergencies, Community Paramedicine Model
3A: Addressing the Opioid Use Public Health Crisis	CDC/AMDG Interagency Guidelines, Six Building Blocks, Prevention, Treatment, Overdose Prevention, Recovery
3B: Reproductive and Maternal and Child Health	One Key Question, Bright Futures, CDC’s Recommendations to Improve Preconception Health and Health Care
3C: Access to Oral Health Services	Mobile Dental Hygiene in Community Settings, Oral Health Delivery Framework, Increase oral health access points
3D: Chronic Disease Prevention and Control	Chronic Care Model (complemented by disease specific interventions such as CDC diabetes prevention, Million Hearts Campaign)

ASSESSMENTS

Each ACH has discussed in their project plans and semi-annual reports that they have conducted their own surveys and assessments multiple times, including most recently the Current State Assessments. ACHs had their own approaches to how to assess the current efforts and resources in their regions, and there is variation in the type and amount of assessment that has been conducted. Many of these assessments sought to understand readiness for change in a particular area (e.g., fully integrated managed care, VBP, HIT/HIE, workforce transformation) and the organization's or region's current efforts in a particular area (e.g., physical and behavioral health integration, HIE/HIT, fully-integrated managed care, and general assessments of capacity and gaps in efforts). It appears that ACHs are attempting to leverage this information to target regional gaps and needs, and to leverage and build on existing efforts, where they exist. It will be interesting to understand what they learned from these assessments and how they are using this information to identify needs and mobilize to address them.

TARGET POPULATIONS

All of the ACHs have identified target populations, or have laid out plans to identify target populations, for each of their selected project areas. There is variation among ACHs in their selection of target populations, but there are some populations that are common across several or most of the ACHs. Table 4 presents common and noteworthy target populations by project.

TABLE 4. COMMON AND NOTABLE TARGET POPULATIONS ACROSS SELECTED PROJECTS

Project	Common Models*
2A: Bi-Directional Integration of Physical and Behavioral Health	<ul style="list-style-type: none"> All Medicaid beneficiaries (comorbidities) Additional risk or at-risk factors such as homelessness
2B: Community-Based Care Coordination	<ul style="list-style-type: none"> High-risk pregnancy or other risk factors Jail transition (BHT) ED visits in past 12 months (NCACH)
2C: Transitional Care	<ul style="list-style-type: none"> Transitioning between acute care to housing Individuals who are homeless or do not have stable housing Multiple or preventable ED visits
2D: Diversion Interventions	<ul style="list-style-type: none"> Accessing ED care for non-emergent needs Individuals released from jail (OCH)
3A: Addressing the Opioid Use Public Health Crisis	Beneficiaries with: <ul style="list-style-type: none"> SUD/ODU or at risk for developing Multiple ED visits Overdosed Opioid prescription (or chronic use)
3B: Reproductive and Maternal and Child Health	<ul style="list-style-type: none"> Men and women of reproductive age Pregnant women and mothers Those with SUD Those who have suffered abuse, trauma, or ACE
3C: Access to Oral Health Services	<ul style="list-style-type: none"> Adults and children with limited access to oral health care Pregnant women Chronic conditions or high service utilization Beneficiaries who are homeless
3D: Chronic Disease Prevention and Control	Beneficiaries with: <ul style="list-style-type: none"> One or more chronic conditions Under or over utilize health services Care access barrier Behavioral health concerns

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LONG-TERM SERVICES AND SUPPORTS AND FOUNDATIONAL COMMUNITY SUPPORTS

Importantly, the LTSS and FCS initiatives are largely separate from the ACH work and are operated by different agencies, including DSHS and Area Agencies on Aging. We have few documents available to us documenting details about these initiatives. While we have been able to speak with HCA and DSHS staff about these programs at a high level, enabling us to learn more about eligibility and services provided through these new offerings, more discussion is needed to develop a detailed understanding of the efforts in these areas. Interviews will be especially helpful to connect with and learn from state and regional leaders who are involved in the work.

Next Steps

Through document analysis we have developed a greater depth of understanding of MTP and each initiative. Part of our work in the document analysis was to keep a list of people and organizations intimately involved in MTP work. We will use our findings to identify key stakeholders for semi-structured interviews, and to tailor our interview protocol to each key informant's expertise and areas of knowledge. We look forward to beginning interviews with State and ACH leaders once the WSIRB application is approved.