Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Identify point person, telephone number, e-mail address:* **Shawnie Haas, Executive Director, SignalHealth, (509) 249-5046, shawniehaas@signalhealthwa.com** *Which organizations were involved in developing this project suggestion?* **Greater Columbia Accountable Community of Health**
Project Title	*Title of the project/intervention:* **Patient-centered medical homes for Medicaid and dual eligible beneficiaries in integrated health systems**

Rationale for the Project

Include:

- *Problem statement – why this project is needed.* **Wagner et al. state "a robust primary care sector is the foundation of a more effective and efficient health care system. However, achieving a robust primary care sector will require widespread practice transformation. A growing consensus supports the patient-centered medical home (PCMH) model… as the blueprint for practice transformation."[1] Signal Health, a Clinically Integrated Network, will lead PCMH transformation for approximately 450 primary, specialty, and tertiary care members in central Washington.**
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.* **The Washington State Institute for Public Policy (WSIPP) has identified "PCMHs in integrated health systems" as an evidence-based policy that can lead to better outcomes.[2]**
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.* **The project will: 1) increase and strengthen coverage of low-income individuals as it will provide PCMH services for Medicaid and dual eligible beneficiaries; 2) increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations as it will provide PCMH services for Medicaid and dual eligible beneficiaries across providers; 3) improve health outcomes for Medicaid and low-income populations as PCMH improves clinical prevention services, access to primary care clinicians and services, and patient satisfaction;[3] and 4) increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks as PCMH improves quality of care and reduces hospital admissions and readmissions, avoidable emergency department visits, length of stay, specialist visits, and in-person visits.[2]**

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

☑ **Reduce avoidable use of intensive services**
☑ **Improve population health, focused on prevention**
☑ **Accelerate transition to value-based payment**
☑ **Ensure Medicaid per-capita growth is below national trends**

Which Transformation Project Domain(s) are involved? Check box(es)

[1] Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes.* New York, NY: The Commonwealth Fund, 2012.
[2] Source: WSIPP. Accessed January 2016 at http://www.wsipp.wa.gov/BenefitCost/Program/484.
[3] Nielsen M, Olayiwola JN, Grundy P, Grumbach K. *The Patient-Centered Medical Home's Impact on Cost and Quality: An Annual Update of the Evidence, 2012-2013.* Washington, D.C.: Patient-Centered Primary Care Collaborative, 2014.

☑ **Health Systems Capacity Building**
☑ **Care Delivery Redesign**
☑ **Population Health Improvement – prevention activities**

Describe:

- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).* **The project will impact Medicaid and dual eligible beneficiaries in Kittitas and Yakima Counties.**
- *Relationship to Washington's Medicaid Transformation goals.* **The project will: 1) Reduce avoidable use of intensive services and settings as PCMH reduces hospital admissions and readmissions, avoidable emergency department visits, length of stay, specialist visits, and in-person visits;[3] 2) Improve population health as SignalHealth members will record patient information and clinical data, collect and regularly update a comprehensive health assessment, use data for population management, and implement evidence-based decision support;[4] 3) Accelerate the transition to value-based payment (payment model 2, encounter-based to value-based) as SignalHealth Federally Qualified Health Center, Rural Health Clinic, and/or Critical Access Hospital members will provide PCMH services; and 4) Ensure that Medicaid per-capita cost growth is two percentage points below national trends as the benefit to cost ratio of PCMHs in integrated health systems is $3.13.[2]**
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity/reducing health disparities.* **The project goal is to provide PCMH services for Medicaid and dual eligible beneficiaries in Kittitas and Yakima Counties. SignalHealth members will provide the following PCMH services: risk indexing and stratification, provider disease registries, care coordination teams, home visiting programs, group visits for high-risk populations, and hotspotting to reduce avoidable emergency department visits. Expected project outcomes include an improvement or reduction, as applicable, in the 52 prevention, chronic, acute measures listed in the *Washington State Common Measure Set for Health Care Quality and Cost;* and the 20 health/wellness, utilization, and disparities measures listed in the *Report to the Legislature: Service Coordination Organizations – Accountability Measures Implementation Status*. Latinos are less likely than Whites to have PCMHs; an analysis of the 2005 Medical Expenditure Panel Survey Household Component showed that White (57.1%) adults were most likely to have a PCMH, while Mexican/Mexican American (35.4%) and Central and South American (34.2%) adults were least likely.[5]**
- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.* **The Health Home program provides care coordination funding for high-cost/high-risk Medicaid adults, but at the time of submission, will only continue through June 2016.[6] The Health Resources and Services Administration has provided PCMH supplemental funding for health centers.[7]**
- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.* **The project will engage business, community- and faith-based, consumer, education, food system, health care provider, hospital, housing, local government, philanthropy, public health, social services, transportation, and tribal organizations in Kittitas and Yakima Counties.**

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[4] National Committee for Quality Assurance. *PCMH 2014 Standards and Guidelines.* Washington, D.C.: National Committee for Quality Assurance, 2014.

[5] Beal A, Hernandez S, Doty, M. Latino access to the Patient-Centered Medical Home. *J Gen Intern Med. 2009 Nov;24(Suppl 3):514–520.*

[6] Source: Washington State Health Care Authority. Accessed January 2016 at http://www.hca.wa.gov/medicaid/health_homes/Documents/continuation_of_health_homes.pdf.

[7] Source: Health Resources and Services Administration. Accessed January 2016 at http://bphc.hrsa.gov/programopportunities/fundingopportunities/pcmh.html.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* **Proposed activities include risk indexing and stratification, provider disease registries, care coordination teams, home visiting programs, group visits for high-risk populations, and hotspotting to reduce avoidable emergency department visits. The cost estimate is $3,027,213 per year (37,373 participants x $81 per participant.)**
- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. **SignalHealth members will serve an estimated 37,373 Medicaid and dual eligible beneficiaries per year.**
  - How much you expect the program to cost per person served, on a monthly or annual basis. **The WSIPP estimates that PCMHs in integrated health systems cost $81 per participant per year.[2]**
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* **The project is already operating in the region.**
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* **The WSIPP estimates that PCMHs in integrated health systems benefits minus costs (net present value) is $173 per participant per year, so the estimated ROI is per participant per year is $254 total benefits - $81 costs / $81 costs = 214%.[2]**

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47.* **Process measures will include the number of SignalHealth Medicaid and dual eligible beneficiaries in Kittitas and Yakima Counties who receive PCMH services. Outcome measures will include the 52 prevention, chronic, acute measures listed in the *Washington State Common Measure Set for Health Care Quality and Cost;* and the 20 health/wellness, utilization, and disparities measures listed in the *Report to the Legislature: Service Coordination Organizations – Accountability Measures Implementation Status*.**
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? **County-level benchmark performance data are available for the *Washington State Common Measure Set for Health Care Quality and Cost.***