

Interim Findings on Washington's Medicaid Transformation Project

In 2020, Washington State was midway through an ambitious five-year effort to transform its health system for Medicaid beneficiaries.

Washington State's Medicaid Transformation Project (MTP) is a \$1.27 billion effort spanning 2017-2021 to transform health care delivery and payment and improve the quality of care for the state's Apple Health members. MTP is a five-year agreement with the Centers for Medicare & Medicaid Services under a Section 1115 Medicaid demonstration waiver.

The state of Washington engaged the Center for Health Systems Effectiveness at Oregon Health & Science University as an Independent External Evaluator (IEE) to conduct a comprehensive evaluation of MTP. The purpose of this evaluation is to assess whether MTP accomplished its goals of transforming the delivery of the state's health systems and improving care for its Medicaid enrollees.

This brief summarizes the Interim Evaluation Report, the second in a series of three major evaluation reports that assess the success of MTP and communicate lessons of the state's experience. The results in this report reflect data through December 2019. *This period predates the first confirmed COVID-19 case in Washington State and results are unlikely to have been affected by the pandemic.*

Medicaid Transformation Project Evaluation: Interim Report. Center for Health Systems Effectiveness, Oregon Health & Science University, 2020.

[Access the full report](#)

RECOMMENDATIONS

- Address factors driving disparities in access and quality for racial and ethnic minorities.
- Strengthen engagement of non-clinical partners in MTP and continue to assess ACH Health Improvement Projects with consideration for ACHs' roles in COVID-19 response.
- Support the recruitment and retention of key workers necessary for MTP success.
- Provide clear guidance regarding the state's vision for Community Information Exchange.
- Ensure participants understand differences among MAC, TSOA and traditional long-term services and supports.
- Build on early positive results from the FCS Supported Employment program.
- Ensure the SUD waiver does not create incentives for unnecessary residential stays.
- Address challenges identified in MCO payments made to behavioral health and SUD treatment providers.

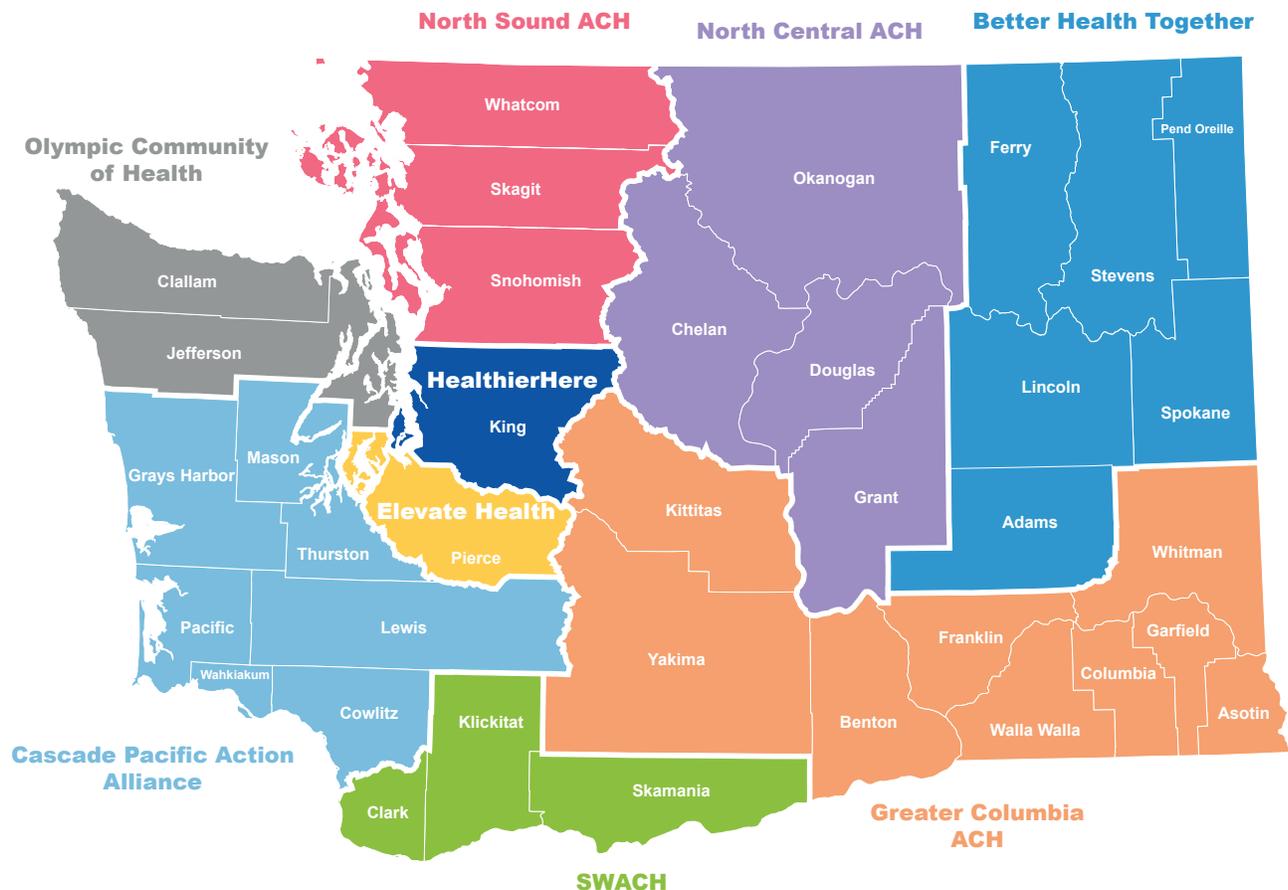


Washington State's Medicaid Transformation Project

MTP consists of five initiatives:

- **Initiative 1: Delivery System Reform Incentive Payment (DSRIP) Program.** Establishes statewide goals for payment reform and delivery system integration, and directs nine regional Accountable Communities of Health (ACHs) to collaborate with partners on a series of locally-led health improvement projects. (see Exhibit 1).
- **Initiative 2: Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).** Establishes new service options for older adults to remain in their homes and avoid the need for more intensive services.
- **Initiative 3: Foundational Community Supports (FCS).** Establishes a statewide network of organizations connecting vulnerable adults with supportive housing and supportive employment services.
- **Initiative 4: Substance Use Disorder (SUD) Amendment.** Expands options for federally funded treatment of substance use disorder in mental health and SUD facilities.
- **Initiative 5: Mental Health Amendment.** Expands options for treatment of mental illness in Institutions for Mental Disease (IMDs). *Initiative 5 was approved in November 2020 and is beyond the scope of this report.*

Exhibit 1. Washington State's Accountable Communities of Health



Medicaid System Performance Midway Through MTP

We found substantial improvements in measures related to substance use disorder and care for chronic conditions. There were modest or no changes in other performance measure domains during this period.

Additional effort is needed to achieve equity in the state's transformation of care.

Racial and ethnic disparities were evident. Black and American Indian/Alaska Native beneficiaries experienced less access and lower quality of care relative to Medicaid beneficiaries of other races. Asian and Hispanic beneficiaries also experienced lower quality of care on some measures compared to the state's Medicaid beneficiaries as a whole. However, these differences were less pronounced than for Black and American Indian/Alaska Native members.

In summary:

Social Determinants of Health measures were largely unchanged from prior years. High rates of homelessness persisted among people with serious mental illness and American Indian/Alaska Native and Black Medicaid beneficiaries.

Access to Primary and Preventive Services measures were mostly unchanged. Rates of access were similar for urban and rural areas but lower among Native Hawaiian and Pacific Islanders.

Reproductive and Maternal Health Care measures were stable. Disparities in access to contraception were evident for Asian, Black, and Hawaiian/Pacific Islander beneficiaries.

Prevention and Wellness measures were also relatively stable. American Indian/Alaska Native beneficiaries had lower rates of preventive screenings and well visits relative to other beneficiaries.

Mental Health measures demonstrated mixed performance. Some measures were slightly better than average for people with serious mental illness and rural residents compared to the average Medicaid beneficiary.

Oral Health Care measures were largely unchanged. Some populations, such as people in rural and high-poverty areas and American Indian/Alaska Native and Black beneficiaries, continued to be served at lower rates than the state as a whole.

Care for People with Chronic Conditions measures improved modestly from 2018 to 2019. American Indian/Alaska Native and Black beneficiaries experienced significant disparities in the quality of care in this domain.

Emergency Department (ED), Hospital and Institutional Care measures increased slightly. These utilization measures were substantially higher for people with chronic conditions or serious mental illness, as well as for Black, American Indian and Alaska Native beneficiaries.

Substance Use Disorder Care improved meaningfully across the state for all performance measures. Quality measures were lower for most communities of color and for higher-poverty areas.

Opioid Prescribing and Opioid Use Disorder Treatment exhibited improvements across the state, including decreases in opioid prescriptions and improvements in access to treatment.

Impact of ACH Health Improvement Projects

Most ACH Health Improvement Projects (see Exhibit 2) were at an early stage of implementation at the time of this analysis. ACHs focused on developing the partnerships, workforce, and HIT

Exhibit 2. ACH Health Improvement Projects

Domain 2: Care Delivery Redesign	Domain 3: Prevention and Health Promotion
<p>Bi-Directional Integration of Physical and Behavioral Health Care (Required): Integrate behavioral health care into primary care settings and primary care into behavioral health settings.</p>	<p>Addressing the Opioid Public Health Crisis (Required): Help achieve the state's goals of reducing opioid-related illnesses and deaths by implementing a variety of opioid prevention and misuse programs.</p>
<p>Community-Based Care Coordination: Help Medicaid members with complex health and social needs access the services they need to improve their health.</p>	<p>Reproductive and Maternal or Child Health: Ensure women of reproductive age, pregnant women, and mothers have access to high-quality reproductive health care.</p>
<p>Transitional Care: Ensure Medicaid members have the right care through transitions between health care settings, such as acute care to home or jail to the community.</p>	<p>Access to Oral Health Care: Increase access to oral health services by integrating oral health into primary care and providing dental care to school-age children using mobile dental units.</p>
<p>Diversion Interventions: Direct Medicaid members who use emergency services for non-emergent conditions toward primary care and social services.</p>	<p>Chronic Disease Prevention and Control: Improve care for people who have or are at risk for a chronic disease, such as asthma, diabetes, or cardiovascular disease.</p>

infrastructure necessary to support new interventions or workflows.

We observed a variety of improvements in outcome measures for target populations in projects 2A and 3A. There were fewer significant or detectable improvements in analyses of other HIPs. These results were based on data from the first year of implementation.

Domain 2: Care Delivery Redesign Project Results

2A: Bi-Directional Integration of Physical and Behavioral Health Care. All ACHs participated in Project 2A and we observed improvements in a number of measures related to mental health treatment in primary care settings and prevention and treatment of substance use disorders.

2B: Community-Based Care Coordination. Six ACHs implemented Pathways Community HUBs to support care coordination and information exchange in their regions. Measures of mental health treatment

penetration and follow-up after emergency department visits for substance use disorders improved in participating ACHs relative to non-participating regions.

2C: Transitional Care. Five ACHs participated in projects for people exiting from intensive or institutional care settings to their homes, supportive housing, or communities. Participating ACHs demonstrated poorer performance on some measures than those ACHs that did not select this project.

2D: Diversion Interventions. Three ACHs engaged in projects to redirect Medicaid beneficiaries from correctional settings or EDs to primary care, behavioral health, or SUD care when appropriate. Among high emergency department utilizers, rates of mental health treatment improved and hospital readmissions declined in participating ACH regions. We observed few other differences across ACHs.

Domain 3: Prevention and Health Promotion Project Results

3A: Addressing the Opioid Use Public Health Crisis. All ACH regions participated in Project 3A to address opioid use disorder (OUD), emphasizing provider education, training in prescribing guidelines, and medications for OUD treatment. Opioid prescribing rates and OUD treatment rates improved during this period.

3B: Reproductive and Maternal or Child Health. Three ACHs participated in Project 3B, often focusing on providing technical assistance to providers to implement evidence-based programs for pregnant and postpartum women. We found no differences in outcomes between ACHs that did and did not participate in this project. Our analyses also revealed that stakeholders may have deprioritized some efforts such as reproductive health projects out of a belief that these projects would not substantially drive changes in performance measures.

3C: Access to Oral Health Care. Two ACHs participated in Project 3C. There were modest improvements in the utilization of some dental services in participating ACHs relative to non-participating ACHs. We observed small declines in performance for other selected measures.

3D: Chronic Disease Prevention and Control. All ACHs participated in Project 3D, promoting partner implementation of screenings and disease self-management programs. There were relatively few improvements in quality measures related to specific chronic diseases during this period. However, there were promising improvements in hospitalization rates and emergency department utilization among people with chronic conditions.

Progress on Value-Based Payment

Washington State has demonstrated progress toward adoption of value-based payments (VBP), including:

- Achieving targets for VBP participation by managed care organizations (MCOs); and
- Expanding participation in VBP arrangements by primary care practices.

Washington's MCOs have made particular progress toward the adoption of shared savings and shared risk arrangements.

According to a 2019 survey conducted by HCA, more than half of MCO payments to Medicaid providers in 2018 were made through arrangements that included shared savings and shared risk, compared with 20 percent of commercial payments and 8 percent of Medicare Advantage payments.

MTP's Impact on Health Care Workforce Capacity

Several findings emerged from the interim evaluation related to Washington's workforce capacity under MTP.

Workforce shortages were cited as one of the top challenges in implementing MTP initiatives. Specific examples included psychiatrists or clinical social workers to support Health Improvement Project 2A (bi-directional integration), providers eligible to become certified to prescribe medications for addiction treatment in support of Project 3A (opioid interventions), and rural health care providers or first responders that ACHs could engage in implementing chronic disease interventions.

ACHs devoted substantial effort to regional workforce development as part of health improvement project (HIP) work. Planning and early implementation of HIPs often required retraining existing workers for new clinical processes ACHs sought to promote,

such as new screening protocols. ACHs also recruited new workers to serve in care coordination or patient navigator roles necessary for project implementation.

Community health workers (CHWs) played an important role in ACH and regional progress toward HIP implementation.

Regions with established CHW workforces at the beginning of the MTP demonstration reported fewer challenges with projects such as care coordination hubs. Retention of CHWs was cited as a challenge that hindered implementation across multiple areas.

MTP's Impact on Health Information Technology Use

These findings on health information technology (HIT) emerged:

ACHs leveraged care coordination platforms developed for Project 2B (Community-Based Care Coordination) to support a wide range of health promotion activities, including all projects within Domain 2 (Care Delivery Redesign) and most projects in Domain 3 (Prevention and Health Promotion). Once in place, a shared HIT infrastructure could be leveraged to support mutually reinforcing activities that were applicable to most HIPs.

MTP required substantial effort from partnering organizations to participate in new HIT/HIE tools. Stakeholders noted that HIT/HIE platforms may be most easily adopted by physical health partners with prior experience with electronic health record systems or OneHealthPort. Behavioral health providers or human service organizations may bear a higher burden to join projects that involve information exchange. ACHs reported the need for community information exchanges or alternative HIT/E tools for these partners.

Stakeholders expressed a desire for a statewide HIT/HIE strategy to promote standardization and interoperability. The diversity of HIT/HIE platforms used across regions and between various types of partnering providers was identified as a challenge for regional coordination or implementation of closed-loop referral networks.

There were concerns about the distribution of HIT/HIE costs and effort related to MTP.

Behavioral health providers incurred new costs to acquire electronic health records and reporting systems to meet MCO billing requirements under integrated managed care (IMC). ACHs expressed concerns regarding the sustainability of the community information exchange (CIE) infrastructure developed for HIPs, citing a lack of renewable funding streams to support that work.

Impacts of MAC and TSOA

We examined the impact of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) on older adults' need for and use of traditional Medicaid long-term services and supports (LTSS).

Enrollment in both MAC and TSOA ramped up slowly, but satisfaction in both programs was high. There appears to have been more interest and incentive to enroll in TSOA than in MAC. Care recipients and their informal (unpaid) caregivers expressed high satisfaction with the two programs. Participants reported that the programs contributed to independence and were beneficial to physical and mental health.

MAC participants had fewer adverse health outcomes following enrollment.

These changes were comparable to results for traditional in-home services users and reflected a relatively early period in the program's implementation.

Only a small proportion of MAC and TSOA participants went on to use traditional LTSS within six months of MAC and TSOA enrollment, suggesting the program may have succeeded in deferring the need for more intensive services among participants.

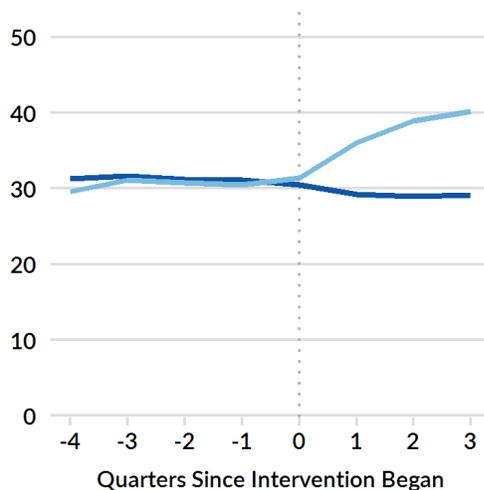
Impacts of Foundational Community Supports

Our evaluation of the Foundational Community Supports program found:

Washington has successfully established a statewide network of FCS providers, but gaps in services remain. The network of FCS service providers has gradually increased since the program launched in 2018. However, engagement of service providers in rural areas has been challenging.

FCS Supported Employment demonstrated progress increasing employment. Rates of employment increased strongly for Medicaid enrollees who participated in FCS Supported Employment, relative to a matched comparison group (see Exhibit 4). These changes were clearly evident in the months following receipt of FCS employment services.

Exhibit 4. FCS Supported Employment participants saw strong improvements in employment. Rate of employment among people enrolled in [Supported Employment](#) and a [comparison group](#).



Source: Employment data from Washington Employment Security Department.

The impact of FCS Supportive Housing is less clear. Rates of homelessness did not improve for Medicaid enrollees who participated in FCS Supportive Housing. Stakeholders noted that FCS housing services typically must be paired with other housing resources, and lack of affordable housing options limited FCS service providers' ability to connect participants with housing after they had enrolled in FCS.

Engagement in primary care and SUD treatment improved for participants enrolled in both the FCS housing and employment programs. However, rates of homelessness and employment did not improve, and the positive finding could be a result of the small sample of these individuals. Nonetheless, this population may have unique service needs not well addressed by current program design.

Progress on SUD Waiver Amendment Implementation

Our assessment of the impact of the Medicaid Substance Use Disorder (SUD) amendment to Washington State's 1115 demonstration waiver found the following:

Access to and quality of substance use disorder treatment improved in the first year of Washington's SUD waiver.

For example, there were substantial improvements in measures of initiation of alcohol and other drug dependence treatment and access to preventive services for individuals with substance use disorders. The number of patients receiving substance use treatment increased.

There was evidence of increased capacity for providers authorized to prescribe medications for opioid use disorders and increases in the number of institutions for mental disease (IMD) billing for substance use disorder treatment.

Despite this progress, there were implementation challenges. The transition to integrated managed care (IMC) appears to have created unintended consequences for SUD treatment providers, including negatively impacting the timeliness of payment for claims to behavioral health providers, and adversely affected provider organizations' financial stability.

The IMC transition also created challenges for residential treatment facilities, including new prior authorization requirements. As managed care organizations (MCOs) took on financial risk for residential services, disagreements emerged between payers and providers about the role of residential care in SUD treatment.

Recommendations

Specific recommendations for Washington State and the Health Care Authority arising from this interim evaluation include:

- 1. Address health disparities.** Our analysis of Washington's Medicaid system performance through 2019 revealed progress on some measures, as well as persistent racial and ethnic disparities in access and quality of care. The state should further investigate structural factors that may be driving differences among specific groups. The state's managed care contracts may also present options to reduce health care disparities.
- 2. Strengthen engagement of non-clinical partners in MTP.** Behavioral health, human services, and other community-based partners have faced particular challenges engaging in MTP. Making progress on social factors – homelessness contacts with corrections, unemployment – may require greater collaboration between the state, Tribes, ACHs, MCOs, Foundational Community Supports providers, and community-based organizations. The state should

also explore how to increase housing options for participants in the FCS Supportive Housing initiative.

- 3. Support the recruitment and retention of key workers necessary for MTP success.** Additional efforts may be needed to address workforce shortages. In rural areas, difficulty recruiting community health worker positions has limited ACH progress on health improvement activities.
- 4. Provide clear guidance regarding Washington State's vision for Community Information Exchange (CIE),** including the desired financing mechanisms to support community information exchange platforms. The state should promote standardization and interoperability of HIT/HIE platforms across regions and sectors, focusing on lowering barriers to participation among behavioral health and SUD treatment providers.
- 5. Continue to monitor progress on ACH Health Improvement Projects.** ACHs' early activities focused on developing the infrastructure and workforce necessary to implement new interventions or programs. A more extended period of observation and consideration of ACHs' roles in COVID-19 response and recovery will yield more robust conclusions about the impact of ACH projects.
- 6. Explore options to ensure benefit packages are clearly understood across TSOA, MAC and traditional long-term services and supports so individuals can make the choice that best meets their needs.** Stronger incentives may be needed to promote enrollment in MAC versus traditional Medicaid in-home services.

7. **Build on early positive results from the FCS Supported Employment program.** The program may play an important role in employment recovery after the COVID-19 pandemic. Further investigation is needed for whether additional or different employment services are needed for FCS participants who enroll in both supported employment and supportive housing services.
8. **Continue to assess the entire system of substance use prevention, treatment, and recovery,** and ensure that the SUD waiver does not create incentives for unnecessary residential stays for SUD treatment.
9. **Monitor challenges identified in MCO payments made to behavioral health and SUD treatment providers,** including timeliness of payments and appropriateness of prior authorization requirements. Assess whether these challenges gradually resolve following the implementation of integrated managed care and the execution of new MCO contracts in 2021, or whether these challenges persist over time and warrant future changes to IMC.

Next Steps for the Evaluation

Many of the findings in the interim report relate to early successes and challenges in implementation. Evaluation of MTP is ongoing, with additional data collection and analysis slated to occur. Interim findings will continue to be reported in quarterly Rapid Cycle Reports. A Final Evaluation Report planned in 2022 will present summative evaluation findings for the demonstration.

The COVID-19 outbreak had little to no effect on Washington's delivery system during the time period described in this report (through December 2019) as this period predates the first known case of the virus in the United States.

As Washington transitions to the final years of MTP, the full impact of the COVID-19 outbreak on the state's Medicaid population is not yet known. Understanding the effects of the pandemic on the Medicaid program and the state's progress in improving quality, controlling costs, and achieving equity will be important areas of focus for the final evaluation.

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