Washington State Innovation Models (SIM) Project Operational Plan Update

Table of Contents

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A. SIM Project Summary

1. Summary of Model Test

During the second year of Washington's State Innovation Models grant, the Healthier Washington team, led by the Health Care Authority (HCA), and our strategic partners focused intensely on the collaborative execution of our goals and objectives. Our projects and programs are moving swiftly toward implementation and concrete planning for sustainability. We are prepared to embark on Award Year 3 (AY3) as planned on February 1, 2017 with a holistic, systems approach to our SIM objectives.

During this implementation year, we came together to embrace a transformation in the system of care that is Healthier Washington. Accomplishments include:

Accountable Communities of Health (ACHs):

Clearly defined regional priorities have been established and ACHs have all made movement toward implementation of their selected projects. The project selection process has defined a clear movement toward collective impact.

ACHs will be evaluated based on key elements that are visualized in the ACH Theory of Change which was developed in partnership with HCA and the ACHs. This includes development of key operational elements, the ability to develop and strengthen regional partnerships, regional health planning and collaboration, capacity for health improvement projects, and participation in the larger Healthier Washington activities. Evaluation of these elements is ongoing through a variety of qualitative methods including interviews, observation, and document review, as well as an annual ACH member survey.

Reports and key conversations were systematically scheduled throughout the year to provide detailed information on ACH progress that can inform the ACH approach and foster continuous improvement, including the following:

- Strategic learning results, including success factors, barriers, and lessons learned, are shared with HCA leadership quarterly to inform any course corrections, clarifications, or strategy changes needed for the ACH approach. This evaluation includes the Plan for Improving Population Health (P4IPH) in AY3.
- ACH member survey results are shared externally in aggregate as well as with the HCA and ACHs at an individual ACH level.
- Information on ACH projects was provided at a cross-ACH level this year, as well as quarterly updates on progress to HCA.
- Updates on operational and governance changes is shared systematically.

For the identification of regional priorities at the ACH level, we required ACHs to develop an understanding of the regional health assessments and resource or service opportunities and gaps. Essentially this was the starting point for the Regional Health Needs Assessment (RHNI). Both the RHNI and Regional Health Improvement Plan (RHIP) are iterative processes and they don't follow a very prescriptive model, although we are considering designing a template. Ultimately the RHNI and priority identification process informed the ACH project selections. Going forward, our requirements will continue to focus more specifically on the iteration of the RHNI and identification of regional needs and opportunities. The RHIP is broader than SIM

activities, so we are intentional about framing our deliverables specific to the RHNI, corresponding regional priorities, and specific SIM activities, all of which fit within a larger ACH strategic plan and vision.

Figure 1: Selected projects list for every ACH

Accountable Community of Health	Regional priorities	Project
Better Health Together (BHT)	• Access to oral health care • Community-based care coordination • Linkages in housing, food security, and income stability systems • Obesity reduction and prevention • Whole-person care	In two pilot projects, the ACH will coordinate five Medicaid managed care plans, four primary care clinics/health systems, and three social determinants of health organizations to implement a standardized process to identify and address the needs of 150 at-risk individuals by connecting them to community based, coordinated services.
Cascade Pacific Action Alliance (CPAA)	• Access to care and provider capacity • Adverse childhood experiences (ACEs) prevention and mitigation • Chronic disease prevention and management • Economic and educational opportunities • Health integration and care coordination	In four pilot sites across four counties, the ACH is coordinating with school districts, clinicians, and behavioral health care providers to identify students with behavioral challenges as early as possible and connect these children and their families to community-based interventions and treatment services.
Greater Columbia (GC ACH)	• Behavioral health • Care coordination • Healthy youth and equitable communities • Obesity/diabetes • Oral health: primary care prevention	The ACH will coordinate the clinical care and social supports for patients at risk for hospital readmission. Nursing students (RN-BSN) will help with discharge planning for patients to assess follow-up medical and social needs and to improve care transitions and communication across care settings. Patients in the program will be geocoded to identify community 'hotspots.'
King County	• Access to care • Care coordination for complex needs • Health equity • Housing-Health intersections • Prevention: chronic disease and social determinants of health • Physical/behavioral health integration	The ACH will work with three organizations' Community Health Worker initiatives in 10 public and affordable housing properties to coordinate care for Medicaid enrollees from historically underserved communities with or at risk of chronic disease.
North Central (NCACH)	• School-based obesity prevention • Whole-person care • Health care transformation	This project will improve the capacity of provider organizations across the North Central region to define and implement effective whole-person care in primary care clinics through collaboration and shared resources.
North Sound ACH	• Behavioral health integration and access • Care coordination • Dental and primary care access • Health disparities • Housing • Prevention	The ACH will bring together health care, Medicaid Managed Care, and community organizations to train providers and educate consumers about Long-Acting Reversible Contraception to increase contraceptive options and decrease unintended pregnancy.
Olympic Community of Health (OCH)	• Access to care • Behavioral health integration and access	The ACH will lead a comprehensive initiative to assess, plan, coordinate and implement a multi-sector, community response to the regional opioid crisis, including opioid abuse, dependence, and overdose. The ACH is engaging the Salish

Accountable Community of Health	Regional priorities	Project
	• Chronic disease prevention and management • Healthy aging: safety and support • Prevention: lifelong health for children	Behavioral Health Organization, tribal representatives, and Kitsap, Jefferson, and Clallam counties in this effort.
Pierce County	• Access to care • Behavioral health • Chronic disease • Health equity and social determinants of health	The ACH will coordinate recruiting, hiring, and training of people with appropriate cultural and linguistic skills as community health workers (CHWs). CHWs will offer chronic disease prevention in non-clinic settings. The project will create a multi-agency CHW hub.
Southwest Washington RHA (SWWA RHA)	• Access to care • Behavioral health integration • Care coordination	The ACH will help address obstacles and implement strategies to develop a nontraditional, reverse co-location model where physical health services are provided in-house at two behavioral health sites.

Plan for Improving Population Health:

The Planning Guide, a website of curated tools to address population health, went live in September.

Practice Transformation:

We executed three contracts to stand up a practice transformation support structure:

- Web-based resource portal
- Regional Health Connector (Connector) role and function
- Traditional practice coaching, training, and facilitation role and function

We were the first in the nation to certify patient decision aids (PDAs). We trained more than 100 providers, moving us toward SIM-funded efforts to spread shared decision-making.

The Community Health Worker Task Force completed its SIM-resourced work with the release of recommendations around attributes, roles, and skills of those who do community health work, and how they can be included in the transformed delivery system. Many of these recommendations are embraced in other Healthier Washington efforts, such as community and practice transformation.

The Sentinel Network completed two rounds of data collection and analysis, providing a foundational evidence base of emerging issues affecting employers, educators, training institutions, and other key stakeholders involved in health workforce development and deployment.

Payment Model 1 / Payment & delivery of physical and behavioral health services:

120,000 people are in managed care plans that are now coordinating whole-person care of physical and behavioral health. As well, the three counties in our North Central region have submitted a binding letter of intent to move to the integrated financing model in January 2018.

Payment Model 2 / Encounter to Value (Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally-Qualified Health Clinics (FQHCs)):

We are very near a compromise approach to launching a Payment Model 2 pilot in 2017.

Payment Model 3 / Accountable Care Program (ACP):

Beginning with a five-county region in 2016, we are now offering a new ACP product with a unique benefit design that promotes lower costs and a high-quality member experience. The two accountable care plans are risk-based contracts with up and downside risk, where the networks are accountable for financial and clinical quality. We saw over 10,000 enrollees in the accountable care plans, and expect to see further gains during open enrollment as networks expand to nine counties.

Payment Model 4 / Multi-Payer:

Model 4 / Greater Washington Multi-Payer has undergone a re-design and will pilot a multi-payer solution with a rural and urban partner.

Analytics, Interoperability, and Measurement (AIM):

Concrete data requirements were gathered to conduct a Request for Proposals (RFP) on a master data management tool and a data model product. A contract was finalized for the MDMT tool with IBM/Truven and implementation is well under way.

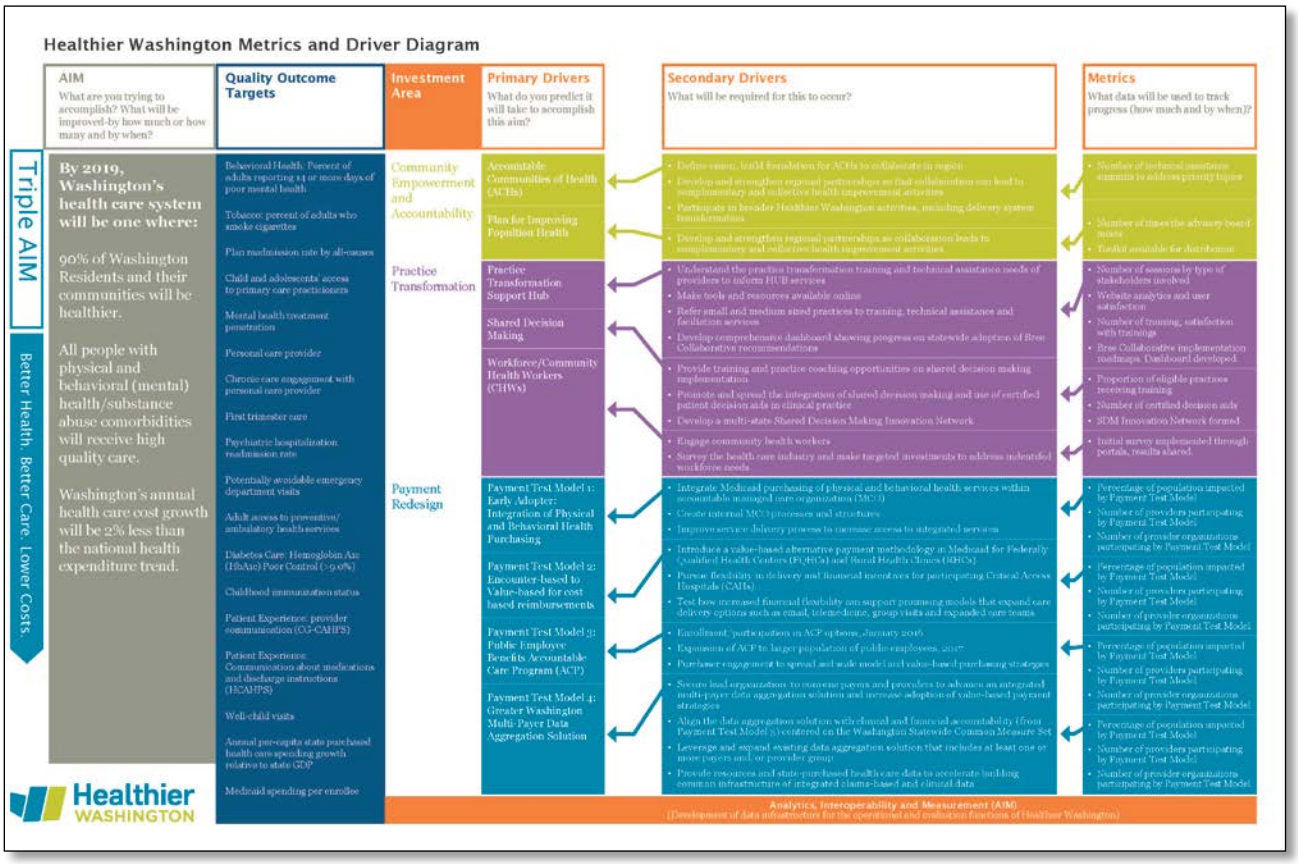
We produced the first two iterations of the ACH dashboard tool – which was well received by our communities.

Healthier Washington engagement:

The HCA continued to engage the public-private Health Innovation Leadership Network (HILN)—a group of providers, business leaders, philanthropists, tribal entities, health plans, and others—to champion the goals of Healthier Washington. HILN and its five accelerator committees have met quarterly throughout the year.

Looking ahead

In the Washington State driver diagram, we highlight our aim.



By 2019, Washington's health system will be one where:

- 90 percent of Washington residents and their communities will be healthier
- All people with physical and behavioral (mental health/substance use disorder) comorbidities will receive high-quality care.
- Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

Our aim is our guiding light. It tells us what we will achieve – how much will we improve – and by when.

It is, of course, a mirror of the Triple Aim: Better health, better care, and lower costs. In the SIM model, we have carefully selected metrics and measures so that we will know when we arrive.

In Washington, we believe our investment areas and primary drivers have coalesced into a coordinated and integrated approach to health system transformation. They are no longer discrete areas of investment – but instead they are truly a collection of levers that cannot be pulled or pushed in a vacuum. In this Operations Plan for AY3, we approach our mission for the next 12 months with a fresh perspective. We are approaching our goal as an integrated team pursuing a transformation that can only be achieved, we believe, by a holistic, linked approach.

Washington remains focused on our aims.

AIM	AIM measure by 2019…	Current strategy statement
Community Partnerships (Comm. Ptnrshp.)	90% of Washington residents and their communities will be healthier.	Build healthy communities and people through prevention and early mitigation of disease throughout the life course.
Integration	All people with physical and behavioral (mental health / substance abuse comorbidities) will receive high-quality care.	Integrate care and social supports for individuals with physical and behavioral co-morbidities.
Paying for Value (P4V)	Washington's annual health care cost growth will be 2% less than the national health expenditure trend.	Pay for value, instead of volume, with the state leading by example as "first mover."

Our transformation efforts, guided by these priorities and strategies, will emphasize full-scale implementation of change and a roadmap to sustainability. For example:

- Accountable Communities of Health have the capacity and mechanisms to be responsive to partnership opportunities and community priorities.
    - ACHs are essential for the transformation of the system of care. In AY3, they will look for regional opportunities within the framework of value-based purchasing to contribute resources within and beyond the health care system.
    - They will look for ever-growing opportunities to engage key partners, including providers, consumers, tribes, public health, state associations, and agency staff.
    - In AY3, the goal for Healthier Washington and for our communities is to build ACH maturity and capacity (to do more, with more). They will activate all the necessary parts of the system of care.
    - Every ACH has a vision statement that grows them from a convening entity to being a leading and action entity that understands the whole system (community delivery, etc.) and can pull the right levers.
    - We will release quarterly updates to the data dashboard.
- People and their families are engaged as active participants in their health and health systems transformation.
    - Accountable care plans will implement and use certified maternity patient decision aids.
    - We will certify decision aids for joint replacement and lumbar fusion.
- State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.
- Payment Model 1 will expand into three counties with over 76,000 eligible Medicaid beneficiaries in the North Central region (Grant, Chelan, and Douglas).
- Strengthen community integration work with effort to mitigate administrative functioning at the state level.

Model 1 expansion counties with 2015 population figures

Jurisdiction	2015 population
Chelan County	75,030
Douglas County	39,990
Grant County	93,930
Total	208,950

- Providers are supported in moving to team-based, integrated care.
    - We will launch a web-based portal of curated resources for supporting our providers on January 31, 2017, and introduce the Connectors and Practice Coaches into a target number of practices.
    - We will assess all practices we work with for movement along the continuum toward value-based purchasing (VBP).
    - We will collaborate with the ACHs to conduct an inventory of community-based resources to share with practices to support whole-person care.
    - We will engage providers in the development of our sustainability plan.
- State, community, and provider information systems support integrated, team-based care.
    - We will implement a Behavioral Health Data Solution (BHDS) to enable integrated financing and integrated care regions to submit all required behavioral health data to the state.
    - We will implement a behavioral health electronic health record (EHR) solution that will enable greater connectivity and interoperability with our behavioral health providers.
    - We will realize significant improvements in our BH data collection process and use it to aid the ACHs and community partnerships strategy.
- Increase the number of providers and payers engaged in Healthier Washington payment models.
    - We will implement Alternative Payment Methodology (APM) 4 in at least one pilot site in June 2017 – and in two additional pilot sites by end of AY3.
    - We will engage brokers, payers, and purchasers to deliver on the spread/scale of Model 3/Accountable Care Program (ACP). An additional 23,000 state employees will be eligible to enroll in the ACP.
    - The ACP will be offered in four additional counties beyond the current five-county Puget Sound starting in 2017. The University of Washington Accountable Care Network will be offered in Grays Harbor and Skagit counties, and the Puget Sound High Value Network will be offered in Grays Harbor, Spokane, and Yakima counties.
- Providers are supported in moving to value-based arrangements.
    - Healthier Washington will work with the Performance Measures Coordinating Committee (PMCC) and ACH stakeholders to develop population health measures that align with the statewide Common Measure Set.

    - We are seeking to have our ACP certified as an Advanced Alternative Payment Model (AAPM) through Medicare Access and CHIP Reauthorization Act (MACRA) so that participating providers will receive credit for contracting with PEB starting in 2021. We will work with CMS on requirements under MACRA/Quality Payment Program (QPP) to designate custom state-based models and other advanced alternative payment models.
    - We will work to align Model 2 providers and practitioners in Hub trainings as needed.
    - We will target key employers and purchasers to implement Bree Collaborative care transformation standards.
    - We will investigate and create incentive models (i.e., Shared Decision Making (SDM) funding) for providers to join accountable care plan networks.
    - We are leveraging the common measures to standardize the way we measure performance by including common measures from the common measure set in 2017 state health care purchasing contracts, specifically PEBB and Medicaid contracts. These measures reflect current measures in the ACP contracts as well.
- Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation.
    - The development of more robust state data and analytic capacity will begin in earnest. We will focus broadly as a state on the health information technology arena – recognizing the benefit of supplemental AIM funding.
    - We will provide data, analytics, and reporting to support to all of the payment model tests and the ACHs.
    - We will realize the benefits of products from the mandated state all-payer claims database (WA-APCD).
    - We will build and deploy a Healthier Washington Innovation Sandbox that will give the AIM team an environment to explore with advanced data mining strategies.
- Washington State is leveraging partnerships, financing, and policy to ensure health systems transformation endures.
    - Sustainability plans have been developed for every investment area / driver. Quarterly deliverables have been articulated for each team and component of Healthier Washington.
    - The HILN will leverage its influence to spread, perform on, and sustain Healthier Washington efforts.

All of these AY3 initiatives are working in harmony, as a system, toward our goal of a Healthier Washington.

End-State Vision

The year is 2020.

Gina is living in the north Puget Sound area of Washington State. As a teenager, she was diagnosed with Type 1 diabetes. This was, at the time, a devastating diagnosis for Gina and her family. Working with their family doctor trained in delivering evidence-based medicine and working under contract with Managed Care Organizations (MCOs) to report quality measures, they tried different insulin strategies and she eventually became stable in her health and well-being. Gina and her family attended seminars and family camps, paid for by a non-profit diabetes support fund, to learn how to deal with her disease. They were connected to these resources through community clinical linkage systems and supported by their regional ACH. Their family doctor was part of a provider system that had an established policy of connecting patients to identified resources before leaving the clinic.

Gina went to college; she seemed to have found her passion and was doing well. However, she had gained some weight, and during a visit to an on-campus clinic, was diagnosed with depression. Before ordering any tests, her campus clinic provider was able to look up Gina's medical records and see that she has diabetes – a condition that very often causes depression. (Access to community medical records was enabled by earlier CMS/HITECH investments in electronic medical records (EMRs). He prescribed some anti-depressants and suggested she find a campus support group for students with diabetes – giving her a list of campus resources that might help her. (The college had recently been working with the regional ACH on useful community linkages for health issues on campus).

During her second quarter of college, Gina began to experience extreme mood and behavior changes. This change seemingly came out of nowhere, stunning her family and friends. After a particularly frightening blow-up, she went to her primary care provider and he suggested she try a temporary hospitalization to ensure she did not hurt herself. She was diagnosed with bipolar disorder. She avoided an emergency department (ED) visit – but the hospital stay was precisely what she needed and through that experience she was able to tap into appropriate care and referrals. The Technical Assistance (TA)/Coaching provided by the Practice Transformation Support Hub included lessons in trauma informed approaches to making patients and providers comfortable talking about interrelation between diabetes/depression.

A case manager was assigned to help Gina. Within a week, her case manager organized a multi-disciplinary care team that included staff from the hospital, a behavioral health case manager, a therapist, and a regional health connector. Everyone had the same goal of providing more support to Gina to reduce the likelihood of her using the hospital for non-emergent needs and to help her feel her best. Gina has been connected with a primary care provider (PCP) who specializes in complex adult cases and she is keeping her appointments. She is also meeting with her mental health counselor routinely and attending a support group meeting on campus. These multi-disciplinary resources are part

of the care team and included in the state's goal to achieve 80 percent of payments to providers under value-based payment arrangements. Because of the federal investment in the Practice Transformation Support Hub and the Payment Model Re-design efforts, 80 percent of all payments made to providers are now value-based.

Gina's support group has formed walking groups, which helps Gina manage her diabetes and improves her mood. Thanks to a "health in all policies" approach by city and campus planning, there are safe routes that are well lit, with trees, and birds.

Gina is doing well and living her best life.

Several population health approaches –inside and outside clinic walls - contributed to Gina "doing well and living her best life." Effective strategies have been identified for the diabetic population, those with co-occurring disorders, and for the college student population – and were collectively applied in Gina's case. Systemic changes, implemented and supported by an ACH serving a specific geographic population, enabled Gina to access Medicaid coverage, have health care access on her college campus, and be connected to multi-sector support services. Additionally, practice transformation efforts helped her provider to be comfortable talking with her about mental health issues, and statewide public awareness campaigns to reduce stigma of co-occurring disorders helped Gina to feel comfortable accessing the support. Investments in these strategies were made possible by a combination of financial incentives for a population health approach and alignment of multi-sector resources toward a common health goal.

Much of this story made possible by the state's investment in technology infrastructure to provide data at the point of care and throughout the region as it develops plans and programs for continually optimizing population health. Multiple financing levers, including HITECH, agency, and CMS funding for Medicaid enhancements were used to connect all resources along the continuum of care. Health Information Technology (HIT) alignment within HCA helped reduce possible duplication of work and increase the interoperability of systems both inside the agency, between the agency and its partners, and in the field.

From the early days of the Washington State Health Care Innovation Plan, to the SIM Grant and the Medicaid Transformation Demonstration, we have been clear-minded, determined and articulate about our end-state vision. We know where we are going and we continue to strive toward being a "first mover" in our state and in our nation. What might that look like?

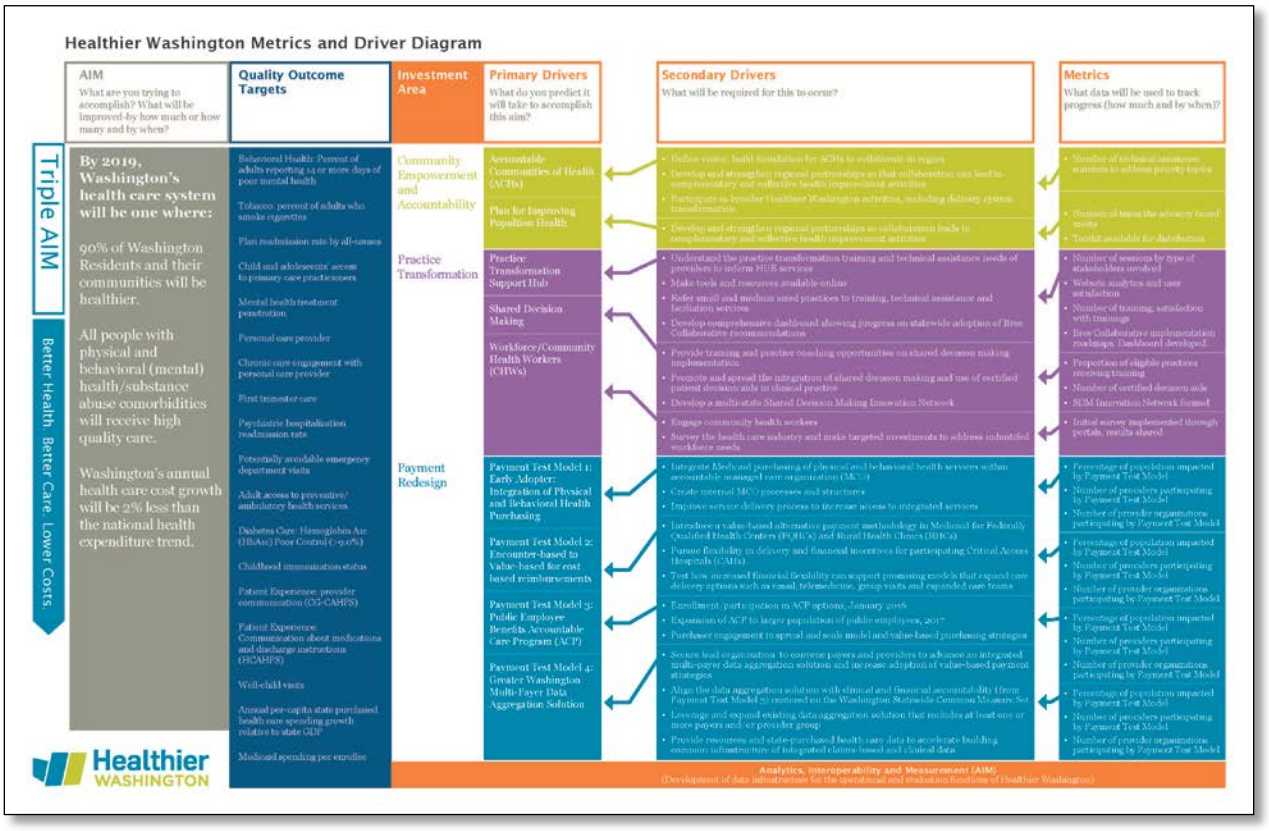
- The biggest systemic change ACHs represent is the creation of a system where people talk to each other and silos are not perpetuated. The model represents a new system where activities and goals can be aligned for outcomes.
- ACHs will address changes that need to occur to better serve communities and people, including but not limited to Medicaid beneficiaries. Working with community-based, cross-sector coalitions is a proven, effective and efficient way

to transform the health system in the state. The ACH provides immense value in convening partners, coordinating health transformation activities, implementing interventions, connecting clinical and community-based organizations and tracking regional health performance.

    - Providers and payers alone cannot reach quality and population health targets without the community component. As we have said before, we want to address 100 percent of the factors that influence health – and not just the traditional, clinical portion.
    - We will look at every component of a community's need through the lens of incentives; we will work closely with our ACHs to ensure they are using this lens as they determine their priorities and move to action.
- Integrated financing of Medicaid services will advance delivery system and payment reform by removing the financial silos that create barriers to achieving value-based payment strategies and paying for services in an integrated clinical model. Delivery of whole-person care and adoption of integrated clinical models in the delivery system will accelerate quickly - while also integrating payment through managed care.
- Providers will feel fully supported with coaching, technical assistance and training support to advance their journey toward clinical and financial transformation of their organizations.
- Paying for value strategies (such as incentive payments for quality targets and risk-based contracts with up and downside risk) have advanced delivery system and payment reform through the spread and scale of the Accountable Care Program and associated payment and delivery system principles, through multi-payer engagement, and through supporting providers to better manage patient populations. More providers are saying yes to risk.
- Payment Model 2 will effectively move Washington's "safety net" providers to VBP. It has maintained and increased a vital capacity in Washington's rural areas and helped rural providers move toward value-based readiness.
- Our AIM capacity will produce dashboards, reports, data, and integration across the delivery and payment systems to support both medical population health and community population health. Data will prove a reliable source for good decision making.

Through this AY3 Operational Plan, we will articulate how our SIM initiative will transform the state's health care system and become our **end state**. Our work plan has been linked to goals and measureable objectives to move our state toward our intended outcomes.

2. Driver Diagram



(Driver Diagram – also found in Appendix 1)

The driver diagram is a logic model of our SIM initiative, and includes measureable aims, primary drivers, and secondary drivers. The driver diagram identifies:

- What aspects of the health system are being targeted and why;
- How the proposed initiatives connect to one or more of the awardee's health transformation goals; and
- What populations will be impacted.

The driver diagram is intended to be a living document. As such, we have made four changes to the secondary drivers and one change to the metrics column specific to the Practice Transformation Support Hub. We dropped the references to the Bree Collaborative and added a measure to obtain key informant interviews with stakeholders as a critical measure of success in AY3.

3. Master Timeline for SIM Model

The following timeline provides a detailed reconciliation of AY2 components in order to lay the groundwork for AY3.

This master timeline captures:

- Completed activities/milestones in AY2 (achievements);
- Where applicable, a brief explanation of AY2 milestones that were not completed and why.

Please reference this legend to interpret the coding of tasks in the AY2 work plan.

Legend:

Color	Meaning
	Complete
	On track / In Progress / Plan to complete by GY2
	Delayed / Plan to complete by GY2
	Delayed / No Plan to complete by GY2
	De-scoped
	Reduction in scope
	Future Milestone

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Provide ACH Development and Implement Technical Assistance	Accountable Communities of Health													2016 Q1-Q2: Priority technical assistance topics identified 2016 Q3-Q4: Summits hosted and adjustments to TA materials and guidance.
Governance/ Structure: Develop and Sustain ACH Infrastructure	Accountable Communities of Health													2016 Q1-Q2: ACHs confirm the lead organization/define shared functions. 2016 Q3-Q4: ACHs have completed a backbone evaluation/survey in alignment with state guidance. 2017 Q1-Q4: ACHs implement improvement strategies; infrastructure sustainability planning options outlined.
Governance/ Structure: Develop ACH Governance and Engagement Structures and Strategies	Accountable Communities of Health													2016 Q1-Q2: ACHs identify gaps and opportunities based on state guidance. 2016 Q3-Q4: ACHs implement necessary adjustments based on identified gaps.
Regional Health Improvement/ Delivery System Trans-formation: ACH Project Implementation	Accountable Communities of Health													2016 Q1-Q2: ACHs finalize a 2016 Regional Health Needs Inventory. 2016 Q3-Q4: All ACHs have implemented the first phase of a project, identified measures, and established mechanisms to track progress.

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Provide Technical Assistance to ensure effective tribal and urban consultation, engagement, and coordination	Accountable Communities of Health													2016 Q1-Q2: Provide assistance with tribal engagement and communication. 2016 Q3-Q4: Analyze survey and develop recommendations. 2017 Q1-Q4: Implement recommendations
Maintain a strong governance and expert advisory function	Plan for Improving Population Health													2016 Q1: External Advisory Board formed. 2016 Q2: Assess and Inventory current and related initiatives. 2016 Q2: Stakeholder Listening Sessions.
Implementation Plan and the Guide / Toolkit (process tools for facilitating evidence-based interventions)	Plan for Improving Population Health													2016 Q1: Define the plan elements, timelines, and expectations 2016 Q3: Package of change interventions that can be implemented to improve population health (now a website) 2016 Q4: Toolkit incorporated into Hub resource portal website
Sustainability Plan	Plan for Improving Population Health													2016 Q3: Sustainability Plan funding and resources are identified to implement plan; continuous improvement of the guide incomplete in AY2. Moved to AY3.
Deliver a web-based clearinghouse portal of curated resources	Practice Transformation Support Hub													Permanent site: Q1: Publish the RFP Q3: Select a vendor Q3: Hub business requirements delivered Q4: Establish the process and team for vetting and aligning the resources for the clearinghouse; this is a service.
Practice Coaching and Facilitation Network	Practice Transformation Support Hub													Q1: Publish the RFP Q2: Select one or more vendors to create consortium of practice coaching services Q2: Cross-agency network group will determine role of Hub to develop referrals process, and additional tools Q4: Have an established catalog of services
Regional Health Connector Program	Practice Transformation Support Hub													Q1: Publish the RFP Q2: Select a vendor Q3: Phased roll-out of agents (1-4) Q4: Phased roll-out of agents (5-9)
Advisory Board created / stood up	Practice Transformation Support Hub													Q1: Select and recruit membership Q2: Determine role related to oversight of services Q2: Start meeting ~ April 2016 Q3: Board will provide feedback on features, services, and guidance on alignment with needs of clinical practice community

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Development of an innovative model to certify PDAs in Washington that builds on key legislation and can be spread to other states	Shared Decision Making													2016 Q1-Q2: Certification process has been approved, tested, and finalized, and staffing is in place 2016 Q2-Q4: Accountable Care Programs have begun to use certified decision aids
Update of current Washington Administrative Code (WAC) to incorporate process of certifying PDAs, encouraging the use and spread of SDM.	Shared Decision Making													2016 Q1-Q2: Final approval and implementation of Washington certification process. Not able to complete in AY2 – moved to AY3
Train providers on SDM Strategies 101	Shared Decision Making													2016 Q1: Initial master training conducted to ensure spread across state 2016 Q2 - Q4: Participants of master training have conducted at least two additional trainings. *Only one training was delivered. Agency for Healthcare Research and Quality (AHRQ) has lost funding for the training; we may offer training in AY3 but may not use the train-the-trainer model.
Provide practice coaching opportunities to assist providers engaged in payment model tests to implement SDM, including use of certified PDAs.	Shared Decision Making													2016 Q2: Implement vendor contract to provide practice coaching 2016 Q3- Q4: Provide training/coaching to at least 10% of eligible practices
Develop a plan to promote and spread the integration of SDM and use of certified PDAs in clinical practice	Shared Decision Making													Q1 - Develop a draft and a final implementation plan – COMPLETE
Certification of Decision Aids to support maternity aids	Shared Decision Making													Q1 - Q3: Complete two rounds of review and certification of maternity care decision aids. Incomplete: *Completed one round only due to number of aids received.*
Certification of decision aids to support joint replacement/ spine care aids	Shared Decision Making													2016 Q3- Q4: One round of review and certification of joint replacement/spine care decision aids 2017 Q1- Q2: Two rounds of review and certification of joint replacement/spine care decision aids Moving to AY3.

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SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Certification of decision aids to support cardiac/end of life care aids	Shared Decision Making													2017 Q3- Q4: One round of review and certification of cardiac and end of life care decision aids 2018 Q1- Q2: Two rounds of review and certification of cardiac and end of life care decision aids Moving to AY3.
Negotiate discounts and/or scholarships for certified decision aid licenses for use by providers engaged in Healthier Washington payment model tests, to integrate into clinical practice.	Shared Decision Making													2016 Q3- Q4: Negotiate discounts/scholarships for at least one certified decision aid 2017 Q1- Q2: Negotiate discounts/scholarships for at least two certified decision aids
Develop benefit design/ payment incentive structure to provide positive incentives for SDM adoption/ use.	Shared Decision Making													2017 Q1 - Q4: Monitor ACP contractual requirements to implement SDM strategies and use of certified decision aids into their health systems 2017 Q1 - Q4: Engage payers in discussions about incorporating SDM methodologies into payment system to provide incentives to providers and members.
Develop a multi-state SDM Innovation Network	Shared Decision Making													2016 Q1 - Q2: Engage national partner to co-sponsor multi-state SDM Innovation Network 2016 Q3 - Q4: Identify and engage states developing and/or implementing innovative
Analysis of development and testing process for Decision Aid Certification, including a summary of findings, successes, lessons learned, etc. to share with other states considering developing a certification process.	Shared Decision Making													2016 Q1 - Q2: Track process, lessons learned, successes, barriers, and resources needed to sustain certification process 2016 Q3 - Q4: Write up and publish summary of findings
Annual follow-up on CHW Taskforce actionable policy recommend-ations	Workforce													*We received a number of suggestions about CHWs in AY2 – while "certifying" CHWs has always been out of scope, the work is actively being pursued by several of the ACHs who have projects targeted specifically at developing CHWs.

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Industry Sentinel Network: web portal survey, collect, analyze, and disseminate workforce trends to educational teams/boards.	Workforce													2016 Q1-Q2: Survey questions vetted and established. Portal established 2016 Q3-Q4 initial survey conducted analysis conducted and results disseminated
Workforce investments identified based on data	Workforce													2017 Q1 Workforce investments identified in response to data 2018 Q1 Workforce investments identified in response to data
Procure managed care organizations providing integrated services and operationalize transition to full-integration.	Payment Model 1, Early Adopter Program													2016 Q2: At least 2 integrated MCOs pass readiness review.
Modify information systems to support integrated managed care and new behavioral health services only benefits.	Payment Model 1, Early Adopter Program													2016 Q1: ProviderOne system changes tested and live (HCA); Healthplanfinder system changes tested and live (Health Benefit Exchange) 2016 Q2: New behavioral health data reporting system tested and live (DSHS) > now estimated at 4/2017. Represents a delay in development – Requirements have been identified to meet these needs in AY3.
Obtain federal/state regulatory approval	Payment Model 1, Early Adopter Program													2016 Q1: CMS approves State Plan Amendment (SPA) and 1915(b) waiver 2016 Q2: WAC amendments approved by code reviser
Develop and implement an early warning capacity to identify and resolve implementation issues rapidly	Payment Model 1, Early Adopter Program													2016 Q1: Identify early warning system metrics, establish and test process for tracking early warning system metrics, and responding via triage system. 2016 Q2: Early warning/triage system implemented.
Develop and implement a culturally appropriate outreach plan to Medicaid beneficiaries, to educate on upcoming Medicaid changes	Payment Model 1, Early Adopter Program													2016 Q1: Outreach plan implemented, materials distributed, and public meetings underway. 2016 Q2-Q4: Continued education and outreach to ensure Medicaid populations understand the transition to integrated managed care.

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Educate integrated managed care plans on behavioral health system and new services in preparation for transition to full-integration	Payment Model 1, Early Adopter Program													2016 Q1: Conduct facilitated trainings/education with integrated MCOs, providers, and county staff to educate them on processes of current behavioral health (BH) system. 2016 Q2-Q4: Continued education and learning opportunities for MCOs, providers and state/county staff to improve BH system
Provide technical assistance to behavioral health and physical health providers to assist in transition to integrated care	Payment Model 1, Early Adopter Program													2016 Q1: Provide a series of trainings to physical and behavioral health providers to assist with the transition to integrated managed care. 2016 Q2-Q4: Provide as-needed continued education and training
Enroll Medicaid clients in integrated managed care plans	Payment Model 1, Early Adopter Program													2016 Q1: Enrollment in integrated managed care plans begins February 29, 2016. 2016 Q2-onging: Same-day enrollment begins in April 2016 and continues through duration of contracts.
Provide practice transformation support to providers to support delivery system integration	Payment Model 1, Early Adopter Program													2016 Q1: Practice transformation resources selected available to providers by January 2016. Train providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT).
Medicaid beneficiaries with co-occurring disorders receive care coordination through a whole-person system of care	Payment Model 1, Early Adopter Program													2016 Q2: ongoing: Enrollees with co-occurring disorders begin to receive or continue the coordinated care specified under the new fully integrated managed care contract.
Expand integrated model to additional regional services areas	Payment Model 1, Early Adopter Program													2016 Q2: 2020 roll-out plan completed. We have a draft timeline (appendix 6) completed; plan to have firm roll-out plan by 2018. Goal is still mandatory 2020 full migration to integrated financing. 2016 Q3: Engage county government and other stakeholders within regional service areas in discussions around integrated care model and timeline for implementation prior to 2020. 2016 Q4: Non-binding letter of intent due from mid-adopter regions in November 2016. 2016 Q3-Q4: Continued engagement regarding the benefits of integrated managed care and the implementation process. Consultant communications campaign on best practices and early successes from Early Adopter region.

SIM Component/Project Implementation Gantt Chart (Award Year 2)													
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
														2017 Q1: Binding letter of intent from mid-adopter regions in February 2017. 2017 Q2- Q3: Conduct procurement to procure integrated MCOs in mid-adopter regions. Apparently successful bidders announced in July 2017. 2017 Q4: Conduct readiness review of integrated MCOs in mid-adopter regions by December 2017. 2018: Q1: Integrated coverage effective on January 1, 2018 in "mid-adopter" regions.
Consulting support for facilitation and APM development	Payment Model 2, Encounter to Value Model													2016 Q1 - Q2: FQHC/RHC alternative payment methodology (APM) working session materials/facilitation. 2016 Q1 - Q2: Provide subject matter expertise to help develop and validate an APM. DELAYED – disagreements on model design. Continuing to push for AY3. The tasks / milestones remain consistent with original plan – but timelines have shifted.
SPA: APM development	Payment Model 2, Encounter to Value Model													2016 Q2 - Q4: Develop and submit a SPA for value-based APM. DELAYED
Pilot implementation	Payment Model 2, Encounter to Value Model													2017 Q1: Pilot implementation for FQHC/RHC APM.
Stakeholder engagement and conceptual model development	Payment Model 2, Encounter to Value Model													2016 Q1 - Q4: New payment and delivery model for CAHs. 2016 Q1 - Q4: Educate and develop community support for piloting participation.
CAH stakeholder development of support	Payment Model 2, Encounter to Value Model													2016 Q1 – Q4: Work plan and summary report.
SPA: CAH payment and delivery model	Payment Model 2, Encounter to Value Model													2016 Q4 – 2017 Q2: Develop and submit a SPA for CAH payment and delivery model.

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Implement regulatory changes: CAH payment and delivery	Payment Model 2, Encounter to Value Model													2016 Q2 – 2017 Q2: Develop and submit regulatory changes in partnership with Department of Health (DOH).
Pilot implementation	Payment Model 2, Encounter to Value Model													2017 Q3: Pilot implementation for CAH payment and delivery.
External validation	Payment Model 2, Encounter to Value Model													2016 Q2 - Q4: Work with external auditors to verify and validate new rates for payment and delivery models.
Transformation support	Payment Model 2, Encounter to Value Model													2016 Q2 - Q3: Working at FQHC/RHC pilot site(s) to educate and support the transformation to a new model. Delayed due to length of stakeholder engagement process. Moving to AY3. 2017 Q1 - Q2: Working at CAH pilot site(s) to educate and support the transformation to a new model.
Provider payment changes	Payment Model 2, Encounter to Value Model													2016 Q1 - Q3: Identify and implement changes to internal HCA systems for facilitating new APM. 2016 Q3 – 2017 Q2: Identify and implement changes to internal HCA systems for facilitating new payment and delivery model for CAHs. – Pending design approval. Moving to AY3.
Statewide adoption planning	Payment Model 2, Encounter to Value Model													2016 Q4 - 2019 Q1: Work with HCA and FQHC/RHC stakeholders to develop an action plan, stakeholder engagement strategy, impact report/glide path assessment, and community engagement activities. 2016 Q4 - 2019 Q1: Work with HCA and CAH stakeholders to develop an action plan, stakeholder engagement strategy, impact report/glide path assessment, and community engagement activities
Enrollment/ participation in ACP options, 2016	Payment Model 3, Accountable Care Program													2015 Q4: A sufficient number of PEBB members enroll in one of the two options for January 2016 coverage (10K+) 2015 Q4: Conduct survey of PEBB members who selected and didn't select new ACP options and apply learnings for 2017 enrollment strategy
Expansion of ACP options,	Payment Model 3, Accountable Care Program													2016 Q2: Signed contracts completed with new ACP partner and/or current ACP partners' expansion plans completed. 2016 Q3 - Q4: Pre-launch activities/operational tasks with new partner completed (if there are new partners)

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Multi-Purchaser engagement to Spread and Scale Model 3 and VBP (activities include individual meetings with public and private purchasers, semi-annual meetings with group of selected purchasers, and annual purchasers conference)	Payment Model 3, Accountable Care Program													2015 Q4: Governor Inslee presents 'Call to Action' to business roundtable. COMPLETE 2016 Q1: Issue VBP Request for Information (RFI) to survey payers and providers on VBP journey using CMS payment framework. COMPLETE 2016 Q1: Purchaser conference held (cosponsored with King County, Washington Health Alliance, and the Washington Roundtable); meet with at least three purchasers. COMPLETE 2016 Q2: First meeting with select purchasers (PAG Plus); meet with at least three purchasers/make presentations DELAYED – Moving to AY3. 2016 Q3: Meet with at least 3 purchasers/make presentations- ON TRACK TO BE COMPLETED 2016 Q4: Second meeting with select purchasers (PAG Plus); meet with at least three purchasers/ make presentations DELAYED – Moving to AY3. *Multi-purchaser activities in 2016 will be repeated annually with the same cadence and milestones.*
Lead organization procurement activities	Payment Model 4, Multi-Payer Strategy													2016 Q1-Q2: Finalize and execute contract with lead organization, including work plan. – DELAYED to Q3-Q4
Manage PEBB/Medicaid data flow from state to lead organization	Payment Model 4, Multi-Payer Strategy													2016 Q3-Q4: Initial data dump complete, move toward periodic transmission – DELAYED to Q4
Apply Model 4 learnings into PEBB purchasing strategies	Payment Model 4, Multi-Payer Strategy													*Due to delay in Model 4 development, these milestones will be re-evaluated if and when we execute the contract and implement the payment model – See work plan for AY3 for new / revised deliverables, milestones, and deadlines. 2016 Q1: Establish internal workgroup/steering committee for oversight to project manager 2016 Q2-Q3: Develop and finalize plan/recommendation for application of Model 4 and PEBB purchasing
Model 4 evaluation consultant	Payment Model 4, Multi-Payer Strategy													DELAYED to AY3: 2016 Q1-Q2: Model 4 evaluation criteria established with UW team 2016 Q3-Q4: Model 4 evaluation data stream established; data collection initiated 2016 Q1-Q2: Strategy for convening additional partners

SIM Component/Project Implementation Gantt Chart (Award Year 2)													
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Contract management	Payment Model 4, Multi-Payer Strategy													2016 Q1: Contract executed, lead organization performance initiated – DELAYED to Q4 2016 Q2-Q3: Plans for convening additional payers/providers and advancing VBP established – DELAYED to Q3 - Q4 2016 Q3-Q4: Lead organization plans for fiscal year (FY) 2017 developed and presented to HCA; seek CMMI approval for contract renewal (most likely delayed until 2017 Q1-Q2) 2016 Q1-Q2: Model 4 evaluation criteria established with UW team DELAYED to AY3 2016 Q3-Q4: Model 4 evaluation data stream established; data collection initiated DELAYED to AY3 2016 Q4: Lead organization fulfills requirements of contract to renew for FY DELAYED to AY3
Healthier Washington Dashboard Reporting Tool (DRT)	Analytics, Interoperability, and Measurement / Accountable Communities of Health													2016 Q1 • (1a) Data infrastructure design • (1b) DRT design • (1c) Work plan • (1d) Data infrastructure build • (1e) DRT build • (1f) Data validation • (2a,b,c) Select measure development, validation, filters • (2d) Initial DRT Release 2016 Q2 • (2a,b,c) Additional measure development, validation, and filters • (2d) HW Data Dashboard updates 2016 Q3 • (2a,b,c) Final measure development, validation, and filters • (2d) DRT Updates 2016 Q4 • (2d) DRT Updates
Healthier Washington Information Governance	Analytics, Interoperability, and Measurement													2016 Q1 • Healthier Washington Information Governance contract approved 2016 Q3 • Healthier Washington Information Governance charter approved Activities de-scoped. To be performed by HCA in 2017.

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
AIM project quality assurance	Analytics, Interoperability, and Measurement													2016 Q1 • AIM Project Quality Management Plan • AIM Initial Quality Assessment Report 2016 Q2 • AIM Quarterly Quality Progress Report 2016 Q3 • AIM Quarterly Quality Progress Report 2016 Q4 • AIM Quarterly Quality Progress Report 2017 Q1 • AIM Quarterly Quality Progress Report DESCOPED – Will now be performed by HCA.
AIM BI/Analytics platform implementation	Analytics, Interoperability, and Measurement													2016 Q1 • AIM BI/Analytics Platform Procurement Strategy and Plan approved • RFPs for AIM BI/Analytics Platform released 2016 Q2 • Apparent Successful Vendors for AIM BI/Analytics platform and Implementation Support selected • Contracts finalized for AIM BI/Analytics Platform and Implementation Support • AIM Data Acquisition Plans finalized 2016 Q3 • AIM BI/Analytics Platform Design Plans complete • AIM BI/Analytics Platform Implementation Plans finalized 2016 Q4 • AIM data source Data Use Agreements finalized 2017 Q1 • AIM BI/Analytics Platform implemented • AIM data source acquisition mechanisms (e.g., ETL) built • AIM data sources added to Healthier Washington AIM Logical Data Warehouse
Healthier Washington evaluation support	Analytics, Interoperability, and Measurement													2016 Q1 • Assist with Healthier Washington Evaluation Plan 2016 Q2 • Refine Healthier Washington evaluation metrics and supporting data collection plan 2016 Q4 • Evaluation data sources identified, Data Use Agreements (DUAs) in place 2017 Q1 • Evaluation data collection repositories designed, implemented and populated
BH Data Assessment	Analytics, Interoperability, and Measurement													2016 Q1 • BH Data Assessment Gaps, Alternatives, and Recommendation Report

SIM Component/Project Implementation Gantt Chart (Award Year 2)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
BH EHR implementation	Analytics, Interoperability, and Measurement													2016 Q1 Healthier Washington Leadership decision on BH EHR approach If decision to move forward with BH EHR Implementation: 2016 Q3 • BH EHR RFP released; vendor selected 2016 Q4 • BH EHR contract finalized • BH EHR Implementation Project start DELAYED due to need for governance decision on investment– this task in the work plan and budget for AY3.
BHO Data Consolidation Project	Analytics, Interoperability, and Measurement													2016 Q1 • BH Data Consolidation Tool development • BH Data Consolidation Tool testing 2016 Q2 • BH Data Consolidation Tool release
Washington All Payer Claims Database (APCD)	Analytics, Interoperability, and Measurement													2016 Q1 • Vendor selected – Q2/3 – COMPLETE • WA-APCD project starts – COMPLETE 2017 Q3 • WA-APCD released – ON TARGET
Evolution and evaluation of the Statewide Common Measure Set: **Convening Governor-appointed Performance Measures Coordinating Committee (PMCC)**	Performance Measurement Analytics, Interoperability, and Measurement													2016 – 2018 - Convene the PMCC quarterly to develop and submit recommendations to HCA for annual updates to the common measure set. Q1 2019: Final Common Measure Set
Evolution and evaluation of the Statewide Common Measure Set: **Convening ad hoc measure selection workgroups**	Performance Measurement													2016 Q2: Identify members for up to three ad hoc workgroups 2016 Q2 - Q3: Convene ad hoc measure selection workgroups to research, review, and identify measures to include in Statewide Common Measure Set 2016 Q4: Convene ad hoc evaluation workgroup to review current measure set and submit any proposed changes to PMCC for consideration. Annually: Public comment survey to solicit feedback for proposed changes to Common Measure Set

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SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Communication campaign: Promote the spread and uptake of the Statewide Common Measure Set	Performance Measurement													2016 -2018: • Implement communication campaign to promote the spread and uptake of the common measures set by engaging payers, purchasers and providers – IN PROGRESS • Develop and implement process to track reach of campaign - IN PROGRESS
Reporting: Accelerate statewide spread of medical group level reporting	Performance Measurement													2016 Q1-Q2: Submit provider rosters for four new communities 2016 Q3-Q4: Submit provider rosters for three to four new communities Q1 2017: Roster complete
Reporting: Produce and report results for Statewide Common Measure Set	Performance Measurement													2016-2018 - Q4: Annual public report results for Statewide Common Measure Set released, using a web-based platform, annually through 2018, (or when WA-APCD is established and ready for reporting.)

B. General SIM Policy and Operational Areas

1. SIM Governance

a. Management Structure and Decision Making Authority

As directed by state law, the HCA will continue its leadership role and executive sponsorship of Healthier Washington, with agency Director Dorothy Teeter serving as executive sponsor. HCA Chief Policy Officer Nathan Johnson is the SIM grant program sponsor and Healthier Washington coordinator. Governor Jay Inslee directs the Healthier Washington initiative, and is closely involved in ensuring alignment with other state innovation initiatives including the development of Healthier Washington.

In Healthier Washington governance, decision making is not merely vertical it is also horizontal. Each staff member wears an organizational hat and a functional hat. Representatives from the state Department of Social and Health Service (DSHS), Office of Financial Management (OFM), and Department of Health (DOH) are members of the team and valued for both their subject-matter expertise and their ability to link and liaison with their home agencies.

Team leads are encouraged to make the most of their decision-making authority. Each level of program governance has a specific role and accountability, as follows:

- Executive Governance, comprised of members of the Governor's cabinet and his senior advisors, provides strategic policy direction and ensures the overall success of the program.

- The Healthier Washington coordinator and deputy coordinator ensure work is quality, timely, and communicated. As the program sponsor, the coordinator is a critical resource for team leads for decision making and strategy. Sponsors are

leaders and subject-matter experts who are available to consult and advise on all decision types. Of paramount importance is the sponsor's ability to present an escalated or cross-agency program issue to the Consulted Leadership Team or Executive Governance. The Healthier Washington coordinator is a key program sponsor who informs decision recommendations and suggests strategies.

- In a sponsoring and advising role, the Consulted Leadership Team, comprised of leaders and subject matter experts across the agencies, provides weekly consultation to ensure the success of Core Team and Project Teams.

- The Core Team is the functional and operational coordinating body for the program. The Core group meets bi-weekly to review status, address hot topics, resolve issues, and ensure the forward momentum of Healthier Washington.

- Healthier Washington has a number of Project Teams, comprised of team leaders, program managers, and staff, working collaboratively to manage the projects under the Healthier Washington umbrella. The program managers are responsible for identifying decisions that need to be made as well as helping to prepare the requisite data required to make a final and firm decision. The project management group is also responsible for documenting and tracking all project-related decisions.

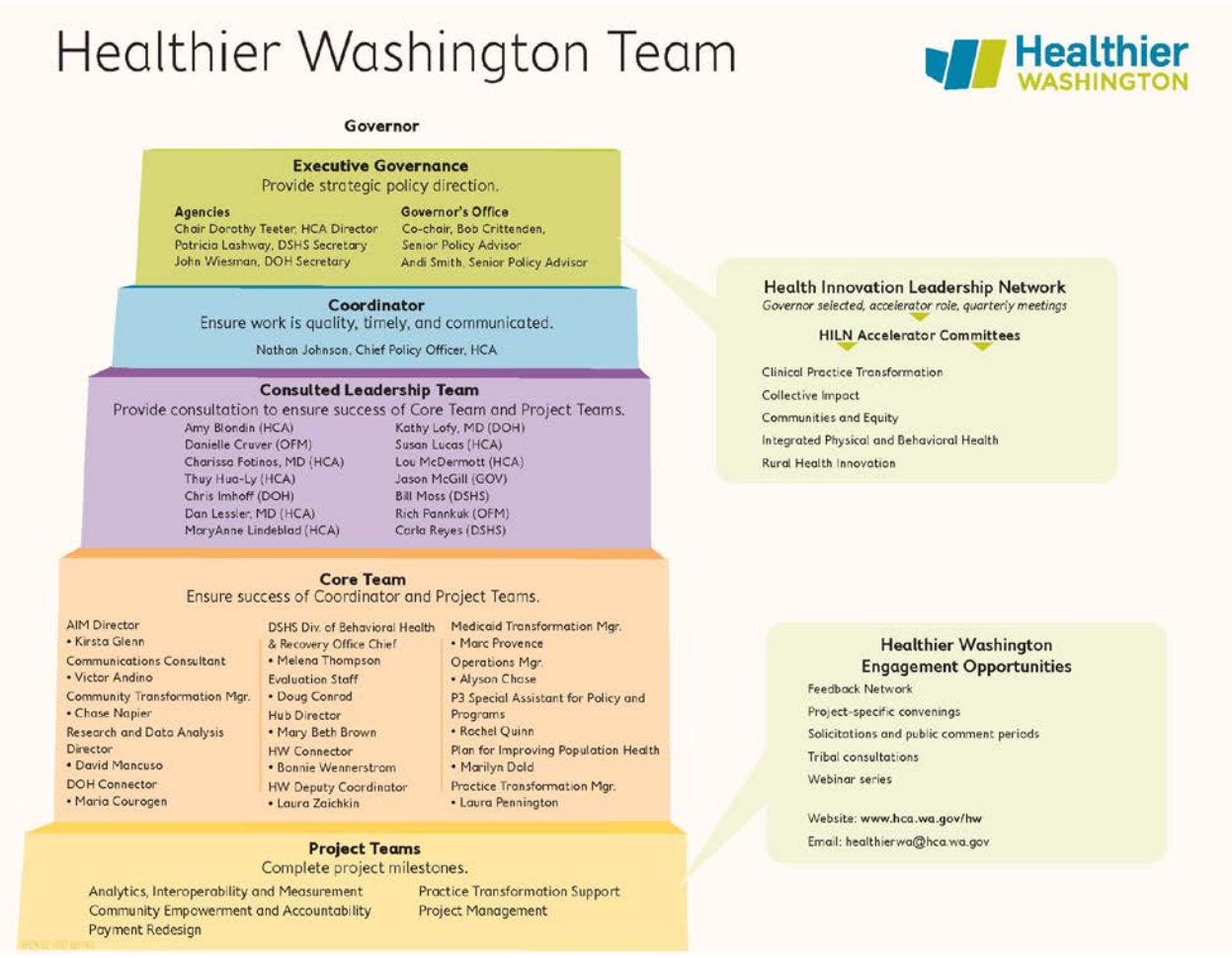


Figure: The Healthier Washington "Layer Cake" Governance Structure

As directed by state law, the HCA will continue its leadership role and executive sponsorship of Healthier Washington. Governor Jay Inslee directs the Healthier Washington initiative, and has been closely involved in ensuring alignment of the initiative with other state innovation initiatives, including the development of Healthier Washington. The governor has directed alignment of agency initiatives and performance measures in support of health and wellness, and emphasized the importance of health system reform at the state and community levels.

Similar to Healthier Washington's multi-sector approach to innovation and the achievement of the Triple Aim, the initiative is led, managed, and implemented by leveraging the talents and resources of multiple state agencies in addition to HCA, namely, DOH, DSHS, and OFM.

In addition to building upon the strengths of multiple state agencies, Healthier Washington leverages strong private sector support and adoption of the initiative. Some of this exists within the contractual arrangements between the state and private entities, while some is voluntary. For example, Healthier Washington's partnership with the Washington Health Alliance includes funded deliverables around quality measurement and reporting, but it also has contributed in-kind resources and subject matter expertise around value-based models.

b. Leveraging Regulatory Authority

Washington has the authority in place to implement Healthier Washington. The State has taken full advantage of expanding Medicaid enrollment and was recently granted provisional approval for an 1115 Medicaid Demonstration. (*Please see Appendix 5 for a detailed description of the 1115 Medicaid Demonstration).*

In 2014, to implement the Innovation Plan, the governor requested two landmark pieces of legislation, which passed with bipartisan support. House Bill 2572 adopted key recommendations from the Innovation Plan, including Accountable Communities of Health, the Practice Transformation Support Hub, developing and reporting on the common measure set, and directing the state to increase value-based purchasing for Medicaid and public employees. Senate Bill 6312 set the path for the phased approach to whole-person care by 2020.

E2SHB 2572 – "Better Health Care Purchasing"
• Creates legislative oversight • Establishes and funds first two Accountable Communities of Health • Establishes statewide performance measures committee • Creates practice transformation support hub • Establishes all-payer claims database and creates a safe harbor • Directs HCA to increase value-based contracting for Medicaid and public employees

2SSB 6312 – "Treating the Whole Person"
• Medicaid purchasing for physical, mental health, and chemical dependency services must be fully integrated by 2020 • Creates behavioral health organizations by 2016 to integrate chemical dependency and mental health services administration

- Medicaid purchasing will be aligned in regional service areas by 2016
- Incentives for early-adopters of full integration
- Incentives for outcome-based performance
- Reciprocal contracting arrangements required for co-located services

This built upon Washington's history of legislation that supported innovation.

- **Shared decision making.** In 2007, the state passed the Blue Ribbon Commission bill that promoted a shared decision-making pilot within the state. Additionally, it provided that if a patient signs an agreement to use a "certified decision aid" as part of the informed consent process, there is a presumption that the patient has given his or her informed consent. Consequently, in 2012, the state passed legislation that grants HCA's chief medical officer the authority to certify patient decision aids.
- **State Health Information Exchange (HIE).** In April 2009, the Washington State Legislature passed Substitute Senate Bill 5501 designed to accelerate the secure electronic exchange of high-value health information within the state. SSB 5501 directed the HCA to designate a private sector organization to lead implementation. In October 2009, the HCA designated OneHealthPort to serve as the Lead HIE Organization. New services to address interoperability challenges in sharing health information across delivery systems are now being tested for the Medicaid population.
- **All Payer Claims Database (WA-APCD)**. In 2015, the Washington State Legislature passed Chapter 246, Laws of 2015 (Engrossed Substitute Senate Bill 5084), which directs OFM to establish a statewide all payer health care claims database (WA-APCD) to support transparent public reporting of health care information. The Medicaid program, the Public Employees Benefits Board Program, all health insurance carriers operating in the state, all third-party administrators paying claims on behalf of health plans in the state, and the state Labor and Industries program will be required to submit medical, pharmacy, and dental claims to the WA-APCD. This year, OFM released the Request for Proposals to procure the lead organization to coordinate and manage the database. OFM selected Oregon Health Sciences University (OHSU) as the successful vendor and expects reporting from the WA-APCD will begin in 2017.
- **Telehealth**. The 2015 legislature passed Senate Bill 5175 broadens the scope of telemedicine to enable its use in urban and underserved areas in addition to rural areas. It also enables payment for both the originating and the distant site in a telemedicine transaction beginning in 2017. This will encourage more extensive use of this growing technological tool to serve individuals and enhance provider capacity and resources.

Washington State has been striving for the Triple Aim by leveraging its purchasing influence for the past 30 years, beginning in 1986 when the state Medicaid agency was directed to contract with managed health care systems to provide services to recipients of aid to families with dependent children. Recognizing opportunities to more effectively manage care and cost, Washington brought purchasing for Medicaid and public employees into the same agency and amplified the state's commitment to managed care in 2011. In addition to the adoption of E2SHB 2572 in 2014, recent statutory requirements for Medicaid include: performance-based managed care for the integrated delivery of medical and mental health services; compliance with network adequacy

standards; incentives for chronic care management within health homes; comprehensive medication management; assessment of evidence-based practices utilization in children's services; outcome and performance measures to assess and improve mental health, long-term care, or chemical dependency services; outcome and performance measures developed by the statewide performance measures committee; and integrated managed health and behavioral health care for foster children (2015).

Over the last several years, the Legislature created avenues to move to quality and value. In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative (Bree Collaborative), a multi-stakeholder consortium charged with identifying specific ways to improve health care quality, outcomes, and affordability in Washington State. Stakeholders are appointed by the governor as Collaborative members and represent public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. Since its inception, the Bree Collaborative has convened and published evidence-based recommendations including alternative payment models recommendations to improve the quality of care and reduce variation for the following topics: obstetrics, readmissions, total joint replacements, low back pain, spinal fusions, end-of-life care, and addiction and dependence treatment. HCA's Care Transformation strategies in the Model 3 contracts include Bree Collaborative recommendations. Both networks are required to demonstrate implementation and adherence to the Bree recommendations through annual Quality Improvement plans. This approach will be replicated in the other payment models, most notably Model 4.

Washington State eased administrative barriers to mental health and substance use disorder treatment integration at the delivery level for agencies that provide behavioral health services by creating behavioral health administrative and service rules. In July 2013, these rules were finalized and they provide streamlined administrative guidance in support of treatment agencies wishing to provide mental health, substance use disorder, and/or problem and pathological gambling treatment. Additional regulatory changes in 2014 broadened the venues where chemical dependency professionals may practice if those chemical dependency professionals are also licensed mental health counselors, psychologists, advanced or independent clinical social workers, advanced registered nurse practitioners, marriage and family therapists, osteopathic physicians, osteopathic physician assistants, physician assistants, or physicians, as defined by state law. These licensed and certified healthcare professionals may now practice in settings that are not also licensed and certified by the Division of Behavioral Health and Recovery.

Vital to Washington's rural health infrastructure, Payment Model 2: Encounter-based to Value-based addresses some of Washington's most financially stressed Critical Access Hospitals (CAHs). Model 2 seeks to move this subset of CAHs toward a state of value-based readiness and longer-term financial sustainability. Initial intents and needs for CAH payment and delivery redesign work were outlined in a collaborative effort from the Department of Health (DOH) and the Washington State Hospital Association (WSHA).

In 2014, DOH and WSHA identified in the "New Blue H Report" that there exists a subset of CAHs in Washington State that need to be specifically addressed under a new

payment and delivery mechanism. Since this initial report, the Healthier Washington team supporting Model 2 has brought together stakeholders to explore new approaches to payment and delivery. Model 2 has seen strong support throughout the development process and has collaborated with the WSHA and DOH to identify new a model of care. In this effort, Washington has signaled commitment and intent to pilot this new model of care through the passage of HB 2450. Recognizing that the challenges Washington CAHs face is not unique, while Model 2 is working from the most stressed CAHs, the ultimate vision of CAH payment and delivery redesign aligns with Healthier Washington's tenets of value-based purchasing and seeks to build a model of payment and delivery that is applicable to a wide array of Washington CAHs and one that may serve as national model for care.

Washington has an innovative and ambitious agenda to advance coordination of care and improve patient outcomes through development of a statewide electronic exchange of clinical information. The goal is creation of a clinical data repository which, when fully populated with clinical records, will provide near real-time access to integrated medical, dental, behavioral health and social service support data to authorized health providers at the point of care. Successful implementation of the clinical data repository requires identifying and overcoming legal barriers to exchanging protected health information. We are partnering closely with the Office of the National Coordinator for Health IT (ONC) to explore innovative avenues to facilitate the exchange of health information to support clinical care.

Outside of HIPAA, federal law imposes very stringent restrictions on sharing information in patient records that specifically pertain to substance use disorder treatment. Our approach to overcoming this barrier is to explore options for integrating client consent within the electronic data exchange to support seamless care while complying with federal law.

c. *Stakeholder Engagement*

By their very nature, the interdependent elements of the Healthier Washington initiative necessitate community, health system, and marketplace engagement. As such, Healthier Washington partners go beyond payers, providers, purchasers, public health, policymakers, and consumers, and reach into communities and to those that impact the social determinants of health such as housing, education, philanthropy, and social service providers. Healthier Washington's multi-sector approach is reflected in the workgroups and advisory bodies that have been formed under the initiative.

Our multi-stakeholder engagement strategies are carried out through the Health Innovation Leadership Network, external engagement activities such as the Healthier Washington Symposium and other conference participation, and hard-wired into the work performed at ACH tables.

It may be instructive to refer you to the program from our October 2016 Healthier Washington Symposium, which convened over 250 stakeholders to discuss various topics related to health systems change.

Also, Washington launched a Healthier Washington "story bank" in November 2016 to capture lessons and stories, and give a face to the contributors and

beneficiaries of Healthier Washington. We plan to expand our story bank with new stories and tales of a synchronized system of care working for the people of Washington.

Finally, we have included an appendix that lists the providers engaged with each of our ACHs.

Government – State, County and Tribes (Government to Government)

State, county, and tribal governments will continue to have a key role as conveners, regulators, purchasers, and policy makers.

Due to the volume of Medicaid-related policy changes in 2016, HCA and the American Indian Health Commission (AIHC) agreed to extend the deadline for their formal report and deliverable to January 2018. Upon request of the tribes and the commission, HCA held two tribal consultations on the ACH program in 2016 and agreed to require every ACH to adopt a model ACH tribal collaboration policy and communication procedure with the following elements:

- An expectation of respectful collaboration and communication
- A committee of ACH staff and participants and designees of tribes, Indian Health Service (IHS) facilities, and urban Indian health programs (UIHPs) to determine whether any ACH actions being contemplated, including the development of policies, programs, or agreements will have an impact on American Indians/Alaska Natives, tribes, IHS facilities, or UIHPs
- Delivery of written information to tribes, IHS facilities, and UIHPs concurrent with, and in the same format and method as, the delivery of written information to board members for board meetings, to committee members for committee meetings, and to other ACH participants for participant or other meetings

An ACH may adopt a different policy/procedure if the ACH and every tribe, IHS facility, and UIHP agree to it.

During 2017, HCA and the commission will continue to work with tribes, IHS facilities, and UIHPs to help them understand the ACH role, determine how they want to be engaged in the ACHs, whether they want to develop a tribal coordinating entity, and, if so, how they want to structure the tribal coordinating entity.

In addition, the tribes have expressed interest in the other initiatives under the Healthier Washington initiative. HCA is actively recruiting a tribal liaison to support the Healthier Washington initiative and hopes to have this position filled by January 2017.

Engagement at the county level has been of particular importance to the early implementation of Payment Model Test 1. Counties have a traditional role in the organization and delivery of behavioral health services to local populations. Model Test 1, with its emphasis on integration of physical and behavioral health services, creates an opportunity to think regionally and consider how other elements of the system can complement the achievement of whole person health. Counties are responsible for signaling to the state their readiness to transition to integrated physical and behavioral health. Our initial experience in Southwest Washington served as an early learning

opportunity for how the state will achieve its mandate to integrate physical and behavioral health services statewide by 2020. We are already taking the lessons learned from Southwest and applying them to North Central.

Purchasers and Payers

Purchasers and payers alike play a key role in Healthier Washington as both directly and indirectly influencing payment and delivery of services. Active engagement and participation of both stakeholders is necessary in order to achieve Healthier Washington's paying for value goal: drive 80 percent of state-financed health and 50 percent of commercial health care to value-based payments by 2019.

HCA is wielding its purchasing power to engage payers in transformation strategies. The three commercial plans under the state employee program have agreed to report on a set of measures under the State Common Measure Set for Health Care Quality and Cost. In addition, the Medicaid MCOs and behavioral health organizations (BHOs) are actively participating in the ACHs and community engagement work.

In Washington, we have nine BHOs and five MCOs, which we contract with for behavioral health and physical health services. Two of the five MCOs currently have contracts for the Apple Health Integrated Managed Care (AH-IMC) Program. Stakeholder engagement with the MCOs and BHOs continues to be central to the organization, financing and delivery of integrated behavioral and physical health services under Model Test 1. BHOs are engaged on at least a monthly basis, through BHO administrator meetings and through other opportunities regarding integration at a financial and delivery-level.

MCOs have participated as key stakeholders in the development of the "early adopter" and "mid-adopter" approach to integrated managed care. The MCOs not only have incorporated behavioral health providers in their networks, but have reached out to the providers of crisis services in order to more fully coordinate services. As active participants in the regional Accountable Communities of Health (often as members of governing boards), the MCOs are actively engaged and attentive to community health concerns, as well as opportunities that extend beyond their managed care agreements with the state.

In 2016, the BHOs implemented managed care for the first time for substance use disorder (SUD) services. Under the guidance of our partners at DSHS Behavioral Health Administration, BHOs are now responsible for integrating SUD services with the managed care delivery system formerly operated by county-based regional support networks for mental health services. BHOs contract with state licensed and certified behavioral health agencies for their Medicaid members. By 2020, all regions will have integrated Medicaid managed care – as mandated by state legislation. The success in Southwest Washington – and the upcoming migration of North Central region (in January 2018) – will set the stage for complete migration by 2020. Lessons learned in each wave or migration are being captured and rolled forward into each successive wave.

Providers

The aims of Healthier Washington cannot be achieved without active provider engagement. With the consolidation of clinics and small group practices into larger systems, Washington has the opportunity and the challenge to drive health care delivery transformation through a systems approach. Not only are individual providers and provider systems participating in the fulfillment of Healthier Washington's aims, but their associations are as well. Those groups actively involved in Healthier Washington initiatives include, but are not limited to, the Washington State Hospital Association, Washington Council for Behavioral Health, Washington State Medical Association, Washington Association of Community and Migrant Health Centers, Rural Health Clinic Association of Washington, and many others. Providers are engaged in every element of Healthier Washington, as illustrated by the following:

- Health care providers are included as participants in every ACH and participate actively in the organization and development of those entities. (*See Appendix 4 for a comprehensive list of providers, by type, engaged with ACHs.)*
- Providers of mental health and substance use disorder services, as well as primary care providers, have been working closely with HCA and community representatives in the development of the integrated managed care model. (Model 1)
- The introduction in 2016 of value-based payment under Model 3 is the result of successful recruitment and negotiation with two accountable care provider systems, the Puget Sound High Value Network and the University of Washington Accountable Care Network. These two systems represent a significant proportion of physician and hospital systems in the five-county Puget Sound area.
- In late 2016, the Practice Transformation Support Hub will provide coaches, trainers, facilitators, and "connectors" directly into the field to support providers in their transformation to high quality care, integrated care, and paying for value. Supports and activities will include:
    - Preparing a technical assistance package in AY3 for the North Central ACH.
    - Collaboration between the Hub and Model 1 teams on change management activities related to the transition to integrated financing.
    - Collaboration between the Hub and the ACHs to define key roles and responsibilities for the changes required for integrated financing.
    - Practice assessments administered by the Hub to measure movement along the behavioral health/integration continuum.
    - Migrating content from the population health Planning Guide to the Hub site to support collaboration.
    - Toward the end of AY3, we will complete an environmental scan and summary of practice transformation and community clinical linkages by regional service area.
- In 2016, Washington developed a process to certify patient decision aids and we certified five decision aids for use in maternity care. We will use the Practice Transformation Support Hub and providers within Accountable Care Networks to spread shared decision making as a practice, as well as the use of certified patient decision aids. You can find certified decision aids here.

- Washington conducted a statewide assessment of the capabilities of EHRs and needs of behavioral health providers who did not qualify for Meaningful Use incentives, and is exploring solutions (and braided funding) to increase the capacity of these providers to connect with the state.

  Specific investments to create a comprehensive view of clinical data in the clinical data repository (CDR) for *all* Medicaid clients and *all* provider types include the investments described below. The timing for these and other investments can be found in the HIT plan. These investments are intended to benefit all provider types as well as strengthen HCA's and DSHS's efforts to integrate mental health, substance use disorder (SUD) and physical health services as noted:

  1. **Build re-useable interfaces**: Support clinical data sharing and break down cost barriers from EHR vendors.
     a. Develop interfaces for ambulatory practices' EHR systems to the statewide HIE and CDR. Advances integration of behavioral health by reducing costs for submitting mental health and SUD data to the CDR through the HIE.
     b. Develop interface for DSHS instance of Cerner EHR for state hospitals. Enables integration of behavioral health by supporting state hospitals to contribute mental health information from their EHR for Medicaid clients and access integrated health records for new patients.
     c. Develop interface to HIE for local health jurisdictions for use of CDR.
  2. **Offer onboarding incentive bundle and technical assistance:** Offset some of the onetime costs for Medicaid ambulatory providers that join the HIE to contribute, access, and use care summaries.
     a. Provide technical and workflow assistance to ambulatory providers to contribute, access and use care summaries within their specific environment. Assistance may be delivered via regional practice transformation hubs. Provides consultation, readiness, and training support for mental health and SUD providers without EHR systems to access and use integrated clinical health information in the CDR through a portal.
     b. Set triggers in EHR systems to automatically contribute care summaries after each Medicaid patient visit.
     c. Develop method for assigning confidentiality codes to restricted and very restricted data elements for patient privacy. Enables behavioral health integration by supporting collection and aggregation of restricted and very restricted SUD data as part of the integrated health record.
     d. Submit provider directory data elements to the statewide HIE vendor, OneHealthPort, for CDR dashboard reporting.
  3. **Acquire extraction and record locator tools**: Develop tools that locate and move data from one source to another.

a. Data transformation service to pull data from non-certified systems, cleanse, transform and load into CDR, making it available to other authorized providers. Enables mental health and SUD providers to contribute behavioral health information from their noncertified EHR system to the integrated health record.
b. Extract large data sets from the CDR for sharing with HCA and authorized organizations for advanced analysis of health outcomes and performance measures. Collects and uses clinical information from medical and behavioral health clinics to measure health outcomes.
c. Acquire record locator service to access diagnostic imaging reports and images from CDR.

4. **Expand CDR clients and data**: Increase Medicaid client records and data elements stored in the CDR.
   a. Add fee-for-service clients (only Medicaid clients enrolled in managed care are loaded now).
   b. Develop application allowing caregivers to complete health assessments and transmit to the CDR for access by others using a constrained "assessment" Consolidated Clinical Document Architecture (C-CDA) in support of Health Homes and Health Action Plan data collection.
   c. Make information from DOH's Prescription Drug Monitoring (PDM) program and immunization registry available to Medicaid providers via the CDR so that health care providers are able to identify clients identified as part of the PDM program.
   d. Implement solution for consent management for very restricted data that allows for sharing of SUD information as part of the integrated health record when appropriate consents are in place.
5. **Expand Alerts**: Expand the ability to inform providers of critical events.
   a. Make alerts to providers and care coordinators available when Medicaid-covered individuals enter correctional settings to support continuity of mental health and substance abuse treatment and inclusion of care coordinators in the overall treatment planning as needed.

Community

Accountable Communities of Health follow a cascading engagement strategy that balances the need for a nimble decision-making structure with meaningful multi-sector engagement of community leaders. Examples of community sectors that are included in one or more of the multiple layers of ACH engagement include delivery system providers, insurers, philanthropy, business, housing, Area Agencies on Aging, criminal justice, emergency medical services, and tribes. These partners are engaged for the purpose of identifying common health priorities across sectors to align measures and commit to mutually reinforcing activities. Local health jurisdiction (LHJ) capabilities have allowed them to be valuable partners at ACH tables, in some cases serving in

leadership roles. (*See Appendix 4 for a list of community stakeholders engaged in each ACH.)*

Consumers

The principles of transparent engagement, continuous learning, and collaboration will continue through established workgroups and communication outlets, such as the Healthier Washington website and quarterly webinars.

As part of their cascading engagement strategies, ACHs are expected to engage consumers within their communities. Health is local and the identification of local issues and corresponding solutions requires authentic local engagement. ACH membership includes consumers and consumer advocates.

Under Model 3, patient engagement is foundational. Both accountable care plans are at financial risk for timely access and patient experience as a number of Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measures are included in the quality improvement model (which determines the savings or deficits for the plans).

At the same time, HCA has worked to encourage healthy behaviors of state employees through educational tools like SmartHealth, the employee wellness program. For example, state employees received a lower annual deductible if they completed the wellness assessment and follow-up health activities that they self-report on the SmartHealth web portal. Follow-up activities included completing an advance directive to align with strategies implemented on the supply side. HCA will continue to develop and promote additional consumer tools as consumer engagement is the number one priority of Public Employee Benefits program for 2017.

Health Innovation Leadership Network (HILN)

Key to success in AY3 is the commitment of a public-private and cross-agency leadership group that included the Governor's office, HCA, DOH, DSHS, Commerce, Early Learning, the Health Benefit Exchange, Community and Technical Colleges, Labor and Industries, Financial Management, Insurance Commissioner, and the Superintendent for Public Instruction. HILN members are the stakeholders and decision-makers in their own institutions. HILN and its subcommittees are not governance, as decision making for Healthier Washington occurs at an agency level.

In 2016, we saw the HILN mature and evolve. HILN has formed its subcommittees, called "accelerator committees." The HILN accelerator committees focus on specific and timely efforts that directly impact and drive toward the achievement of Healthier Washington's aims.

All HILN members are coming to the end of their two-year term. We will be altering membership to ensure focus on the full Healthier Washington scope and to ensure we have the right people to accelerate the spread, performance, and sustainability of Healthier Washington.

HILN Accelerator Committees have:

- Accelerated the goals and objectives of Healthier Washington

- Evolved, expanded, and dispersed over time as Healthier Washington itself evolves in response to rapid-cycle learning and improvement.
- Built upon existing efforts and groups already in place.
- Been reflective of the HILN structure in public-private, multi-sector membership.
- Been championed by HILN members, with membership including leadership from HILN and non-HILN organizations.

The AY3 Accelerator Committees include:

- Healthier Washington Clinical Engagement Accelerator Committee: Accelerate provider commitment to and adoption of Healthier Washington aims and strategies.
- Healthier Washington Communities and Equity Accelerator Committee: Elevate and act on Healthier Washington's commitment to every Washingtonian getting a fair chance to lead a healthy life.
- Healthier Washington Integrated Physical and Behavioral Health Accelerator Committee: Accelerate the transition to fully integrated care systems by leveraging cross-sector action.
- Healthier Washington Rural Health Innovation Accelerator Committee: Accelerate the uptake and spread of value-based payment and delivery models in the state's rural communities, and influence the uptake of rural health innovations that support these models.
- Healthier Washington Collective Responsibility Accelerator Committee: Promote the concept of shared accountability and collective impact in achieving the aims of Healthier Washington

Accelerator committees are coordinated by Healthier Washington staff, and every effort is made to incorporate committee ideas into Healthier Washington projects and initiatives, as well as promote community alignment activities wherever possible. A comprehensive repository of accelerator activities can be found on our website.

The HILN roster is currently comprised of the following individuals representing public and private leaders and subject-matter experts across the state:

Name	Organization
Dorothy Teeter, Co-Chair	Health Care Authority
Rick Cooper, Co-Chair	The Everett Clinic
Chris Ackerley	Ackerley Partners, LLC
Peter Adler	Molina Healthcare Washington, Inc.
Teresita Batayola	International Community Health Services
Randi Becker	Washington State Senate
Nicole Bell	Cambia Grove
Diana Birkett Rakow	Group Health Cooperative
Brian Bonlender	Department of Commerce
Marty Brown	State Board of Community and Technical Colleges
Antony Chiang	Empire Health Foundation

Name	Organization
Ann Christian	Community Mental Health Council
Eileen Cody	House of Representatives
Sean Corry	Sprague Israel Giles, Inc.
Bob Crittenden	Office of the Governor
Winfried Danke	CHOICE Regional Health Network
Regina Delahunt	Whatcom County Health and Human Services
Greg Devereux	Washington Federation of State Employees
Sue Elliott	Arc of Washington
Michael Erikson	Neighborcare Health
Andre Fresco	Yakima Health District
Nancy Giunto	Washington Health Alliance
Mike Glenn	Jefferson Healthcare, Port Townsend
Amy Morrison Goings	Lake Washington Institute of Technology
Paul Hayes	Harborview Medical Center
Ross Hunter	Department of Early Learning
Uriel Iniguez	Washington Commission on Hispanic Affairs
Nancy Johnson	Colville Business Council
Mike Kreidler	Office of the Insurance Commissioner
Patricia Lashway	Department of Social and Health Services
Pam MacEwan	Health Benefits Exchange
Tom Martin	Lincoln Hospital and North Basin Medical Clinics
Todd Mielke	Spokane County
Peter Morgan	Family Health Centers
Steve Mullin	Washington Roundtable
Diane Narasaki	Asian Counseling and Referral Service
Dan Newell	Office of the Superintendent for Public Instruction
Diane Oakes	Washington Dental Service Foundation
Richard Pannkuk	Office of Financial Management
Gail Park Fast	Educational Service District 105
Kathleen Paul	Virginia Mason Medical Center
Chris Rivera	WA Biotechnology and Biomedical Association
David Rolf	SEIU 775 NW
Joe Roszak	Kitsap Mental Health Services
Bill Rumpf	Mercy Housing Northwest
Peter Rutherford	Confluence Health, Wenatchee
Joel Sacks	Department of Labor and Industries
Marilyn Scott	Upper Skagit Indian Tribe
Jill Sells	Reach Out and Read Washington State
Preston Simmons	Providence Regional Medical Center
Andi Smith	Office of the Governor, Legislative Affairs
Diane Sosne	SEIU 1199 NW
Aren Sparck	Seattle Indian Health Board
Hugh Straley	Dr. Robert Bree Collaborative
Jurgen Unutzer	University of Washington, Department of Psychiatry
Joe Valentine	North Sound Accountable Community of Health
Janet Varon	Northwest Health Law Advocates
Ron Vivion	Washington State Council on Aging
Rick Weaver	Central Washington Comprehensive Mental Health
David Wertheimer	Gates Foundation, Pacific Northwest Initiative

Name	Organization
Caroline Whalen	King County
John Wiesman	Department of Health

2. Health Care Delivery System Transformation Plan

In Washington State, we are pursuing delivery system transformation holistically, by adopting a systems approach to change.

Healthier Washington and the broader health care environment are shifting the physical and behavioral health care landscape toward rewarding value, rather than the volume of services provided.

Creating effective linkages across the care continuum requires overcoming challenges related to the historic fragmentation of physical and behavioral health care service delivery within most communities, in which provider organizations may not share a common mission, orientation to the goals of care, or up-to-date information exchange platforms. Our goal is to strengthen clinical provider practices and their participation with communities. The desired outcome is to achieve better health, better care, and reduced costs. This requires a variety of transformational strategies to strengthen the diverse primary and behavioral health care practices in the state, support their readiness for payment reform, and to address complex problems that cut across delivery systems, social supports, and community environments.

a. *Service Delivery Model(s) and Payment Model(s)*
   Healthier Washington is about putting the tools and systems in place to work collectively in order to transform health and health care. When we talk about ACHs or AIM or the Hub, none of these initiatives alone will create the sweeping change that CMS has asked us to deliver under SIM. Our transformation includes changing the way we pay for care – and it depends critically on population health strategies and community supports necessary for health. We cannot do any of this without data to make decisions and support evidence-based approaches to strategy revisions.

   While the ACHs are not, by definition, a service delivery model, they are a key part of our system and innovation model.

Accountable Communities of Health

Healthier Washington recognizes and leverages pockets of innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared health goals. Nine regional ACHs are now in place in Washington. Through these diverse multi-sector partnerships, ACHs are an integral part of achieving the Triple Aim and an equitable health system. Specifically, ACHs are:

- Bringing together diverse public and private community partners to identify and work on shared regional health goals – by engaging the optimal mix of individuals on each ACH.

- Identifying opportunities for the ACH and community partners to understand and bridge health and quality of life issues.

- Partnering with the state to inform the development of other Healthier Washington investments, recognizing ACHs are the connection to communities and the local conduit to achieve true systems change.

ACHs lead local transformation that connects Healthier Washington investments within the context of communities across the state. While ACHs have flexibility to tailor projects based on regional needs, the expectation under the SIM test is that ACHs employ a "Triple Aim" strategy that links communities to health care delivery systems, public health and supports that contribute to the health of the individual, in addition to better care and lower cost. For example, one of the state's ACHs found a need within their region regarding adverse childhood experiences. The ACH will rely on the activities and expertise of school districts, social service organizations, and health care providers to implement a project focused on earlier identification and treatment of children with mental health or chemical dependency issues. This project requires a common agenda across partners with mutually reinforcing activities – a demonstration of regional collaboration that can have a far greater impact than any one sector or organization working independently.

This project also allows for alignment with the population health toolkit. The challenge under the P4IPH is to look for ways to connect the regional projects with the test areas – which in this case could directly be connected to both diabetes and well-child visits.

ACHs are key partners in many Healthier Washington initiatives. Below are a few examples:

On our P4IPH website there is a "how to use" page: Population Health Planning Guide. In addition to this tool, we plan to provide hands-on technical assistance. For example, our population health lead is currently meeting with the North Central ACH's Population Health Work Group. We will talk about their priorities and current work, take a guided exploration of the Population Health Planning Guide web resource tool, and invite input to inform future iterations of the web resource.

With clear alignment between ACH regions and the regional service areas for Medicaid purchasing, ACHs are a local partner under the SIM payment model tests. Specifically the ACHs are functioning as a partner in the move to integrated care as Washington moves away from traditional fee for service and drives toward paying for value that focuses on the health of the community and individual. One example under Payment Model 1 is what we call an "early warning system," which provides an on-the-ground perspective of the transition to whole-person care. This includes alerts regarding regional/local health and community system or access issues and corresponding recommendations.

In addition to value-based purchasing, ACHs will play a key role as part of the Practice Transformation Support Hub's Connector model (formerly called "extension program") to promote clinical-community linkages and physical and behavioral health integration. The Connectors will have a strong link with each ACH.

The Analytics, Interoperability, and Measurement effort will provide measurement and population health data to drive decision-making. We have been and will continue to rely upon the ACHs to identify local requirements and inform statewide priorities. The evaluation requires short-term and long-term measures, along with a Triple Aim lens based on the representation that exists within the ACH and the desire to link communities and delivery systems.

The AIM team has bi-weekly calls with the ACH liaisons to better understand current ACH challenges and opportunities related to data and measurement systems. These calls also serve as an opportunity to learn about other ACH activities that the AIM team could join. These include ACH convenings, ACH individual meetings focused on measurement, and other ad hoc meetings. Additionally, Center for Community Health and Evaluation (CCHE) is a contractor who works closely with ACHs providing technical assistance. They have served as a very effective intermediary to identify opportunities for the AIM team to be brought into ACH conversations and planning.

ACHs are not new service delivery organizations nor a replacement of managed care or health care delivery roles and responsibilities. ACHs include managed care, health care delivery, and many other critical organizations as part of their multi-sector governance and as partners in implementation of delivery system reform initiatives. Managed care organizations (MCOs) will continue to serve the majority of Medicaid enrollees in the provision and coordination of State Plan services. Through coordination of activities and new partnerships, ACHs will support but not interrupt the relationship that Medicaid beneficiaries currently have with their MCO, which remains the central delivery mechanism for services.

The ACHs' value and lever regarding reform and VBP goals exists through the collaboration within the ACH, including the ability of the ACH to connect new supportive services to address relevant social determinants of health related to value-based purchasing targets and corresponding outcome measures. In addition, as independent entities, ACHs will lead regional strategies and ensure mutual accountability between health plans, providers and other community members for health system transformation.

AY3 plans include the following strategies and key activities:

Milestone/ Measure of Success	Action steps necessary to complete activity	Start Date	End Date	Task Owner	Vendor	Strategy
By end of AY3 all ACHs will receive aligned information and various opportunities for support from DSHS, DOH, HCA, and HW consultants to inform regional priorities,		Q1	Q4			Pay for Value (P4V)

strategies and overall ACH development.						
	Formative feedback to inform opportunities for ACHs and the state to better align initiatives	2/1/2017	2/1/2017	Center for Community Health and Evaluation (CCHE); Chase Napier, Lena Nachand, Seibs		P4V
	HCA develops a feedback mechanism for ACHs	2/1/2017	3/1/2017	Chase Napier, Lena Nachand, Seibs, CCHE		P4V
	HCA reviews and elevates feedback			Chase Napier, Lena Nachand, Seibs		P4V
	Identify and communicate opportunities for the ACH within payment model and VBP spread/scale based on regional context	2/1/2017	3/31/2017	Gary Swan; J.D. Fisher; Rachel Quinn; Chase Napier; Lena Nachand; Laura Zaichkin		P4V
	Identify engagement opportunities between ACH leaders and key stakeholders, including WHA, associations, agency staff (e.g., PT Hub)	2/1/2017	4/1/2017	Chase Napier; Lena Nachand; Rachel Quinn; Laura Penning-ton; Mary Beth Brown; Seibs		P4V
	By the end of AY3 efforts will be in place, related to changes internal to HCA for sustainability and transition to operations. One or more process measures will be implemented, supporting the move of DBHR into HCA by 2018					P4V

By June 1, collaboratively establish roles and responsibilities of the ACH in integrated regions. ACHs serve as the primary local resource to engage the State in integration implementation activities.	Coordinate detailed work plan development and deliverables with ACH workgroup	Q1	Q2			Integration
By end of AY3 all ACHs will receive aligned information and various opportunities for support from DSHS, DOH, HCA, and Healthier Washington consultants to inform regional priorities, strategies, and overall ACH development.	Provide ACHs with access to technical expertise and consultation available through various DSHS Administrations. Provide guidance to help ACHs avoid duplication and/or complement services delivered by or through DSHS.	Q1	Q4			Comm. Ptnrshp.
	Attend ACH Regional Meetings to establish relationship with ACHs and respond to requests for information and access.	2/1/2017	1/31/2018			Comm. Ptnrshp.
	Empower cross-agency staff to attend ACH Regional Meetings.	2/1/2017	1/31/2018			Comm. Ptnrshp.
	As alignment and intersects of ACH and DSHS program and services emerge, link up DSHS program staff.	2/1/2017	1/31/2018			Comm. Ptnrshp.
	Develop directory of key program staff at DSHS administrations.	5/1/2017	8/31/2017			Comm. Ptnrshp.
	Present cross walk to ACH regions via development council or other and solicit input on DSHS topic areas.	2/1/2017	5/31/2017			Comm. Ptnrshp.

	1st Qtr. DSHS Webinar	2/1/2017	5/31/2017	Jim Jackson		Comm. Ptnrshp.
	2nd Qtr. DSHS Webinar	6/1/2017	9/30/2017	Jim Jackson		Comm. Ptnrshp.
	3rd Qtr. DSHS Webinar	10/1/2017	1/31/2018	Jim Jackson		Comm. Ptnrshp.
	Consideration of providing travel resources for DSHS attendance (beyond ACH Liaison) at ACH Convenings – Quarterly to support DSHS workshop component as part of ACH Convenings according to ACH interest and emerging needs.	2/1/2017	1/31/2018	Jim Jackson		Comm. Ptnrshp.
	Facilitate further discussions with NoHLA, NAMI, Mental Health America, etc.					Comm. Ptnrshp.
By end of Q2 AY3, all ACHs have a decision-making process and organizational infrastructure that meets the state's expectations	Provide feedback and lessons learned based on evaluation. TA delivered according to need for adjustment or growth. Priorities updated to reflect ACH strategies to improve health outcomes.	Q1	Q2			Comm. Ptnrshp.
	Guidance issued. Technical assistance provided. ACH decision-making and functional capacities developed (e.g., data, clinical, financial, executive, administrative, community)	2/1/2017	2/28/2017		Cascade Pacific Action Alliance /ACH TBD	Comm. Ptnrshp.

	Project guidance provided to inform ACH adjustments, updates, etc.	2/1/2017	2/28/2017	CCHE, Chase Napier, Lena Nachand		Comm. Ptnrshp.
	Project evaluation to incorporate effectiveness and utility of P4IPH tools and planning guide.	2/1/2017	12/1/2017	CCHE		Comm. Ptnrshp.
	Project work plans updated to reflect lessons learned, resources, etc.	3/1/2017	3/31/2017	ACHs	ACH sub-awardees	Comm. Ptnrshp.
	Budget Item – ACH funding for operational projects	2/1/2017	6/30/2017		ACH sub-awardees	Comm. Ptnrshp.
	Budget Item – Seib engagement work	Q1	Q2		Seib PPA	Comm. Ptnrshp.
	Regional strategies updated to reflect engagement improvements and expanded representation.	Q1	Q2			Comm. Ptnrshp.
	ACH leadership support provided upon ACH or HCA request and/or in conjunction with convening	3/1/2017	3/31/2017	Cascade Pacific Action Alliance, Chase Napier, Lena Nachand	Cascade Pacific Action Alliance	Comm. Ptnrshp.
	Targeted or cohort technical assistance provided based on ACH-identified needs	2/1/2017	2/1/2017	Empire Health Foundation, ACHs	Empire Health Foundation	Comm. Ptnrshp.
	Plan for delivery developed, based on convenings and other appropriate targeted or cohort opportunities	2/1/2017	2/28/2017	Empire Health Foundation	Empire Health Foundation	Comm. Ptnrshp.
	ACH convening to promote shared learning across regions, including leadership development	3/1/2017	3/1/2017	Empire Health Foundation	Empire Health Foundation	Comm. Ptnrshp.

	ACH convening to promote shared learning across regions, including leadership development	6/15/2017	6/15/2017	Empire Health Foundation	Empire Health Foundation	Comm. Ptnrshp.
	ACH convening to promote shared learning across regions, including leadership development	9/30/2017	9/30/2017	Empire Health Foundation	Empire Health Foundation	Comm. Ptnrshp.
	Evaluation and feedback provided regarding ACH development, engagement and organizational infrastructure		2/1/2017	Group Health Research Institute ACHs, Chase Napier, Lena Nachand	Group Health Research Institute	Comm. Ptnrshp.
	Budget Item – ACH Evaluation	Q1	Q2	CCHE, Chase Napier, Lena Nachand	Group Health Cooperative	Comm. Ptnrshp.
	Formative feedback to inform lessons learned and contribute to project success/sustainability	2/1/2017	1/31/2018	CCHE, ACHs, Chase Napier, Lena Nachand		Comm. Ptnrshp.
	ACHs respond to feedback and implement adjustments	2/1/2017	1/31/2018	ACHs		Comm. Ptnrshp.
	Tribes consulted and surveyed to inform recommendations regarding mechanisms for ACH collaboration and HW engagement	2/1/2017	1/31/2018	AIHC		Comm. Ptnrshp.
	Budget Item – AIHC work	Q1	Q2		American Indian Health Commission	Comm. Ptnrshp.
	Respond to recommendations, including guidance to ACHs as appropriate.			HCA, ACHs		Comm. Ptnrshp.

	ACH resources shared based on HCA approval (at least quarterly and/or in conjunction with convening's)			ACH Leader		Comm. Ptnrshp.
	TA website updated at least quarterly to reflect shared learnings and resources			Empire Health Foundation		Comm. Ptnrshp.
	RHNIs and RHIPs updated to reflect any necessary adjustments or refinements	2/1/2017	3/31/2017			Comm. Ptnrshp.
	Opportunities/ guidelines identified for Practice Transformation connectors to support ACHs w/ linkages and awareness	2/1/2017	3/1/2017	Chase Napier, Lena Nachand, CCHE, Seibs, ACHs; Mary Beth Brown		Comm. Ptnrshp.
	ACHs review data/resources and consider updates to RHNI and RHIP	4/1/2017	1/31/2018	ACHs		Comm. Ptnrshp.
	ACHs develop regional approach to coordinate with Practice Transformation connectors, including potential provider engagement strategies	2/1/2017	2/1/2017	ACHs, Mary Beth Brown, Qualis Health, Chase Napier, Lena Nachand, Hub		Comm. Ptnrshp.
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	ACH convening / shared learning, including value proposition, regional sustainability planning (e.g., workshop re: Berry Dunn's work)	Q1	Q3	HCA, ACHs		Sustainability
	ACH and partner/ association engagement opportunities	Q2	Q4	HCA, ACHs		Sustainability

	Ongoing: VBP and HW education opportunities for ACHs, including role of the ACH	Q1	Q4	HCA, ACHs		Sustainability
	Assess current-state of agency/HW "expectations" surrounding long-term ACH role (e.g., MCO contract language, VBP role, etc.)		Q1	HCA, ACHs		Sustainability
	Map expected long-term ACH functions as they relate to operations and purchasing levers		Q2	HCA, ACHs		Sustainability
	Work with ACHs to get feedback on the list of assumed/ potential roles		Q3	HCA, ACHs		Sustainability
	Elevate potential funding considerations regarding assumed long-term ACH role		Q4	HCA, ACHs		Sustainability
	ACH peer TA (e.g., Cascade Pacific Action Alliance) re: sustainability planning / shared resources, likely in conjunction with Berry Dunn's recommend-dations	Q1	Q2	HCA, ACHs		Sustainability

CMMI asked...

Please describe how Washington's ACHs fit into broader payment reform strategies – specifically, how are ACHs aligned under SIM, the proposed DSRIP, and beyond? What activities will the ACHs be taking to achieve the goals set out in the ACH projects and regional health needs assessments?

While other states were moving in a similar direction with their health reform efforts, the success with "Accountable Communities" gave Washington further reason to pursue its own version – built on existing organizations, and designed to serve broadened interests called out in the Innovation Plan. State legislation passed in 2014 provided criteria and funding for two community of health pilot sites. Additional specifications

and funding to support ACHs were included in the State Innovation Model Test Award received by the state later that year. Through these diverse multi-sector partnerships, ACHs are an integral part of all strategies under the Healthier Washington initiative.

The ACHs present an opportunity to address the system changes that need to occur to better serve communities and people, including but not limited to Medicaid beneficiaries. It is the state's belief that working with community-based, cross-sector coalitions is an effective and efficient way to transform the health system in the state. The ACH provides immense value in convening partners, coordinating health transformation activities, implementing interventions, connecting clinical and community-based organizations and tracking regional health performance. This is their chief value under our Medicaid transformation demonstration proposal and one that we see continuing beyond the demonstration.

Consider use of the Olympic ACH project as an example of cross-sector excellence – involving criminal justice, behavioral health, social determinants, etc.

Olympic Community of Health (OCH) selected the Olympic Peninsula Coordinated Opioid Response project to focus on the region's high burden of opiate addiction and overdose, including both prescription opiates and heroin. OCH has hired a project manager, met with topic experts from University of Washington, started a three-county assessment to scope the opioid problem, met with state agencies to identify available data, and begun outreach to regional stakeholders such as law enforcement. OCH keeps an engagement log to track meetings and stakeholders interested in participating in the project, too. They are planning a one-day Opioid Summit on January 30, 2017 to gather stakeholders and discuss and commit to a regional plan. OCH will be working with the Salish BHO to coordinate the multi-strategy, multi-sector regional effort for the project moving forward. Group Health's Center for Community Health and Evaluation (CCHE) has attended OCH's Regional Health Assessment and Planning (RHAP) Committee meetings where project selection, submission and planning activities are discussed. CCHE has also provided preliminary feedback to OCH on the data and measurement aspects of the project.

It is HCA's belief that working with community-based, cross-sector coalitions is an effective and efficient way to transform the health system in the state. The ACH provides immense value in convening partners, coordinating health transformation activities, implementing interventions, connecting clinical and community-based organizations and tracking regional health performance. This is their chief value under our Medicaid Transformation Demonstration proposal and one that we see continuing beyond the demonstration.

We liken the future state of the ACH to a "balanced portfolio" approach to achieving the value proposition of Healthier Washington. Under SIM, we are attempting to change a system of care. Under the Medicaid demonstration, we will be more focused on Medicaid and upstream determinants. They are two different, yet similar, challenges.

In line with the HCA value-based purchasing roadmap, ACHs will have incentives (upside only) to reach regional VBP goals. For providers to feel more comfortable in agreeing to VBP arrangements, they need ACH support in areas including communications, social determinants of health, and data.

Importantly, Washington's Medicaid Transformation Demonstration (DSRIP) is not centered on the creation of ACHs, which are already developing with support from the state's SIM grant. Rather, the Medicaid demonstration aims to leverage the ACHs to test whether community-based partnership can accelerate redesigned care delivery, expand health system capacity, and improve individual and population health outcomes.

We will test this assumption by evaluating the value of a system of care versus a clinical-only model.

More extensive community and provider engagement will occur under the Medicaid demonstration, which will further support each ACH's ability to convene delivery system and community partners to collaborate on shared strategies related to care coordination, integration, and prevention. For example, some ACHs place less emphasis today on provider engagement. A few lack adequate provider participation. The Medicaid Transformation Demonstration is more health system focused – we know we can't achieve our health outcomes without changing our system of care – including housing, transportation, and other social determinants.

In addition, the ACH infrastructure and governance model is a solid foundation for the additional capacity build and tiered decision-making that will be supported under the Medicaid demonstration. Currently, the ACHs have limited financial capacity. There is not a lot of money to invest in projects and population health. Of course, the ACH is not intended to be a grant program and there is limited belief about what an ACH can accomplish with the amount of money we've given them. They need websites, a broad community engagement plan, and seed money.

It is worth noting that the DSRIP focus areas directly align with the previously identified ACH focus areas, and DSRIP will also support the necessary capacity build and sustainability planning, including the alignment with and evolution of the state's VBP roadmap and measurement strategies.

Regarding next steps for ACHs as supported by SIM, ACHs will continue to refine their project evaluation and project measurement strategies to gauge success as SIM-supported projects are implemented. In addition, ACHs will partner closely with our evaluation team to develop a shared understanding of the formative evaluation process and then applying that directly to make real-time adjustments. Many of the ACH projects require broader engagement of community partners and providers, especially as ACHs think about potential spread, scale, and enhancement.

Engagement and regional health improvement planning will continue to be the foundation of ACH activities, and these two functions directly relate to the intentional alignment between DSRIP activities as one function of the broader ACH convening, planning and coordination role. The ACH function will be largely the same under SIM and the Medicaid transformation demonstration – the basic functions will be convening, aligning, prioritizing, and activating community partners. ACHs will need to increase their focus on clinical community linkages as a key outcome of the Medicaid demonstration award.

Population Health as an Enabler

Work on the P4IPH began later in the SIM timeline than development of the ACHs and identifying of regional projects/priorities. However, all ACHs were provided with the Prevention Framework, a foundational predecessor to P4IPH. Additionally, each of the ACHs had a representative serving on the P4IPH External Advisory Group. These representatives provided input into the development of the Plan, and identified appropriate resources to include in the Guide. ACHs have selected projects – and they will be launching more projects. The Guide can be used for those current and future projects. Also, the state has selected two focus areas - diabetes and well-child visits - to "test" the transforming health system. The P4IPH will be an important piece of enabling successful alignment of data, strategies, and resources around a statewide effort.

The P4IPH will serve as a resource to further ACH implementation of regional health improvement projects while not prescribing their regional health priorities. Across Washington, ACHs prioritize the Triple Aim, including paying for value, and coordination and integration of care. The Cascade Pacific Action Alliance (CPAA) offers a good example of the type of projects ACHs across the state will be working on. CPAA found a need within its region for earlier identification and treatment of children with mental health or chemical dependency issues. They facilitated a formal work group, including representatives of school districts, social service organizations and health care providers. The work group selected behavioral health screening tools, inventoried relevant treatment resources within the region, discussed the proper role of school staff and treatment providers, and mapped how these roles would be coordinated on behalf of these children. CPAA then identified four project test sites through a process that included developing selection criteria, researching potential school partners, designing a scoring matrix, and reaching out to selected schools.

Finally, we will be conducting specific evaluation to show how ACHs leverage population health principles, using the well-child visit and diabetes test areas as overarching measures. This will also allow for activation of the ACH "Theory of Change" that demonstrates the community role in broader health systems transformation. This approach allows for the evolution of our population health efforts within Healthier Washington.

The Practice Transformation Support Hub

The key aims of the Healthier Washington clinical practice transformation strategy are to support primary and behavioral health providers to:

- Participate in an integrated system of care that addresses the needs of the whole person
- Respond to value-based purchasing models
- Link to community resources for their patients

The Practice Transformation Support Hub investments have successfully purchased the following in 2016:

- Practice Coaching, Facilitation and Training Program – Qualis Health

- Regional Health Connectors, a Health Extension Network – Qualis Health
- Web-Based Resource Portal – led by University of Washington Primary Care Innovation Lab

Also, in 2016 we have worked extensively to define the role of the regional health connector. In short, the connector will:

- Serve as an ambassador to the providers (and vice versa)
- Be a voice (advocate) to the community from the providers
- Inventory and track local resources
- Refer and connect providers to resources
- Track provider requests and needs
- Share successes and gaps in resources with the ACH/community

CMMI asked…

Who provides governance for the Practice Transformation Support Hub activities, and how are decisions made?

Regarding Hub governance, it is key to distinguish between governance and decision making vs. stakeholder engagement and feedback. The Hub is a core component of Healthier Washington, and as such it is governed by the Healthier Washington Core Team, the Consulted Leadership Team, and the HW Executive Governance Council. Additionally, the Hub has its own dedicated clinician sponsorship to guide its evolution and more appropriately ensure its adoption and success. The Hub executive sponsors are Dan Lessler (HCA), Charissa Fotinos (HCA), and Kathy Lofy (DOH). Via the Healthier Washington governance guidelines, projects may have executive sponsors and they are empowered to make decisions so long as they are appropriately communicated, documented, and cascaded. The Clinical Engagement Accelerator Committee acts as an ad hoc advisory group for the Hub. Operational decisions are brought to DOH/HCA workgroups that support the Hub under the leadership of the Executive Sponsors. Qualis Health and UW Health Innovation Lab make operational and implementation decisions where not specified for DOH input in their deliverables-based contract.

We plan the near-term launch of the Practice Transformation Consortium and four dedicated work groups that will engage providers and community liaisons in proactive conversations about the effectiveness of the Hub coaches, connectors, and the portal.

AY3 Plans:

Goal/Driver 1: Providers are supported in moving to value-based arrangements.					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task owner**	**Strategy**
By end of AY3, Hub coaches will provide skill and capacity building - toward VBP in a minimum of two regions	Disseminate just in time information to providers using the Hub web portal, stakeholders, mailing lists, etc. to help providers be successful as they prepare for and transition to new payment models	Q1	Q4		P4V
	Align FQHC/RHC APM 4 pilot sites with Hub resources	1/1/2017	12/31/2017	Gary Swan, Marc Provence, Mary Beth Brown, Mark Rozner	P4V

Goal/Driver 1: Providers are supported in moving to team-based, integrated care						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
By end of AY3, practices enrolled in Hub coaching services show progress towards advancement along continuum of integration	Practice Assessments will be conducted to measure movement along BH continuum	Q1	Q4			Integration
	Provider training conducted (spend down, payment/billing, contracts	Q1	Q4	Hub		Integration
	Client education conducted: These trainings will primarily be conducted in the form of "knowledge transfers" that will occur (depending on the topic) between the Providers and the BHO, MCOs, ASO, DSHS staff and HCA staff. Topic areas	Q2	Q4	Hub, MCOs, BHOs, ASOs, etc.		Integration

Goal/Driver 1: Providers are supported in moving to team-based, integrated care						
	currently identified as areas to be addressed include:					
By the end of AY3, community-based resources are available through the Hub web portal and analytics reflect usage/access from within each ACH region.	The Hub will collaborate with the ACHs to conduct an inventory of community-based resources to share with practices to support whole-person care	Q1	Q4			Comm. Ptnrshp.
	Step/Sub-Step 2: Convene a representative sample of providers/practices accessing Hub services to provide input to a sustainability plan.	2/1/2017	8/31/2017			Comm. Ptnrshp.
	Step/Sub-Step 3: DOH drafts proposed sustainability plan	8/31/ 2017	1/31/2018	DOH and Qualis Health		Comm. Ptnrshp.
	Budget - UW web-based portal	Q1	Q4		UW	Comm. Ptnrshp.
	Budget - PM Support (Hub)	Q1	Q4		OTB	Comm. Ptnrshp.
	Budget Item - Coaching	Q1	Q4		Qualis Health	Comm. Ptnrshp.
	Budget Item - Connectors	Q1	Q4		Qualis Health	Comm. Ptnrshp.

Goal/Driver 1: ACHs have capacity and mechanisms to be responsive to partnership opportunities and community priorities					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor Strategy**
Health equity resources are available to, and utilized by, ACHs and state partners	Engage clinical community to assess sustainability options for Hub components	2/1/2017	1/31/2018	DOH and Qualis Health	P4V
	ACHs develop regional approach to coordinate with Practice Transformation connectors, including potential provider engagement strategies	2/1/2017	2/1/2017	ACHs, Mary Beth, Qualis Health, Chase, Lena, Hub	P4V

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Engage practice transformation consortium to identify provider support capacity in Washington State.		Q1	Hub	Sustainability
	Assess effectiveness and alignment of Hub services with provider needs. Identify value and demand for Hub services.		Q2	Hub	Sustainability
	Convene provider community (associations and others) with practice transformation community to establish priorities based on needs and capacity information.		Q3	Hub	Sustainability
	Develop proposal for sustaining capacity for provider support to consider centers of best practices and centers of technical assistance.		Q4	Hub	Sustainability
	Identify DOH, HCA and DSHS activities that provide TA to the provider community (BH and Physical Health)		Q2	Hub	Sustainability

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.					
	Define a process to assess fit of Hub Services with DOH mission and organizational structure.		Q3	Hub	Sustainability
	Develop recommendations for role of DOH in sustaining Hub services.		Q4	Hub	Sustainability
	Gather funding sources for existing provider supports.		Q1	Hub	Sustainability
Dependency	Willingness of owners to share funding information.		Ongoing	Hub	Sustainability
Dependency	Availability of data to track demand for and effectiveness of Hub services.		Ongoing	Hub	Sustainability
Dependency	Need inventory of best practice sites and practice transformation.		Ongoing	Hub	Sustainability

CMMI asked...

Please describe Washington's strategy for alignment between SIM practice transformation efforts and Transforming Clinical Practice Initiative (TCPI) activities. Please attach a copy of the alignment plan (even if a draft version) between Washington's SIM and TCPI (CMMI guidance on this will be coming soon).

Subject to approval by CMMI, the Hub intends to pursue a provider-centric approach to aligning coaching and transformation resources. The Hub will create a menu of services and ask each practice to identify coaching services they will access and from which TCPI, SIM or other source to support their practice transformation. The RHCs will track that each practice has avoided duplication of resources before deploying a coach to work with that practice. This strategy would be shared through the Practice Transformation Forum convened by the Hub.

The Practice Transformation Forum will be formed in AY3.

Shared Decision Making

Shared Decision Making has been a key component of our practice transformation support endeavors. Our success in AY2 in getting several maternity decision aids created has energized our plans for AY3.

Patient engagement is at the core of SDM, and if done well will increase patient and provider satisfaction. As patient satisfaction is a key component of high quality care, we believe that training providers in good shared decision making skills, including the use of high quality patient decision aids will not only improve the provider-patient relationship, it will also lead to more informed patients who are better able to manage their care, and should lead to a reduction in variance of services across the state, potentially reducing costs as well.

The training for providers will be provided through the Practice Transformation Hub, targeting providers within ACHs where there are large variances in care for specific areas as identified by the Bree Collaborative. Current and planned PDAs include: maternity (VBAC), joint replacement/spine care, cardiac health and end-of-life care. We are piloting SDM and the use of certified patient decision aids through the Accountable Care Program, to test the process of integration of SDM into the clinical workflow and the use of certified aids to change provider practice as well as patient practice and maybe even improved health outcomes. We are evaluating these pilots carefully to see if this model (set of tools) can be spread.

AY3 plans:

Goal: People and their families are engaged as active participants in their health and in health systems transformation efforts.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
By the end of AY3 we will increase the number and	Provide training and outreach to providers to implement use of	Q1	Q4	Laura Pennington	Karen Merrikin	P4V

Goal: People and their families are engaged as active participants in their health and in health systems transformation efforts.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
breadth of SDM tools that have been certified.	shared decision making and patient decision aids that address maternity care					
AY3 objective: By January 2018, offer up to five trainings on shared decision making, targeting providers engaged in HW activities	Collaborate with key stakeholders to co-sponsor, plan, convene, and promote trainings on shared decision making to providers engaged in Healthier Washington activities.	2/1/2017	1/31/2018	Laura Pennington	Karen Merrikin	P4V
AY3 objective: By January 2018, offer up to five trainings on shared decision making, targeting providers engaged in HW activities	Budget Item	Q1	Q4	Laura Pennington	Karen Merrikin	P4V
	Budget Item	Q1	Q4	Laura Pennington, Hub	TBD (GHRI/ Healthwise)	P4V
	Initiate, track, and finalize Washington Administrative Code (WAC)	2/1/2017	9/30/2017	Laura Pennington, Karen Merrikin, HCA Legal	Karen Merrikin	P4V
	Budget Item	Q1	Q4	Laura Pennington	TBD (Healthwise / GHRI)	P4V
	Activity 1: Develop process to integrate certified patient decision aids Implement use of certified maternity PDAs Implement outreach to maternity	2/1/2017	12/31/2017	Laura Pennington	Karen Merrikin	P4V

Goal: People and their families are engaged as active participants in their health and in health systems transformation efforts.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	providers Offer training and incentives for SDM					
	Activity 2: ACPs implementing use of certified maternity PDAs	3/1/2017	3/1/2017	Laura Pennington	Karen Merrikin	P4V
	Activity 3: Implement outreach activities to maternity providers	2/1/2017	12/31/2017	Laura Pennington	Karen Merrikin	P4V
	Activity 4: Engage with liability insurance community to offer training and incentives for SDM	2/1/2017	12/31/2017	Laura Pennington	Karen Merrikin	P4V
AY3 objective: By July 2017, certification of up to five decision aids that address joint replacement/ spine care	Activity 1: Solicit submissions for aids that support joint replacement/ spine care, convene review panel, and certify successful submissions as appropriate.	2/1/2017	6/30/2017	Laura Pennington	Karen Merrikin, Expert review consultant TBD (OHSU/ UW/GHRI)	P4V
	Activity 2: Decision aids are certified and posted to Healthier Washington website	7/1/2017	7/1/2017	Laura Pennington		P4V
	Budget Item	Q1	Q4	Laura Pennington	TBD (OHSU/ UW/GHRI)	P4V
By January 31, 2018 evaluate implementation of SDM and use of certified PDAs in at least three clinical sites	Conduct an evaluation program to assess how ACPs are impacting patient engagement through implementation of shared decision making maternity	Q1	Q4	Laura Pennington	TBD	P4V

Goal: People and their families are engaged as active participants in their health and in health systems transformation efforts.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	pilots and use of PDAs					
	Activity 1: Evaluate the implementation of SDM and the use of certified decision aids into practice	2/1/2017	12/31/2017	Laura Pennington	UW	P4V
	Activity 2: Develop a written summary of findings of the evaluation of the ACP maternity SDM pilot	1/31/2018	1/31/2018	Laura Pennington	UW	P4V
AY3 objective: By January 31, 2019, 100% of Managed Care Plans and at least 50% of commercial plans commit to supporting the integration of SDM strategies in provider practices.	Activity 1: Discussions with up to three payers to support integrating SDM into clinical process, including members and providers	2/1/2017	1/31/2019	Laura Pennington	Karen Merrikin	P4V
	Budget Item	Q1	Q4	Laura Pennington	University of Washington	P4V
AY3 objective: By January 31, 2018 co-convene at least two national meetings of stakeholders from SIM states implementing shared decision making	Activity 1: Collaborate with the National Quality Forum to co-coordinate the develop-ment of a multi-state SDM innovation network to collaborate with other states implementing shared decision making	2/1/2017	12/31/2017	Laura Pennington	Karen Merrikin	P4V
AY3 objective: By January 2019, up to three FQHC sites have implemented SDM into their clinical	Provide onsite and virtual hands on training and coaching to practices to build systems within their practices that	2/1/2017	1/31/2018	Laura Pennington	Karen Merrikin, consultant TBD (Healthwise/ GHRI)	P4V

Goal: People and their families are engaged as active participants in their health and in health systems transformation efforts.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
workflow, including the use of maternity PDAs	incorporate SDM and use of certified decision aids.					

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Host developer roundtable discussion to discuss options for future processes		Q1	SDM		Sustain
	Share draft cost plan with stakeholders for feedback		Q3	SDM		Sustain
	Revisit financial model and track actual staffing costs for certification model		Q1	SDM		Sustain
	Develop draft cost plan for PDA certification submissions		Q2	SDM		Sustain
	Implement application costs into submission process		Q4	SDM		Sustain

Paying for Value

Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019. In achieving this vision, Washington's annual health care cost growth will be two percent less than the national health expenditure trend. Paying for value is key to achieving the Triple Aim and ensuring systems contribute to the health of the whole person. Meeting this goal will require shifting reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes as measured by the

common measure set. Washington State will use its position in the marketplace to drive transformation.

Payment Model Test 1

In AY3, we will implement integrated financing for Medicaid services in North Central region. This region is comprised of three counties. We will also seek additional counties to enroll as mid-adopters of integrated financing in 20018 (AY4).

By 2020, Medicaid beneficiaries in every service area in Washington will be served by managed care systems providing an integrated set of physical and behavioral health services.

We will incorporate behavioral health services into the state's contracts with MCOs. In both the integrated and non-integrated regions, the set of physical and behavioral (including mental health and substance use disorder) services will be reimbursed on a per capita basis.

Our experience in Southwest Washington has demonstrated the possibilities and the impact of community involvement in planning and executing the transition to integrated care. With leadership from the counties and active engagement by the Southwest Washington Regional Health Alliance (the region's ACH), Southwest Washington became the state's first "early adopter" of the integrated managed care model. The ACH has served as an important partner in helping to convene stakeholders and to reinforce communications with a broad audience of providers, consumers, local government and the public at large. This experience will help inform the role of ACHs as other service areas transition to full integration.

The leadership shown by the counties and ACH in Southwest Washington has also set the stage for longer-term sustainability of the integrated financing model. Their investment of time, talent and local resources in convening partners and confirming a commitment to the success of the model not only helps assure continuation of services to their own residents, but sets an example that the other regions can follow.

CMMI asked...

Please clarify how Federally Qualified Health Centers (FQHCs) fit into Payment Model 1 – What is the linkage between integration and FQHCs in Washington?

FQHCS currently contract with MCOs for medical services and in some cases with BHOs if they provide a SUD service or specialty mental health service that is covered by a BHO. When a region transitions to FIMC, the FQHCs in that region transition to contracting with the fully integrated MCOs for all services, and no longer contract with the BHO for BH services, because the BHO ceases all operations. HCA also continues to conduct a reconciliation process with the FHQCs to ensure that they receive the full FQHC encounter rate for each service rendered.

AY3 plans include:

Goal/Driver 1: Providers are supported in moving to team-based, integrated care.					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Strategy**
By end of AY3, practices enrolled in Hub coaching services show progress towards advancement along continuum of integration	Step/Sub-Step 1: Establish a TA contract with North Central Region (Grant/Chelan/ Douglas counties) for project management and provider TA	2/1/2017	12/31/2018	PM1 Staff	Integration
	Step/Sub-Step 2: Meet with BH providers to understand TA needs	2/1/2017	3/31/2017	PM1 Staff and Hub	Integration
	Step/Sub-Step 3: Engage the Hub to ensure TA is available and meeting the needs of providers and consider if additional TA contracts need to be established outside of county TA and Hub	2/1/2017	3/31/2017	PM1 Staff and Hub	Integration
	Step/Sub-Step 4: Engage selected MCOs in NC region to ensure significant TA is provided directly to the BH providers on billing protocols, in advance of go-live	7/1/2017	12/31/2018	PM1 Staff, Alice Lind, Alison Robbins	Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
By Q1 2018, HCA executes Payment Model 1 implement-ation plan for Mid Adopter Region(s), transitioning 75,000 Medicaid lives to integrated financing				PM1		Integration
	Contract	Q1	Q4	mid-adopter Regions	Mid-adopter regions	Integration
	Contract	Q2	Q3	Mercer / TBD	Mercer / TBD	Integration
	Contract	Q2	Q3	Milliman	Milliman	Integration
	Contract with Beacon to obtain TA on how data can be collected to satisfy necessary reporting requirements	1/1/2017	2/1/2017	PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	As an interim strategy, any data that can be submitted via the DSHS Behavioral Health Data Solution is submitted	2/1/2017	12/31/2018	PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	Develop a recommendation and obtain DSHS and HCA leadership approval on an alternate method for obtaining necessary non-encounter BH data			PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	Develop and execute a work plan to implement the strategy identified in Activity 3.	3/1/2017	1/1/2018	PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	Begin to obtain data via new method from MCOs/BH-ASO in SW region.	4/1/2017	4/1/2017	PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Conduct a readiness review to ensure that data can be collected in the NC region beginning on January 1, 2018.	9/1/2017	12/31/ 2018	PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	ProviderOne system changes are developed and tested			PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	Data architecture and reporting systems are developed and tested			PM1, Adam Aaseby, Cathie Ott, Venys Prestidge, Scott McCarty/ DSHS		Integration
	Encounter and non-encounter data is shared between state agencies, MCOs, providers, and others					Integration
	Data sharing will meet the needs/ requirements of MCOs, multiple agencies, providers, and others					Integration
	Establish an implementation team in the North Central region comprised of County officials and Accountable Community of Health representatives.	2/1/2017	1/31/ 2018	PM1 Team and Nathan Johnson/ MaryAnne Lindeblad		Integration
	Establish a community advisory body that will engage with HCA and implementation team on the design of integrated managed care in the NC region.	2/1/2017	1/31/ 2018	PM1 Team and ACH Team		Integration
	Establish tribal engagement details			Jessie Dean		Integration
	Establish tribal consultation process			Jessie Dean		Integration
	Establish a TA Contract with the North Central Region to support	2/1/2017	1/31/ 2018	PM1 Team and Hub should be engaged to		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	project management activity at the local level and TA for providers as they transition to managed care.			ensure nothing is duplicated		
	Determine number of health plans to participate	1/1/2017	1/1/2017	Alice Lind		Integration
	Determine if county will act as BH-ASO or if HCA procures	1/1/2017	1/1/2017	Isabel Jones, Alice Lind, and implementation team		Integration
	Determine carve-outs (population and benefits)	1/1/2017	1/1/2017	Alice Lind		Integration
	Determine implications of fully integrated foster care plan going live in 2018	2/1/2017	3/1/2017	Alison Robbins, Alice Lind, Isabel Jones, DSHS input		Integration
	Build in addressing impacts of new Federal Medicaid Regulations	2/1/2017	3/1/2017	Alison Robbins, Alice, Isabel, DSHS input		Integration
	Determine AI/AN carve-outs	1/1/2017	1/1/2017	Jessie Dean		Integration
	Submit change requests if necessary and conduct work to transition enrollees from any MCOs that will no longer provide coverage to a new integrated MCO plan effective January 2018.	2/1/2017		Cathie Ott, Alice Lind, Alison Robins, Gail Krieger		Integration
	Determine bed allocation	1/1/2017	1/1/2017	Christy Vaughn, Savannah Parker, Isabel Jones, Colette Rush, Alice Lind, DSHS		Integration
	Develop and release RFP	2/1/2017	4/1/2017	PM1 Team, Alice Lind's staff, Contracts staff and DSHS input		Integration
	Procure an organization to act as a Behavioral Health	2/1/2017	4/1/2017	PM1 Team, Alice Lind's staff, Contracts		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Administrative Service Organization (BH-ASO) in the North Central Region			staff, and DSHS input		
	Draft and finalize fully integrated MCO contracts and BH-ASO contract	2/1/2017	4/1/2017	PM1 Team, Alice Lind's staff, Contracts staff, DSHS input		Integration
	Set an integrated Medicaid per-member-per-month rate for fully integrated managed care plans.	2/1/2017	4/1/2017	Christy Vaughn, Finance, and Milliman with assistance from DSHS staff		Integration
	Determine distribution of non-Medicaid funds between MCOs and BH-ASO and any other entities	5/1/2017	7/1/2017	Christy Vaughn, Finance, and DSHS finance staff		Integration
	Conduct readiness review to verify that MCOs and BH-ASO are prepared for go-live	8/1/2017	9/1/2017	Gail Krieger's staff is lead with PM1 staff, Alice Lind, and DSHS assistance		Integration
	Network Adequacy established	6/1/2017	7/1/2017	Alison Robbins, Kirk Webster		Integration
	Provider training conducted (spend down, payment/billing, contracts	Q1	Q4	Hub		Integration
	Client education conducted	Q2	Q4	Hub		Integration
	DSHS/HCA Agency staff training conducted	Q3	Q4	TBD		Integration
	Facilitate "knowledge transfer" to educate MCOs on BH programs and services	7/1/2017	12/31/ 2017	Isabel Jones and Alice Lind		Integration
	MACSC plan ready			HCA, TBD		Integration
	Eastern State infrastructure ready	8/1/2017	12/31/ 2017	Colette Rush		Integration
	Send client notifications per	7/1/2017	12/31/ 2017	Alice Lind, Alison Robbins,		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	CMS requirements, informing clients of transition from BHO coverage to integrated MCO coverage			and Gail Krieger with DSHS input		
	Facilitate the sharing of continuity of care client information between the BHO and the integrated MCOs and BH-ASO. Includes establishing data sharing agreements between parties	11/1/2017	12/31/ 2017	Alison Robbins's staff		Integration
	Process client transfers/ enrollments in P1	7/1/2017	12/31/ 2017	Robin Knudsen, Office of Medicaid Systems and Data		Integration
	Complete releases and transfer agreements with clients	7/1/2017	12/31/ 2017	Robin Knudsen		Integration
	E&T services confirmed	4/1/2017	4/1/2017			Integration
	Establish an Early Warning System Steering Committee and identify early warning system indicators for tracking on 1/1/2018	7/1/2017	1/31/ 2018	PM1 and Alice Lind staff with DSHS input		Integration
	Integrated financing contracts in SW and for NC include language that incentivizes the use of value-based purchasing payment methods with providers and also incentivizes plans to work with providers to move to more integrated clinical models.			Alice Lind and Alison Robbins lead; Christy Vaughn		Integration
	Data and reporting systems in production			BHA, Jerry Britcher		Integration
	PRISM System access, reports modified			DSHS, David Mancuso's team		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	ProviderOne system changes in production			P1 Team, Adam Aaseby, Cathie Ott		Integration
	Stakeholder access modified as needed	1/1/2018	1/31/ 2018	BHA, DSHS, HCA, P1 Teams		Integration
	ITA, BH, Unavailable Bed reports available	1/1/2018	1/31/ 2018	BHA, HCA		Integration
	Establish monitoring group for 1/1/2018 implementation and set up daily calls to triage transition issues	7/1/2017	1/31/ 2018	PM1, Alice Lind, Alison Robbins's staff and DSHS		Integration
	Activate support processes for MCO, Provider Reps, Eastern State, Eligibility	1/1/2018	1/31/ 2018	Isabel Jones, Alice Lind, Colette Rush, Alison Robbins		Integration
	Confirm information systems functioning correctly (data integrity and functionality)	1/1/2018	1/31/ 2018	BHA, DSHS, HCA, P1 Teams		Integration
	Leverage support process to identify and implement systemic improvements	1/1/2018	1/31/ 2018	Isabel Jones, Alice Lind, Colette Rush, Alison Robbins		Integration
	Participate in local working groups focused on integration of physical and BH services and financial integration models.	2/1/2017	1/31/ 2018	Isabel, Alice Lind, and Melena Thompson or delegated DSHS staff, HUB		Integration
	Proactively engage ACH's to educate about integrated care, answer questions, and dispel myths.	2/1/2017	1/31/ 2018	PM1, ACH team lead with DSHS inclusion		Integration
	Develop and execute a communications plan to educate stakeholders statewide about integrated care and financing.	2/1/2017	1/31/ 2018	PM1 and Communication staff		Integration

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Obtain a binding letter of intent from at least one regional service area to pursue integrated financing in 2019.	6/1/2017	9/1/2017	PM1 staff lead		Integration
	Good quality measures of the integration of care and whole person wellbeing have been identified and implemented					Integration
Integration (BH/PH) is VBP based	Create a pathway to clinical integration of BH/PH					Integration
	Budget Item	Q1	Q4		TBD	Integration
	Budget Item	Q1	Q4		TBD / Cambria	Integration
By Q3, two regions have submitted Binding Letters of Intent for late mid-adopter integrated financing	Proactively engage and educate stakeholders about integrated financing & incentives for mid-adopters	Q1	Q3			PM1
	Step/Sub-Step 1: Obtain feedback from ACH's regarding how they believe they should play a role in both the development of integrated managed care in their region, and also the post "go-live" role (Committees they will manage, etc.)	2/1/2017	6/1/2017	PM1 staff and ACH staff		PM1
	Step/Sub-Step 2: Issue guidance regarding the ACH role in an integrated region, both the design of integrated financing and the options for post-implementation roles	12/31/2018	12/31/ 2018	PM1 staff and ACH staff		PM1
	Step/Sub-Step 3 Include ACH representative in	2/1/2017	12/31/ 2018	PM1 staff and ACH staff		PM1

Goal/Driver 1: State financing and administrative approaches promote integrated and coordinated service delivery in physical and behavioral health settings.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	North Central implementation team					
	Step/Sub-Step 4: Provide clarity on ACH role in integrated care models and financing	2/1/2017	12/31/ 2018	PM1 staff and ACH staff		PM1

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Conduct change management activities to mobilize commitment to integrated financing Establish working groups and community stakeholdering committees to participate in implementation efforts in mid-adopter region(s) Include ACH rep in NC implementation team BH Providers in mid-adopter region(s) receive coaching/TA to successfully contract with MCOs	Q1	Q4			Sustainability

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Proactively engage and educate stakeholders about integrated financing and incentives to solicit mid-adopter letter of intent. Implement Behavioral Health Data Solution (v2.0) to enable Early Adopter region, MCOs, BHOs and providers to submit all required behavioral health data and reporting for all non-encounter BH data for services covered under all General Funds – State and Medicaid funding	Q1	Q2			Sustainability
	Implement mid-adopter BH data submission and reporting plan for all non-encounter data for services covered under all General Funds – State (GFS) and Medicaid funding ProviderOne system changes developed Implement plan for BHO Transfers to integrated care coverage	Q2	Q3			Sustainability

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Implement payment integration incentives for VBP Provide BH providers TA on billing protocols in mid-adopter Region(s) Prepare stakeholders for transition to whole person care (Agency staff, providers, clients, MCOs, MACSC Plan) Confirm network readiness to implement integrated care Implement early warning systems and processes	Q3	Q4			Sustainability
	Develop viable BHA/HCA data integration solution to enable long-term (2020 and beyond) non-encounter BH data submission and reporting for services covered under all GFS and Medicaid funding Develop BHO termination process ACH supports for integrated care defined and implementation planning underway Engage HUB to ensure TA is available/meeting the needs of providers		Q1			Sustainability

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	Develop viable plan to enable mid-adopter region(s), MCOs, BHOs, and providers to submit all required behavioral health data and reporting for all non-encounter BH data for services covered under all GFS and Medicaid funding ProviderOne system changes defined					
	BH Providers in mid-adopter region(s) receive coaching/TA to successfully contract with MCOs Implement ACH supports for integrated financing and care		Q2			Sustainability
	Complete mid-adopter procurements (minimum of 2 MCOs and BH-ASO if needed) BH Providers in mid-adopter region(s) receive coaching/TA to successfully contract with MCOs		Q3			Sustainability
	Complete mid-adopter procurements (minimum of 2 MCOs and BH-ASO if needed) BH Providers in mid-adopter region(s) receive coaching/TA to successfully contract with MCOs Implement payment integration		Q4			Sustainability

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
	incentives for VBP Provide BH providers TA on billing protocols in mid-adopter Region(s) Complete BHO termination process					
	Implement mid-adopter BH data submission and reporting plan for all non-encounter data for services covered under all GFS and Medicaid funding ProviderOne system changes developed		Q3			Sustainability
	ProviderOne system changes tested and implemented		Q4			Sustainability

Payment Model Test 2

Model Test 2 aims to move FQHCs, rural health clinics and critical access hospitals to a value-based payment system that allows them the flexibility to achieve better care, better health and lower costs for the populations they serve.

Federally Qualified Health Centers and Rural Health Clinics

Model 2 is intended to reform the payment system for FQHCs and RHCs in a way that provides the flexibility and sustainability to meet changing community needs.

Model 2 aims for a payment system that is simple, fair, transparent, and inexpensive to administer. It will link gain sharing and risk to quality and provide the opportunity for shared savings. It will also address the burdensome reconciliation process. Ultimately, the payment model developed will pave the way for a true population-based pay for performance system.

More specifically, this model moves these health center types from the current encounter-based payment methodology to a value-based methodology. It converts the current encounter rate to a per-member-per-month amount (PMPM). In compliance with federal regulations, the PMPM will be tied to performance metrics, such that, should an FQHC or RHC not perform against metrics their PMPM would be reduced in the subsequent year. FQHCs and RHCs would retain the right to earn back the full benefit their baseline PMPM would have earned upon performance against metrics.

As denoted in the Operations Plan, our immediate next steps are to finalize the metrics component of the model with the stakeholders willing to adopt the model.

a. Critical Access Hospitals

Under Model 2, we are seeking to create a new facility type designation that allows CAHs to scale their services and care relationships to the needs and care patterns of the communities they serve.

Under the work of Model 2 we are seeking to create a new facility type designation that meets the needs of both payers and providers and offers the opportunity for care to be organized and delivered in ways that are responsive to the health needs of rural communities.

In refining our model, we intend to work not only with the hospitals and their association representatives, but with the ACHs in the affected service areas in order to assure that we are being responsive to community needs. We will also coordinate the hospital work with the modeling for RHCs as described above. In addition, we intend to leverage the resources of the Practice Transformation Support Hub in working directly with providers.

This work has focused on identifying the current state reality for small rural CAHs, and determining the appropriate mix of services. This has guided the development of potential payment approaches to preserve access in a sustainable way, and has allowed for the development of value-based approaches. We have identified primary care, emergent and outpatient services, and long-term care as areas of focus. We are currently in the process of finalizing the proposed model for delivery in January.

AY3 plans include:

Goal/Driver 1: ACHs have capacity and mechanisms to be responsive to partnership opportunities and community priorities						
Milestone / Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
By June 1, collaboratively establish roles and responsibilities of the ACH in integrated regions. ACHs serve as the primary local resource to engage the State in integration implementation activities	Align with and help inform ACH role in PM2 - Need to draw distinction for rural providers/client needs			Gary Swan, Marc Provence, Chase Napier, Lena Nachand, Mark Rozner, Nathan Johnson		Integration

Goal/Driver 1: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Vendor**	**Strategy**
25% of commercial payments are VBP	Budget Item - Rate development / ProviderOne changes	Q1	Q4		TBD	P4V
30% of state financed payments are VBP	Summary Line	Q1	Q4		TBD	P4V
	Budget Item - Support for CAH engagement	Q1	Q4		WSHA	P4V
	Agreement in principle with CMS on the final APM 4 model.	11/1/2016	3/30/2017	Gary Swan, Marc Provence, Nathan Johnson, Mark Rozner		P4V
	Identified pilot sites and signed memorandum of under-standing	1/1/2017	1/1/2017	Gary Swan, Marc Provence, Mark Rozner		P4V
	Implementation preparation of APM 4.	11/1/2016	6/1/2017	Gary Swan, Madina Cavendish, Karin Freeman, Gail Krieger, Mark Rozner		P4V
	Implementation of APM4 in pilot site, in alignment with BH / PH incentivized payments		Jun-17			P4V
	Statewide planning and spread of FQHC/RHC APM4	6/1/2017	12/31/2017	Gary Swan, Marc Provence, Mark Rozner		P4V
	Feedback mechanism developed on appropriateness of measures - efficacy at the pilot sites	1/1/2017	6/1/2017	Gary Swan, Madina Cavendish, Karin Freeman, Gail Krieger, Mark Rozner		P4V
	Finalization of the proposed model	1/1/2017	6/1/2017	Gary Swan, Marc Provence, Jean Bui, Pat Justis, Mark Rozner		P4V
	Agreement in principle with CMS on the final model.	1/1/2017	9/1/2017	Gary Swan, Marc Provence, Nathan		P4V

				Johnson, Mark Rozner		
	Agreement in principle with leadership (HCA, DOH, DSHS) and external stakeholders on the final model.	1/1/2017	9/1/2017	Gary Swan, Marc Provence, Nathan Johnson, Mark Rozner		P4V
	Identified pilot sites and signed memorandum of understanding	9/1/2017	9/1/2017	Gary Swan, Marc Provence, Mark Rozner		P4V
	Align FQHC/RHC APM 4 pilot sites with Hub resources	1/1/2017	12/31/2017	Gary Swan, Marc Provence, Mary Beth Brown, Mark Rozner		P4V

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures.					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owner**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Implementation readiness/best practice development	Q1	Q4		Sustainability
	Process development - engagement with finance and operations	Q1	Q4		Sustainability

CMMI asked…

Payment Model 2 (both FQHC/RHC and CAH strategies) has been slower to develop than anticipated. Please provide an updated timeline/strategy for these approaches that Washington feels is feasible and realistic, given the existing environment. What are Washington's updated risk mitigation strategies for these payment models?

Our health center and clinic partners share our sense of urgency and commitment to timely resolution on points of disagreement. Progress is contingent on timely resolution of logistical issues and a final decision.

FQHC/RHC APM 4 timeline:

- Target implementation – Q2 2017
- Quality metrics strategy – Q2 2017
  - Establishment of baselines
  - Build out reporting processes
  - Build competency in provider reporting
  - Prepare for implementation
  - Reconciliation process and per-member per-month (PMPM) adjustment

The main risks to APM4 stem from our ability to gather accurate quality data and attach this data to payment in a timely fashion. We understand this is a gap in our HIT plan that needs to be addressed immediately. Establishing a process that measures the provider against their own data, using clinical chart information, may be timely and cost prohibitive. There are a number of ways this can be done and once we define the model we will move quickly to define our HIT/data strategy.

CAH model

In AY3, we will identify the regulatory and policy changes that need to occur. We will make changes to payment systems to allow for implementation and collaboration with partners. Depending on scope and scale, some elements of the payment model may be adopted in 2017.

Paying for Value: Payment Model Test 3

The model test 3 tests accountable care delivery and payment strategies first for public employees in Western Washington. At the same time, the accountable care strategy will be spread and scaled statewide, as other public and private purchasers adopt similar risk-based and value-based strategies.

Under this model test, providers will be paid based on value of care delivered, including state employees' satisfaction with their health care experience, and improved health outcomes. Our two ACP networks have been adhering to specific health transformation requirements.

Both networks are required to participate in Healthier Washington initiatives including:

- Shared decision making pilots and their accountable community of health;
- produce Quality Improvement Plans documenting their progress on implementing Bree Collaborative recommendations for various high cost, high utilization, and high variation procedures annually;
- Participate in established community quality improvement programs for obstetrics, cardiology, and spine care;
- Adopt certified health information technology infrastructure, including electronic health records, and participate in the Washington State Health Information Exchange; and
- Invest in infrastructure to advance primary care medical home (PCMH) standards across all network partners (as defined by NCQA PCMH Level III standards or equivalent).

Both networks have offered timely and convenient access to both primary care and specialty providers, as well as expanded service hours for primary care, urgent care, and 24/7 consulting nurse and tele-urgent care services. The networks are providing enhanced communications to members, including plan-specific websites, dedicated contact centers for scheduling, prescriptions, and additional support services, and proactive member engagement through printed and electronic materials.

The networks are risk-bearing contracts. In other words, within set parameters there are potential financial consequences to both HCA and the accountable care network plans if financial, quality, and member experience targets are not met.

Each accountable care network has agreed to annual targets for financial trend guarantees. If the network exceeds its trend guarantee target – resulting in more savings than the target would have created – HCA will pay the network a share of the savings. If the network does not achieve its trend guarantee target – resulting in less savings than the target would have created – the network will pay HCA a share of the deficit. The deficit can be mitigated or savings shared could increase depending on the network's performance (improvement and movement toward achieve measure target for each measure) in the quality improvement model (QI model).

The QI model includes 19 quality measures, a subset of measures from the Washington Statewide Common Measure set in the following five categories: chronic conditions; behavioral management; client experience; medical screenings and immunizations; and obstetrical care.

As of November 25, 2016, the last week of open enrollment, approximately 14,976 people had enrolled in the UMP Plus options.

AY3 plans include:

Goal: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owners**	**Vendor**	**Strategy**
HW efforts are aligned with Federal VBP initiatives (QPP/MACRA, CPC+), to include Alignment of MACRA with state-based activities – number of providers in advance payment model	Work with CMS on requirements under MACRA/QPP to accept customized state-based model Work with CMS on QPP requirements to be payer-agnostic and to include community health workers as QPs Provide tools and resources to increase knowledge of population health based VBP	Q1	Q4	Rachel Quinn, JD Fischer, Nathan Johnson	Brad Finnegan, Cambria Solutions	P4V
	Work with CMS on requirements under MACRA/QPP to accept customized state-based model	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
	Work with CMS on QPP requirements to be payer-agnostic and to include community health workers as QPs	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V

Goal: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owners**	**Vendor**	**Strategy**
	Commercial payers are adopting integration					P4V
	By the end of AY3 we will measure the number of commercial payer outreach activities (WA-APCD)					P4V
	Activity 2: Rule finalized.	9/30/2017	9/30/2017			P4V
Cost growth below national average	TBD	Q1	Q4			P4V
	Connect participating providers to the resources from the Practice Transformation Hub	2/1/2017	1/31/2018	Laura P		P4V
	Create incentive program to engage providers not participating in risk-based contracts	6/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
Spread and scale Care Transformation strategies through other purchasers	Budget Item	Q1	Q2		TBD	P4V
	Work with (major purchaser) to help them implement Bree care transformation standards	3/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
30% of state financed payments are VBP		Q1	Q4			P4V
	Budget Item	Q1	Q4		TBD	P4V
	Budget Item	Q1	Q4		TBD	P4V
	Budget Item - Data Aggregation TA	Q1	Q4		TBD	P4V
	Budget Item	Q1	Q4		TBD	P4V

Goal: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Task Owners**	**Vendor**	**Strategy**
	Financial and quality thresholds established in MCO contracts to align with purchasing strategy	4/1/2017	1/31/2018			P4V
	ACP expansion for 2018	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas, Michael Arnis		P4V
	Public purchaser outreach and education	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
	Create incentive (e.g. SDM funding) for providers to join ACP networks	2/1/2017	1/31/2018	JD Fischer, Laura Pennington		P4V
	BHPH financial and quality thresholds established for AY4		1/31/2018	Rachel Quinn, Savannah Parker, Laura Pennington		P4V
	Private purchaser outreach and education - Washington Roundtable	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
	Engaging brokers	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
	Engage additional payers in PM4	2/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V
	Conduct focus groups with purchasers	5/1/2017	1/31/2018	JD Fischer, Rachel Quinn, Kristin Villas		P4V

Goal/Driver 1: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor/ Consultant**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Executive leadership of employers and other purchasers Payers - engage QHPs		Q1			Sustain
	Providers - TA for four foundational elements (care transf., measures, risk, data)	Q3	Q4			Sustain
	Federal engagement - update on P4V progress and identify potential support to spread and scale VBPs to other environments Broker engagement Providers - model 3 expansion; TA Payers - Model 4 expansion	Q1	Q4			Sustain
	Ownership/Agency process merge: P4V team in cooperation with other HW and agency teams	Q1	Q4			Sustain

Population Health as an Enabler

Healthier Washington's four payment model tests focus on value-based purchasing. Central to the definition of "value" is improvement in the health of the population served. Model Test 1 recognizes that those with serious physical and mental illness are at risk of dying decades earlier from preventable chronic disease than those without such a dual diagnosis. If, for example, a population health plan for a given population includes addressing an elevated incidence of diabetes, it is essential that the health system serving that population seamlessly integrates behavioral health services into the provision of diabetic care. By establishing integrated financing managed care agreements, Washington will firmly establish a delivery and payment system that advances whole-person care.

As the largest health care purchaser in the state, HCA is in a position to influence the focus of provider systems toward care that can much more consciously align with population health needs. All four payment test models move along a continuum away from fee-for-service reimbursement toward incentives for improved health outcomes.

These arrangements encourage not only a better use of health care resources, but also create opportunities and incentives for greater engagement of individuals in their own health.

For example, if a provider system redeploys resources to promote healthier behaviors and is rewarded through retaining a share of savings realized, the benefits accrue both to the provider system and to the population served. Such rewards are made possible through a combination of alternative payment relationships, the accountability of a health system for a defined population, and agreement on a common set of outcomes-focused performance measures.

To further scale and spread the accountable care option, this model test will be expanded statewide in 2017 through the following strategies:

- Engagement of senior purchaser leaders through the Washington Health Alliance Purchaser Affinity Group. The Washington Health Alliance will expand its current purchaser group, the Purchaser Affinity Group (PAG) to include C-suite leaders and other large self-insured purchasers not currently members of the purchaser group. Chaired by the Director of the Public Employees Benefit Board, current PAG membership includes benefits managers from Starbucks, King County, Eddie Bauer, and unions. To be held four times a year, the meetings will be a 'call to action' and a mechanism to engage and educate benefit decision makers at organizations.
- Targeted presentations to purchaser groups and 1:1 meetings with public and private purchasers. Healthier Washington staff will proactively select presentations and arrange individual meetings with public and private purchasers to further educate and spread the model test and accountable care tools. Or, in the case of public purchasers or political subdivisions (e.g., schools, water districts, cities, and counties), join the state employee plan and enroll in the model test directly (if risk requirements are met).
- Annual purchaser conference sponsored by HCA, King County, the Washington Health Alliance, and the Washington Roundtable to increase awareness and provide tools to develop and implement accountable care strategies. HCA, King County, Washington Health Alliance, and the Washington Roundtable will co-sponsor a statewide purchaser conference on value-based purchasing. HCA will lead a session on the model test and steps purchasers can take to replicate the model.

CMMI asked...

What is the state's broader sustainability strategy for Medicaid payment reform – will Washington be pushing for alignment with MACRA? Will Washington leave VBP/APM design to Medicaid MCOs? Please provide details as available.

Washington will drive Medicaid VBP reform through a variety of mechanisms: 1) VBP quality incentive and other reforms outlined in the HCA VBP Roadmap; and 2) alignment with MACRA.

Common key quality measures from the common measure set are included in HCA purchasing contracts and for the first time in 2017 we are tying them to additional incentive payments in public employee benefits. All of the measures that are a subset of the measures in the Statewide Common Measure Set will be tied to a form of financial risk using benchmarks. The ACP contracts have 19 measures tied to payment, the PEBB and MCO contracts will have a common set of 33 measures, however only 11 of those in the PEBB contract will be tied to additional incentive payments, and of those 11, seven will be included in the 2017 MCO contracts tied to a premium withhold. Payment model 2 will utilize the same seven measures as are in the MCO contracts.

Payment Model Test 4

Healthier Washington Payment Model Test 4: Greater Washington Multi-Payer seeks to accelerate the adoption of value-based purchasing by increasing providers' access to patient data across multiple payers and health systems. The resulting multi-payer product will have the capacity to coordinate care, share risk, and engage a large population comprising commercial, Medicaid, public employee, and Medicare beneficiaries. Claims and clinical data integration and aggregation will provide a unified view of patient care and timely feedback to providers, regardless of payer, facilitating improved care coordination and population health management.

Rather than directly changing the way we pay for care, as is done through Payment Models 1, 2, and 3, Model 4 aims to accelerate a common infrastructure that integrates multi-payer data as a means to accelerate the participation in value-based payment arrangements and alternative payment models. Money will flow from HCA to the Contractor who is leading the effort to integrate multi-payer data and facilitate providers' transition into value-based payment arrangements.

The principal objective is to increase the adoption of value-based payments by facilitating providers' ability to manage patient populations across multiple payers. AIM will play a key role in the model by supplying attributable Apple Health claims data extracts to the Contractor.

Both Model 4 contractor partners have agreed to build internal capacity and infrastructure to support value-based contracts, achieve VBP targets and report performance on metrics from the Washington statewide Common Measure Set. To support the partners' efforts, HCA will provide Medicaid and state employee data for attributed lives at each partner organization, plus funding and TA support. Funding will flow from HCA to the two contractor Partners who are leading the effort to integrate multi-payer data and facilitate providers' transition into value-based payment arrangements.

AY3 plans include:

Goal/Driver 1: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor/ Consultant**	**Strategy**
Improved quality clinical quality through multi-payer alignment	Payment Model 4 - Contractors submit quality reports - scores on Diabetes, Hypertension, Preventative and Screening, Depression, High Cholesterol, Maternity, Patient Experience, Well-Child, and Prescription Management measures in Model 4 - Model 2 FQHC/RHC APM 4	Q1	Q4		Northwest Physicians Network	P4V
	Budget Item	Q1	Q4		Regence	P4V
	Budget Item	Q1	Q4		Summit Pacific	P4V
	Budget Item	Q1	Q4		Cambria Solutions	P4V
Measure progress through PM4 contract measuring payer and provider participation	Assess semi-annual progress report from PM 4 contractor Assess annual progress report from PM4 contractor Work with PM4 contractor to implement core HW value-based and patient-centered behaviors Engage additional payers and providers in PM4 Assess PM4 contractor's performance on quality measures	Q1	Q4			P4V

Goal/Driver 1: Increase the number of providers and payers engaged in HW payment models						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor/ Consultant**	**Strategy**
	Step/Sub-Step 1: Assess semi-annual progress report from PM4 contractor	7/1/2017	1/31/2018	JD Fischer		P4V
	Step/Sub-Step 2: Assess annual progress report from PM4 contractor	1/1/2018	1/31/2018	JD Fischer		P4V
	Step/Sub-Step 3: Work with PM4 contractor to implement core HW value-based and patient-centered behaviors	2/1/2017	1/31/2018	JD Fischer		P4V
	Step/Sub-Step 4: Engage additional payers and providers in PM4	5/1/2017	1/31/2018	JD Fischer		P4V
	Step/Sub-Step 5: Assess PM4 contractor's performance on quality measures	1/1/2018	1/31/2018	JD Fischer		P4V
	Develop and implement an assessment tool	6/1/2017	1/31/2018	Hub		P4V
	Conduct end-of-year assessment of provider-readiness	11/1/2017	1/31/2018	Hub		P4V

CMMI asked...

Payment Model 4 development has been delayed several times this Award Year and has undergone a redesign. We discussed updates to Payment Model 4 on the 9/15 call and Washington feels confident about the current approach. Please provide the updated strategy and timeline for Payment Model 4 in future award years.

Background

In September 2015, HCA released a Request for Applications (RFA) for Payment Model 4. HCA received two Letters of Intent to Apply, but ultimately received no applications. In the ensuing months, HCA re-evaluated the direction and scope of Model 4 and recognized the need to scale back the contractor requirements to pursue a pilot-style approach in a more targeted environment. Perceiving validity in pursuing both a rural and an urban demonstration of Model 4, HCA has identified prospective contractors for

each setting with the requisite infrastructure and foundational investment necessary to pilot the model:

1. Northwest Physicians Network (NPN) – urban demonstration
2. Summit Pacific Medical Center (Summit Pacific) – rural demonstration

Payment Model Details

NPN and Summit Pacific have verbally agreed to a draft Statement of Work (SOW) covering the following high-level deliverables:

- Leverage a shareable data aggregation solution
- Support partners in the adoption and acceleration of VBPs
- Provide matching funds
- Submit annual work plan to HCA
- Submit semi-annual progress reports to HCA (including reports on quality measures)
- Attend semi-annual meetings with HCA

HCA has committed to:

- Share attributable medical and pharmacy claims data extracts from UMP and Apple Health
- Provide technical assistance around care transformation
- Explore leveraging our purchasing power and stakeholder relationships to incentivize broader participation in the model test

Near-Term Project Goal

We aim to enter into Model 4 contracts with NPN and Summit Pacific in late 2016, and for each contractor to complete key deliverables before the end of grant year 2 (i.e. by January 31, 2017). Currently, HCA staff is developing detailed requirements for the following contractor deliverables:

- Demonstrate the IT capability to aggregate multi-source data into providers' work flow
- Submit initial annual work plan to HCA
- Submit baseline report on select quality measures (ACP measures plus asthma medication management and well-child visits)
- Establish partnerships with additional payer(s)

We are moving forward aggressively on Model Test 4. It is the complement to the ACP in that ACP leverages a system to move toward value. Model 4 engages individual providers via a network in order to drive toward the same quality and cost targets. We firmly believe in testing two different approaches.

Theory

The Model Test 4 theory is that providers need new and expanded sets of real-time data in order to take on financial and clinical accountability, care coordination practices, and population health management responsibilities. Our goal through Model 4 is to accelerate the adoption of value-based purchasing among participating providers and

payers by increasing providers' access to patient data across multiple payers and providers and by aligning quality measurement used to assess provider performance throughout the health care system. We believe that given a population-health perspective of their patients, in a payer-agnostic manner, providers will be more able and willing to enter into risk-based contracts.

Each network represents a unique and independent test of the model. Consider each a pilot project testing this multi-payer strategy in different environments (i.e. rural vs urban). Each contractor will be responsible for engaging additional payers beyond the state employees' Uniform Medical Plan (UMP) and Apple Health.

HCA is committed to providing attributable claims data from UMP (HCA's self-insured product) and Apple Health, with the goal of expanding the model to include additional commercial (and Medicare) payers over time.

Timeline

We are working to execute contracts as soon as possible, with a few deliverables to be achieved by the completion of GY2 (mostly in January 2017), such as successfully engaging an additional payer in the model before January 31, 2017 and successfully demonstrating the ability to receive HCA data by January 15, 2017.

a. Quality Measure Alignment

Historically, providers and payers alike have expressed frustration over a lack of common, statewide quality and cost performance measures. Current efforts to measure performance are burdensome, overlapping, and often conflicting; in addition, they provide no consistent or comparable indication of health system performance and undermine forward momentum to value-based purchasing. In January 2015, the legislative directive to build aligned Medicaid and public-private measures of health system performance was realized.

The passage of E2SHB 2572 required the development of a statewide core measure set to inform health care purchasing. With the adoption of a "starter" set of 52 measures across the domains of prevention, chronic illness, and acute care, the Performance Measures Coordinating Committee will continue to evolve as state priorities evolve and will be consistent with other measure sets to reduce provider burden.

E2SHB 2572 builds upon legislation from 2013 that required a standard set of cross-system performance measures for use across Medicaid delivery systems that include physical health, mental health, chemical dependency and long-term services and supports. The legislation required focus on both traditional and non-traditional measures of performance including improvements in client health status, reductions in client involvement with criminal justice, appropriate use of emergency rooms and increases in stable housing. With the involvement of a broad range of stakeholders, 51 measures were selected across these domains; a subset of these measures is currently being implemented in state Medicaid contracts.

Additionally, the governor's data-driven, continuous improvement system, "Results Washington," is a key underpinning for this initiative's measurement efforts. It

provides health and health care cost and quality targets that the governor reviews with his cabinet and stakeholders every quarter, resulting in a public report.

The Common Measure Set, as the measurement foundation for all Healthier Washington tests, will measure all aspects of the Triple Aim, including health, quality, access, and costs. As such, Washington has already begun and will continue to incorporate the measures into its model tests.

For example:

- ACHs are using dozens of cross-cutting measures as a subset of the common set to measure long-term outcomes in communities. HCA chose the initial 26 measures based on ACH requirements and state needs to demonstrate increases in population health as a result of SIM investment – and since that time we have added other measures to the dashboard for their use in influencing population health. The ACHs use the data to set priorities and determine where to focus their energy. HCA will use this data for evaluation purposes. (These measures were already on the Community Check-up report – but a subset of 26 were reproduced on the Providence Core dashboard).
- All Medicaid contracts, including those for payment model tests 1 and 2, include key common measures (though not all the same measures). These allow for comparability across both the fully integrated region and non-integrated regions. Alignment of measures across the agency, across contracts and across ACHs will be a focus in AY3. This will follow the investment in AY2 to form a team to align measures and perform the task of ongoing measures alignment.
- A subset of 19 measures from the common measure set is included in the ACP shared risk model. Performance on these measures will determine the amount of savings the networks will receive or the deficits they will owe HCA.
- In 2017, the P4IPH will help gain consensus on effective measures that align where possible with the measure set. This will require the creation of new measures that don't exist in the Common Measure Set today. A collaboration between the ACHs, the PMCC, and the DOH will be essential for defining some pioneering measures in this arena.

In 2016, the Common Measure Set has continued to evolve. Based on the state's focus on behavioral health, the multi-sector PMCC—comprised of payers, providers, purchasers, public health, and others—asked an ad hoc committee to research and recommend additional measures. As a result, three new measures that addressed behavioral health were added to the Common Measure Set in 2016. Additionally, an ad hoc workgroup was convened in 2016 to review and recommend six new pediatric measures to the PMCC for the 2017 Statewide Common Measure Set. This is an indication of work and progress that will occur annually and emphasizes the state's commitment to aligning Results Washington and the cross-system Medicaid measures with the common measure set, as well as nationally vetted measures. As the science of measurement evolves, as well as our ability to access clinical data sources, the common

measure set will be outcomes-based and better linked to community goals that address whole person health.

Payers and providers are equally committed to reducing the administrative burden of overlapping measure requirements and are active participants on the Performance Measures Coordinating Committee. All commercial payers have voluntarily committed to participating in public reporting of the common measure set. Additionally, the state is investing in a campaign that targets purchasers to promote the adoption of the measure set. These efforts will result in a measure set that can be effectively used by multiple payers, clinicians, hospitals, purchasers, and communities for health improvement, quality improvement, provider payment system design, benefit design, and administrative simplification efforts, as appropriate.

The Common Measure Set will be used to regularly assess and report performance at the community, health plan, clinical practice, and/or hospital level. Results will be publicly reported in an unblinded manner when numerators and denominators are sufficient to produce results that are statistically valid.

Note: The current set of SIM metrics can be found in Appendix 3: SIM Metrics. It contains the metrics table from the quarterly progress report due November 30, 2016.

Population Health as an Enabler

In an effort to align and standardize the way we approach performance measurement, draft population health measures from the 2014 Prevention Framework influenced the development of the "starter" set of statewide common measures. It is recognized that the current set of common measures are clinical in nature and there is a need, as we continue to evolve the common measures, to incorporate measures that address a broader population health approach. As the P4IPH is developed and the common measure set continues to evolve, efforts will be made to align, where possible, the common measures with priorities and strategies included in the P4IPH, including goals to address health equity.

b. Plan for Improving Population Health (P4IPH*)*

In award year two, our P4IPH website went live after a period of review and feedback by key stakeholders. Initially we have launched the site on the DOH website – but we have near-term plans to move the site to the Hub resource portal for ease of use by our clients.

While our Prevention Framework is widely considered to be a groundbreaking piece of work in public-private partnership, the real value is in the adoption of the toolkit and the use of the tools and theories.

The objectives are:

- Objective One: By December 31, 2018, Washington State will increase the proportion of the population who receives evidence-based clinical and community preventive services that lead to a reduction in preventable health conditions.

- Objective Two: By December 31, 2018, Washington State will increase the proportion of the population with better physical and behavioral health outcomes by engaging individuals, families, and communities in a responsive system that supports social and health needs.
- Objective Three: By December 31, 2018, Washington State will increase the number of communities with improved social and physical environments that encourage healthy behaviors, promote health and health equity.
- Objective Four: By December 31, 2018, Washington State will increase the number of integrated efforts between public health, the health care delivery system and systems that influence social determinants of health to lower costs, improve health, improve the experience of care, and contribute to the evidence base.

In AY3, the P4IPH takes the Prevention Framework firmly from the "what" to the "how" – including how strategies and interventions are implemented so that we align as a state, allow for local flexibility, apply the latest evidence, quantify return on investment, and ensure sustainability.

Finally, we will be working directly with Group Health's Center for Community Health and Evaluation (CCHE) to show evidence of the activation of population health principles, using the well-child visit and diabetes test areas. This activates CCHE's existing "theory of change" that evaluates the community role in broader health systems transformation.

Getting the P4IPH web site up in 2016 required strong governance and leadership from the Secretary of Health and DOH. Our advisory and interagency councils provided a strong foundation. The inclusion of the P4IPH in the Healthier Washington portfolio is intended to ensure the alignment of work across: public health, the health care delivery system, and social determinants.

While we have not yet determined a method for measuring alignment or outcomes for the P4IPH component of SIM, we relish the fact that the ACH provides a forum where clinical health and social determinants/population health can come together on even footing. Clinical healthcare systems have more money and power. Public health finds it harder to engage because of the differentiation of power. At the ACH level, each of us plays a role in contributing to health.

The P4IPH will effectively align population health efforts across state agencies, with priorities informing direction of existing and emerging resources, alliances, policy initiatives, and funding opportunities. The P4IPH will provide the language and taxonomy for public and private partners to speak to one another about population health across systems, agencies and sectors. The P4IPH will effectively align population health efforts across state agencies, with priorities informing direction of existing and emerging resources, alliances, policy initiatives, and funding opportunities. This is the responsibility of the ACH, the Healthier Washington governance structure, and all of the stakeholders in the system of care.

The *Planning Guide* is currently on the Department of Health (DOH) website at www.doh.wa.gov/P4IPH but it will have a new home in early 2017 as part of the

Practice Transformation Support Hub's Resource Portal. The portal is currently being developed by the University of Washington and DOH. Moving the *Planning Guide* to the portal will help further align these two Healthier Washington initiatives, providing a sustainable, curated and connected resource.

We will continue to add information to the site including many of the content suggestions from partners and stakeholders, more health issues (including well-child visits), upstream strategies, templates and FAQs.

CMMI asked...

Detail how your team/project will integrate, align, and coordinate across various state initiatives aimed at improving the health of the population (population health).

By their very nature, ACHs are at the center of health system transformation and require alignment and coordination. Our SIM project will support key linkages at the community level, including feedback to inform coordination at the state level. ACHs push us to mirror the model that we've designed for the community, and our aim is to do just that across HW initiatives and teams. We will focus on our shared goals and common levers to function as a system of care - rather than as a project.

We have selected test areas for 2017 – diabetes and well-child visits. We will be working directly with Group Health's Center for Community Health and Evaluation (CCHE) to show evidence of the activation of population health principles, using the well-child visit and diabetes test areas. A dedicated DOH/P4IPH resource will be working with the ACHs and LHJs to embrace the test areas as well as to define new methods to gauge alignment with ACH priorities.

We will be working with the Population Health Foundation (PHF) to develop a driver diagram specific to the P4IPH. This will take place in a workshop and be led by a PHF quality expert. As with the primary Healthier Washington driver diagram, we will develop primary drivers, secondary drivers and a plan for next steps. While we are still finalizing the statement of work for this exciting effort, we are contemplating how to structure the work and what to include, for example:

- Should the primary and/or secondary driver include a driver in each of the "Three Buckets of Prevention?"
- Including drivers in all three buckets would produce a concrete, actionable model to address a health issue inside and outside clinic walls

Integrated financing models will integrate and align and coordinate across various state initiatives by engaging the ACHs as primary stakeholders in the development of the integrated care program in their region, and by engaging the Hub to provide technical assistance to providers that will support them in moving to integrated clinical models (which is complementary work to the work of integrating the business model). In working with providers and practices, the Hub will follow the lead of Model Test 1 in the early and mid-adopter regions, encouraging the ACHs to enroll providers in coaching services. Population health tools and strategies will be part of the coaching toolkit, including coaching practices toward strengthening linkages to community resources to

support the health outcomes of their patients. Population health resources and strategies will be included on the Web-based Resource Portal.

We are not using provider incentives in our Healthier Washington model. We are focusing on the most engaged providers and anticipate we will get uptake. We are open to discussing potential incentive (carrot or stick) models that would align with our transformation methodology.

Our payment model redesign teams will work closely with our practice supports to connect providers to the resources necessary to transition into value-based contracts and move the needle in terms of population health. We will work with the Washington Health Alliance, Washington Roundtable and brokers throughout the state to engage purchasers and align payment strategies to incentivize providers to provide greater value and quality.

The P4IPH team, specifically, will continue to collaborate with internal and external partners to develop and/or curate population health improvement tools, including those that support VBP. These tools are available, or will be available, on our state P4IPH website, which debuted on September 30, 2016.

Analytics, Interoperability and Measurement (AIM)

The AIM initiative, including its cross-agency Health Information Technology (HIT) advisory body, consists of several efforts to support the health system transformation projects under the SIM grant and build upon Washington's HIT infrastructure. AY3 requires SIM/HIT alignment with multi-agency HIT initiatives, MMIS, MU/MACRA and a recently launched decision support program and department at HCA, which will make use of AIM infrastructure to advance decision support capacity.

The work of AIM in AY3 includes the implementation of the following capabilities and capacities for Healthier Washington:

- Measurement support and reporting (common measure set)
  - AY2: Gathered requirements and provided an interim solution via the Providence Center for Outcomes Research and Education (CORE) dashboard.
  - AY3: Begin using AIM data sources to produce own measures.
- Evaluation support and reporting (for state and federal evaluators)
  - AY2: Gathered requirements and began process of data creation, data acquisition.
  - AY3: Provide data to UW and RTI for purposes of actual evaluation.
- Business Intelligence and Decision Support tools
  - AY2: A master data management tool (MDMT) (by January 31, 2017) for data standardization and definition across HIT entities and agencies. This initiative also supports interoperability by creating a master list of clients, providers, organizations, and information about them that multiple systems can use as primary keys for linking data.
  - AY3: A data model (DM) tool to map all available and future data into a model for reporting with interim or longer-term data stores.
  - AY3: An analytics innovation "sandbox" under SIM to pilot and pioneer select BI/SA products and deliverables.

- These strategies will enable Healthier Washington to do the following:
  - Provide data to UW, Washington Health Alliance, RTI and other partners.
  - Assist Payment Model 2 and 4 with data and reporting to support model development.
  - Support ACH projects with data, reporting, and analytics.
  - Provide ACH's with capabilities for interaction with key measures through Healthier Washington data dashboards.
  - Provide ability to create ad hoc reports and analysis for Healthier Washington initiatives and leadership.
  - Analytics capabilities, allowing Healthier Washington stakeholders to explore data through visualization, programming, modeling and other diagnostic, predictive and prescriptive analysis methods.

Also, a follow-on environmental scan initiative is planned to make decisions about interoperability project components – such as behavioral health integration, jails, etc. The scope of the follow-on project has not been finalized but is confirmed for AY3.

In addition to the scope outlined in the AY2 Operations Plan, new AIM/HIT business requirements have been added to scope in AY3:

Healthier Washington Strategy	**AIM / HIT Added Requirements (AY3)** ***See HIT plan for timeline and additional HIT roadmap components.**
Community Partnerships	• Build out of the Healthier Washington regional dashboards to include additional measures based on prioritization. Analytic support and coaching for ACHs (support could be provided by Center for Community Health and Evaluation, AIM and/or regionally, e.g., LHJs). • Support to develop strategic connections between the dashboard and evidence-informed strategies to address identified population health issues. For example, as the dashboard provides results on the 26 subset measures, how will those measures impact the ACH's intended project outcomes as well as the Healthier Washington test areas (diabetes/well-child)? Having the data will help communities modify their approach or may help the state form opinions about leading practices. This will require data, interpretation of data, and bio-statistic information to work. The AIM Sandbox will be essential to satisfy this requirement. • Practice transformation efforts may likely need regional data related to targeted measures; these work products can be leveraged across ACHs.
Integration	• We may need some new capabilities in order to build a system to receive necessary non-encounter behavioral health data. Depending on design decisions in the North Central (NC) region, we may need ProviderOne changes.
Pay for Value	• Model 2 analytic support from the AIM team/DSHS-RDA, tool and material development from the AIM team Medicare data for CAH work, potential provider one updates, tool built for FQHC/RHC APM 4 payment • Data aggregator funding to support Payment Models and providers as they adopt risk-based contracts • HCA to determine statement of work for AY3 relative to products available via the all-payer claims database.

AY3 plans include:

Goal: Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor / Consultant**	**Strategy**
Provide data, analytics, and reporting support to payment models.	AIM Model Support AIM Model 2 Support AIM Model 3 Support AIM Model 4 Support	Q1	Q3	Arindam Basu, Larry Holden	OTB Solutions	P4V
ACHs have ready access to evidence based strategies linked to health issues identified by Dashboard	Budget Item	Q1	Q4		Washington Health Alliance	P4V
By AY3, the State Common Measure Set has evolved to include additional measures that address population health	Solicit input from key stakeholders and present recommendations to PMCC for consideration at Q3 committee meeting	Q1	Q4	Laura Pennington	Washington Health Alliance	P4V
ACHs have ready access to evidence based strategies linked to health issues identified by Dashboard	Provide web-based tools linking health issues to recommended strategies; provide related TA	Q1	Q4		Providence Core	Com-munity Partner-ships
By end of Award Year 3, AIM will have acquired all data sources needed for support of HW.	Data Use Agreements (TBD) Data Integration efforts (TBD)	Q1	Q4			Cross-Cutting
	Budget	Q1	Q4		Berry-Dunn / TBD	Cross-Cutting
	Budget	Q1	Q4		Desautel-Hege	Cross-Cutting
	Budget	Q1	Q4		OTB Solutions Group	Cross-Cutting
	Budget	Q1	Q4		University of Washington/ DHS	Cross-Cutting

Goal: Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor / Consultant**	**Strategy**
By June 1, 2017 have in place a Data and Analytics Sandbox for AIM personnel to support Healthier Washington.	Master Data Management Tool Release 2 (Provider Domain) 5/1/2017 Master Data Management Tool Release 3 (Reference Data Mgmt) 8/1/2017 Data and Analytics Innovation Sandbox - Development 2/1/2017-03/31/2017 Data and Analytics Innovation Sandbox - Implementation 4/1/2017-06/01/2017	Q2	Q4			Cross-Cutting
	Budget	Q1	Q4		AIM Analytic Sandbox	Cross-Cutting
	Budget	Q1	Q2		Tableau	Cross-Cutting
	Budget / BRFSS	Q1	Q2		BRFSS	Cross-Cutting
	Budget / Data Acquisition	Q1	Q2		TBD	Cross-Cutting
	Budget	Q1	Q2		Truven	Cross-Cutting

Goal: Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor / Consultant**	**Strategy**
Review and update the Statewide Common Measure Set as needed and publish updated version by January 2018.	Activity 1: Convene the PMCC quarterly to review and approve new measure topics for the Statewide Common Measure Set drawing from the current "parking lot of measures"; review recommendations from ad hoc measure selection workgroups; submit recommendations to HCA for annual updates to the current "starter" set of common measures.	2/1/2017	1/31/2018	Laura Pennington	Washington Health Alliance	Cross-Cutting
	Activity 2: Convene ad hoc workgroup annually to explore evidence and feasibility for adding new measures that address measure topics identified by the PMCC.	7/1/2017	12/31/2017	Laura Pennington	Washington Health Alliance	Cross-Cutting
	Activity 3: Convene one ad hoc workgroup of data/results suppliers to evaluate annual implementation of reportingfrom the measure set and recommend changes to the process and/or replacement or retirement ofcurrently approved measures to thePMCC for 2018.	2/1/2017	1/31/2018	Laura Pennington	Washington Health Alliance	Cross-Cutting

Goal: Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation						
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Name of Contractor / Consultant**	**Strategy**
By January 31, 2018 develop and implement a communication campaign to promote and spread the ongoing use of the Common Measure Set through the enhanced Community Check-Up web portal by purchasers, payers, providers, ACHs, and consumers to promote the uptake of users.	Develop, launch, and implement an ongoing communication campaign, including materials, videos, talking points, and web content, to educate purchasers, payers, providers, and communities about the purpose of the Common Measure Set and the new attributes of the Community Check-Up and to promote the uptake of users.	2/1/2017	1/31/2018	Laura Pennington, Washington Health Alliance	Washington Health Alliance	Cross-Cutting
By December 31, 2017, produce a publicly available web-based and written report of cost and quality measures based on results produced from the Statewide Common Measure Set.	Using a web-based platform to capture appropriate data sources, publicly report results using an online platform, as well as a writtenreport for the Statewide Common Measure Set on an annual basis.	2/1/2017	12/31/2017	Laura Pennington	Washington Health Alliance, Office of Financial Management	Cross-Cutting

Goal: State, community and provider information systems support integrated, team-based care					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Strategy**
By April 1, implement BHDS (v2.0) to enable Early Adopter region, MCOs, BHOs and providers to submit all required behavioral health data and reporting for all non-encounter	BH Data Consolidation Project - Phase 1 (implement v2.0) of tool 4/1/2017	Q1	Q4		Integration

BH data for services covered under all GFS and Medicaid funding.					
	Budget Item	Q1	Q4	Centralized 'EHR'	Integration
By end of Q1, develop viable integration solution to enable long-term (2020 and beyond) non-encounter BH data submission and reporting for services covered under all GFS and Medicaid funding.	Communicate, collaborate, and coordinate, and detailed work plan development and deliverables with AIM workgroup	Q1	Q1		Integration

Goal: Washington State is leveraging partnerships, financing and policy to ensure health systems transformation endures					
Milestone/ Measure of Success	**Action steps necessary to complete activity**	**Start Date**	**End Date**	**Resources**	**Strategy**
Ensure stakeholders, agency and finance mechanisms are ready to implement sustainability plans in AY4.	Bi-weekly meetings with ACH/AIM liaisons on data, analytics and reporting needs Quarterly release of HW Data Dashboards, tailored to ACH's evolving data & measurement needs Bi-weekly HW AIM Steering meetings focused on integrating AIM related data and analytics work into operational work of HCA, DOH, and DSHS	Q1	Q4	AIM	Sustain
	Participate in implementation of HCA's Enterprise Data Management Office (EDMA), including policies, processes, and other controls related to agency data, analytics, and reporting Work with multiple programs across HCA that have an analytic and/or data function to collaborate on projects that span programs, to share technical assistance when needed, to ensure customers experience a seamless interaction with HCA, and to align investments in data and analytic infrastructure	Q1	Q4	AIM	Sustain
Dependency	As we develop data sources to support value based purchasing, innovative payment model design, and behavioral and physical health integration, we will need to ensure that data sources have long-term	Q1	Q4	AIM	Sustain

	technical, legal, and analytic support and integration with existing data systems. We will also want to ensure that the development of measure and reporting systems are consistent and integrated with other efforts throughout Healthier Washington. There are several other data initiatives underway in the state. One is an All Payers Claim Database and another is a Clinical Data Repository. Both these data bases have the potential to be complimentary and value added sources of information on purchasers, system performance, and collaboration. AIM will continue to align, keep open communication, and identify and pursue opportunities for support and leveraging of resources and investments.				
	PMCC/Alliance develop strategies for engaging payers and purchasers in uptake of common measures		Q1	Performance Measures	Sustain
	Implementation of strategies to align common measures across payers and other key stakeholder groups		Q2	Performance Measures	Sustain
	Convene PMCC evaluation workgroup to evaluate appropriateness of current measure set		Q3	Performance Measures	Sustain
	Finalize measures for 2018 measure set and need for ongoing PMCC involvement		Q4	Performance Measures	Sustain
	Contract in place and contractor begins building out WA-APCD.		Q1	Performance Measures	Sustain
	Coordinate reporting of common measures with OFM		Q2	Performance Measures	Sustain
	Identify measures for 2018 state contracts to tie to payments		Q3	Performance Measures	Sustain
	Finalize approvals for 2018 contracts		Q4	Performance Measures	Sustain

c. Workforce Capacity / Community Health Workers and Sentinel Network

Industry Sentinel Network

- The Sentinel Network will draw from rapid periodic polling of employers such as hospitals, clinics, community-based organizations, and from workforce organizations. It will assess the workforce and areas of additional focus areas in training needed.
- The University of Washington Health Workforce Center has developed a survey, established a portal, has begun gathering information and presented its first round of results in the autumn of 2016.

- In AY3, we will continue to fund the Sentinel Network and explore their findings and survey results. We will develop a forum and mechanism for reviewing the results and taking some action based on the data.

Community Health Workers

- In AY2 we delivered on our SIM commitment to provide a CHW recommendation. We consider the SIM commitment complete – even as we look to the ACHs in AY3 to explore expanded use of CHWs. (Taskforce findings and recommendations available upon request.)
- In 2016 we made a policy decision to *not* certify CHWs. In short, we elected to advocate for training and empower the communities at large to engage CHWs as they deem necessary.
- About half of our ACHs have selected projects that involve CHWs. We will be exploring infrastructure requirements for regional workforce development initiatives through the ACH projects.

Community Health Worker Task Force Follow-up

The community health worker (CHW) task force submitted a report with recommendations on February 25, 2016. The 55 CHW task force members represented various sectors from across the state including legislators, physical and behavioral health care delivery systems, local health jurisdictions, community-based organizations, managed care organizations, tribes, education, professional associations, labor, philanthropy, and state government. To ensure that authentic community voice and leadership was embedded into these recommendations, more than 30 percent of task force members were CHWs themselves.

To meet the goals and demands of the Triple Aim, the task force suggested a review of ways to carry out efficient and effective care with the community as the center. The task force recommended that Healthier Washington, the Accountable Communities of Health, the Practice Transformation Hub and key health reform partners use four overarching strategies to guide the development of policies related to CHWs detailed in the report.

- Describe the CHW model as an innovative strategy for health, social service and educational systems. At the center of this model are the CHWs; whose essence is their 'heart of service' and whose passion is the health and well-being of their communities.
- Include CHWs and key leaders in all decision-making forums affecting CHWs' work.
- Build the CHW model into Healthier Washington's strategic and operational plans to recommend best practices of how to integrate and support CHWs for greatest individual and system outcomes.
- Convene a group of leaders to further design and develop flexible and secure funding mechanisms, for a thriving CHW workforce. This is the time to use and invest in CHWs as an essential community engagement and population health strategy to support meeting the Triple Aim.

The recommendations outlined in the task force's report provides a platform for government, policymakers and stakeholders, as well as private sector providers, payers,

and other organizations to support a CHW workforce and integration of CHWs within the Healthier Washington initiative areas and supporting health reform efforts.

Plans for Award Year 3

Washington confidently states that the CHW taskforce exercise was more than academic. We saw a 51 percent CHW composition on the task force. It was impactful and has ripple effects into other elements of our work. (The ACH project selection is one example).

Washington State is taking a different approach; we want to empower our ACHs to build and activate CHWs in the transformative work of Healthier Washington. We want to do so without requiring certification or minimum qualifications from CHWs. Our secretary of health and HCA director strongly advised against creating additional barriers to anyone providing CHW work. We do want to get to appropriate reimbursement for these services. We want to understand how the CHWs want to move forward.

We never planned on additional funding for this CHW work – though we could consider some additional exercise if there is a value proposition. We view it as our responsibility to provide the valuable recommendations to our ACHs, our payers, and to anyone working at a community level and trying to drive practice transformation. We provided the landscape and convening function. CHWs have been identified as key levers for our ACH projects. We want to see how this plays out through our ACH evaluation.

We will be evaluating the success of our health systems transformation – and CHWs will be factored in as part of the overall evaluation. The work is done. Baseline on this is completion. We will be exploring technology options through our HIT plan as we receive feedback from the ACH evaluation that CHWs could benefit from select tools.

We did review each of the ACH projects and provided feedback on success measures, thoroughness of planning, etc. Going forward, it may be instructive to have our technical assistance partners contribute to our feedback to the ACHs.

3. SIM Alignment with State and Federal Initiatives

Because of the broad interagency and stakeholder engagement in the development of Washington's State Health Care Innovation Plan, which served as the foundation for Healthier Washington, many health care innovation activities are already well coordinated with the SIM grant. Even with close coordination, SIM funding neither duplicates nor supplants federal or state funds that support such activities. Specific instances of coordination are described below – and with the exception of the Medicaid transformation demonstration have not changed since the inception of the grant.

Federal Initiatives:

- CMMI Innovation Awards
- Health Care Innovation Awards
- Health Care Innovation Awards Round Two
- Community-based Care Transitions Program
- Bundled Payments for Care Improvement (BPCI) Models 2 and 3

- Transforming Clinical Practice Initiative (TCPI)
- Medicare Care Choices Model
- Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient-Centered Medical Homes
- Meaningful Use and HITECH
- Initiatives from related agencies such as CDC, ONC, SAMHSA, HRSA and AHRQ
- Medicaid Transformation Demonstration

Initiative	Alignment / Approach re: SIM / Federal Initiatives
Accountable Health Communities	The HCA Value-based Purchasing Roadmap lays out how HCA will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. This Roadmap braids together major components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health, for example), the Medicaid transformation Demonstration, and the Bree Collaborative care transformation recommendations and bundled payment models. Through the Demonstration, ACHs will also be able to structure incentive programs regionally to reward providers who are undertaking new VBP arrangements, these will be tied to the same VBP targets.
TCPI	Offer practices a menu of services offered by each initiative and ask the practice to verify their choice of where they receive technical assistance for each service selected.
Health Homes	HCA is geographically expanding the Medicaid Health Home initiative to better more timely care for patients with complex care needs.
CPC+/other multi-payer models	We are aiming to drive multi-payer alignment on quality measures and practice transformation through our payment redesign models, particularly Model 4, by leveraging the quality improvement model of our Accountable Care Program, the Statewide Common Measure Set, and the Practice Transformation Support Hub.

Medicaid Transformation Demonstration

On September 30, 2016, Washington State and the Centers for Medicare and Medicaid Services (CMS) reached an agreement in principle on a five-year Medicaid Demonstration project. This is an opportunity to accelerate changes in our state's Medicaid program that support the goals of Healthier Washington—better health, better care, and lower costs.

Paying for Value Instead of Volume

Value is where affordable, transparent costs meet appropriate high-quality care. The federal government and states across the nation are recognizing that new health care delivery models that reward providers and health plans for value are key to controlling costs and fostering health.

The Medicaid demonstration investments will help us spend our Medicaid dollars more wisely by rewarding providers and health plans based on the quality of care people receive and its effect on their health, instead of the number of procedures and services provided.

Much of the Medicaid demonstration's focus will be on supporting providers and plans as they build their capacity to transition to these new delivery and payment systems.

Through the principled agreement, CMS and Washington State have agreed on the core facets of the project, including the structure and role of Accountable Communities of Health (ACHs) and financing. Final approval by CMS is subject to the special terms and conditions (STCs), the actual contract for the demonstration. This agreement will "waive" certain federal Medicaid requirements, allowing the state to use Medicaid funds for innovative projects, activities, and services that otherwise would not be eligible for funding. This is not a grant; the state must demonstrate that it will not spend more federal dollars on its Medicaid program than it would have spent without the Medicaid transformation demonstration.

Medicaid Transformation Goals

- Reduce avoidable use of intensive services and settings—such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.
- Improve population health—focusing on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health.
- Accelerate the transition to value-based payment—using payment methods that take the quality of services and other measures of value into account.
- Ensure that Medicaid per-capita cost growth is below national trends—through projects and services that improve health outcomes and reduce the rate of growth in the overall cost of care for Medicaid clients.

The Medicaid transformation goals will be achieved through three initiatives.

Initiative 1: Transformation through ACHs

This initiative will provide communities with the financial resources to improve health system performance for Medicaid clients at the local level. Each region, through its Accountable Community of Health (ACH), will be able to pursue projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely. These projects will be aimed at:

- Health systems capacity building—Support for development of new primary care models; workforce development, including non-conventional service sites; and improvements in data collection and analytic capacity.
- Care delivery redesign—Bi-directional integration of physical and behavioral health care; improved care coordination, including clinical-community linkages; and better transitions between services and settings.
- Prevention and health promotion—Focusing on chronic disease prevention and management, and maternal and child health, for Medicaid beneficiaries.

This is not a grant. ACHs and their partners will receive funds only after they meet project goals. In the early years, payments will be made for meeting process milestones. Later, payments will be based on improvements in outcome measures.

Initiative 2: Broaden the array of service options that enable individuals to stay at home and delay or avoid the need for more intensive care

The state will create a "next generation" system of care focused on outcomes that supports families in caring for loved ones, delaying or avoiding more intensive long term services and supports (LTSS) when possible; creates better linkages within the health care system; and continues its commitment to a robust LTSS system for those who need it. These services will be provided by two new limited benefit packages—Medicaid Alternative Care (MAC) and Targeted Supports for Older Adults (TSOA).

Initiative 3: Provide targeted foundational community supports

Targeted supportive housing and supported employment Medicaid benefits will be available to those enrollees most likely to benefit. Initiative 3 is built around the growing body of evidence linking homelessness and unemployment with poor physical and mental health. While Medicaid funds cannot be used to provide housing or jobs, supportive services can promote stability and positive health outcomes while preventing homelessness and dependence on costly medical and behavioral health care, and long-term institutional care.
Medicaid transformation demonstration activities will not require new state general fund dollars.

The Medicaid transformation demonstration builds upon—but does not duplicate—the work initiated under the SIM grant. The Medicaid demonstration will leverage ACHs as coordinating entities, overseeing the selection, implementation and evaluation of regional transformation projects. As Coordinating Entities under the Medicaid transformation demonstration, the ACHs will, in collaboration with the state, build upon such SIM-initiated activities as value-based purchasing; and will make greater use of performance assessment and other tools created under SIM.

C. Detailed SIM Operational Plan By Driver

Our planning approach in 2017 is heavily focused on the "how" and the "action steps" that we need to take to successfully achieve our SIM project goals – especially in the two areas where we have been unable to launch a pilot.

Unlike last year, our work plans for AY3 have been aligned to our goals and objectives. Our push this year has been to align teams and activities in support of our three aims – rather than allowing work to be performed in silos by investment area. Our entire work plan for AY3 has been organized by aim – and the efforts to support those aims. We endeavored to capture needs and dependencies from other projects, especially for those projects and groups seen as an "enablers" or providing infrastructure.

In AY3, project plans are built for manageability and maintainability – and will rely on quarterly build-out of finer detail; making this an iterative process. There are a number of goals and benefits we hope to achieve with this method:

- More accurate task reporting (over time, more detailed plans become less accurate, causing more changes to be managed),
- Improve risk management as we flush out more detail,
- Team leads will achieve a clear view of the end-state vision (for AY3 and AY4),
- Team leads will find a clearer line of sight of those longer lead-time, critical-path work efforts, such as supporting funding, contracts, policy and regulatory requirements and timing, transfer to operational groups, and overall sustainability,
- Better understanding of cross-initiative, cross-project, cross-agency dependencies,
- It will help us identify needs from "enabling" projects and groups

Our work plan tables for AY3 were embedded in section B for your convenience.

D. Program Evaluation and Monitoring

The measures outlined in *Appendix 3: SIM Metrics* identify and detail the specific quality performance metrics intended to capture data on quality, cost, utilization, and population health. The cross-system measures were selected for their ability to demonstrate performance across all SIM investment areas. While CMMI provided a set of recommended metrics, as permissible HCA chose alternative metrics that better reflect the demographics, needs, and priorities of Washington State. The following information will be collected and reported annually for each performance metric:

- Metric area
- Metric title
- Metric definition/description
- Numerator definition
- Denominator definition
- NQF number, if applicable
- Alignment to other CMS programs
- Baseline value
- Accountability target

These metrics will allow us to better identify, track and understand the impacts Healthier Washington activities have on quality, cost, utilization, and population health over the performance period.

1. State-led Evaluation

Washington State is highly committed to working with CMMI on the state and federal evaluation process. We understand the need to collaborate closely with our federal evaluation team (RTI) to ensure our local evaluators are not duplicating efforts unnecessarily. In many cases, required components to complete any evaluation may require formal and legal approvals and may not be entirely within our control.

We have partnered with the University of Washington as the primary agent to complete our statewide evaluation. They have been working closely with DSHS, Medicaid, and HCA public employee data owners to obtain all necessary data to conduct the evaluation. We are working on a Medicare data request for parts A, B, and D.

While it waits for the AIM and Link4Health CDR solutions, the DSHS Research and Data Analysis (RDA) organization stores significant amounts of Medicaid data with which we can examine the integration of physical and behavioral health. This detailed data set will be used for the project evaluation and the federal evaluation. Other partners, such as the Washington Health Alliance, have been storing data from many private payers in the voluntary all payer claims database (APCD); we estimate that the Alliance currently has data from 20 different payers and 30 unique suppliers. Additionally, by the end of the SIM grant we will have a mandatory WA-APCD – and we expect to have deliverables available in 2017.

The Washington Health Alliance, which has been administering a voluntary APCD, has been providing us with annual reports of statewide common measures that reflect healthcare quality and cost of state purchased healthcare. In contrast, the mandatory WA-APCD, which is being built out in AY3, will include reporting of health care quality, but will also reflect pricing data, something that the voluntary APCD does not currently offer. Although we have been told that the mandatory WA-APCD will have quality and pricing data available in the fourth quarter of AY3, we still expect to have the quality and cost reports from the Alliance in this contract year as well. Going forward, we will review and see what makes the most sense, ensuring there is no duplication of services.

ACH Evaluation

The Group Health CCHE team is actively engaged in evaluation of ACHs. In AY3 they will continue to monitor the ACH entities and their projects for success. They will be looking at the system of care – inclusive of community stakeholders, providers, CHWs, and other players. (AY2 Annual Report available upon request; it is largely a formative evaluation report and does not comment on outcomes).

A role for data

Of course, CMMI may already possess some required Washington beneficiary data: TMSIS data (Medicaid) has been provided to CMS per our agreement and we also submit BRFSS data to CMS. CMS would already have access to the Medicare contingent and could leverage that for Medicare surveys.

One of the foundational Healthier Washington data components is the state's Link4Health Clinical Data Repository (CDR). The Link4Health CDR is in the process of gathering data from "first movers" in the state who have a stake in building a clinical data repository and having it available in the state's HIE (by the fourth quarter of 2016).

(This date represents a slippage as the vendor selected to host the CDR became insolvent and OneHealthPort took over as the host entity). Eventually Link4Health CDR data will become aggregated into the AIM strategy. (See the HIT plan for a timeline of activities; the CDR integration likely a post-2019 project).

Data security is of paramount importance to the Healthier Washington AIM initiative. Part of the strategy driving the AIM endeavor is to further secure and control access to our mission critical data and protect our clients. Across the Washington State agencies involved in health and health care, we have modernized our Identity and Access Management systems, locked down our desktop and laptop and mobile computing devices, and maintained strict data access approval requirements for all state data.

Under the direction of our Healthier Washington privacy and security manager, we will ensure we have the requisite data sharing agreements in place. We also have launched a Link4Health Privacy and Security work group that will play a role in AIM data governance. We are aware we need agreements with all sub-contractors (and sub-sub-contractors) as well as primary contractors.

Both RDA and HCA have methods of identifying patients (for Medicaid services) to compile a picture of services delivered across the continuum. In its Medicaid business, HCA uses a client ID within ProviderOne, and RDA has created a patient identifier in their Integrated Client Database. Medicare beneficiaries are identified with a CMS-generated ID. We also track “duals” with a unique ID. Both Milliman and the Alliance have models for patient identification and a common identifier – across payers. We are able to identify dual-eligibles and track them across the continuum.

Our Evaluation Plan calls for comparing select SIM populations against non-SIM comparable populations. It will be necessary to pinpoint individuals impacted by each model test – and to find other like non-SIM populations against which to measure the SIM effect. While the data will be de-identified, individuals will be assigned an identifier that will allow our Evaluation team to pull data related to the evaluation of each test model. Comparison states (Hawaii, California, etc.) have been identified to provide a synthetic control group and a comparison model. Long-term, AIM will provide a unifying identification mechanism to map individuals across payers to planned interventions. At that point, given the strength of the Link4Health CDR and the Washington APCD strategies, we will have claims and clinical encounter data in our AIM data warehouse that will cover every individual in Washington.

2. Federal Evaluation, Data Collection, and Sharing

If CMMI decides to proceed with beneficiary surveys and/or focus groups as part of the Federal evaluation, we can indeed target specific populations (with a plus/minus error ratio) and we have confirmed we have demographic data on file. While we believe CMS already has our beneficiary information (and therefore our identifiers), we could provide those as needed.

Related to the federal evaluation, we can: release data for Medicaid patients and PEB beneficiaries (subject to the appropriate data sharing agreements), and assist CMS in working through the Alliance process (a vendor request) for getting client contact information from private payers.

Related to the federal evaluation, we can't: guarantee payer compliance with data requests, give precise lists of populations impacted by SIM (we can get close), or guarantee participation by all providers of which CMMI may make requests.

Healthier Washington is committed to measuring client experience. We recently partnered on a survey with DSHS to survey clients on their experience. Also, HCA conducts a small, routine survey monthly to confirm clients received services billed; we do about 500 of those a month to ensure bills reflect services received. While we have not previously conducted a focus group on patient experience, we have quality improvement targets built into our contracts for administering the PEB program (which is CAHPS reporting with de-identified data). We also measure client experience in some SIM areas:

The Alliance has been conducting "Your Voice Matters" surveys for the last four years to measure patient experience related to CG CAHPS provider groups.

Under Model 3 (ACP), five CAHPS measures are in the quality improvement model that impacts payment – either gainsharing or payment penalties.

We have also asked the two ACPs to use the Alliance CAHPS questions in their surveys. There are two measures in common measure set of 52 related to patient experience (they are CAHPS questions and build upon the Alliance's survey) – and Model 3 has already built these into contracts.

As outlined in the ACH Evaluation Plan, the Center for Community Health and Evaluation (CCHE) will use several data sets to evaluate the regional ACHs and the initiative as a whole. Related to client experience, data used to inform the evaluation will include ACH multi-sector member feedback based on regional surveys.

Finally, there are future plans to survey the Practice Transformation Support Hub stakeholders related to client experience, and the Link4Health CDR team will be sampling to measure client experience in the provider environment.

We do plan, as part of our state-based evaluation, to conduct broader surveys, focus groups, and key informant interviews as a component of our formative and process-oriented evaluation. We would be happy to share those data and results with CMMI. We share our SIM quarterly updates with CMMI.

We recently collaborated with CMS on an evaluation of our "duals" population. It required significant clean-up in order to ensure a strong survey response. Our goal is always to deliver clean data and to collaborate with CMS on effective surveys and evaluations. Providing clean data requires time and resources and, often, translation work. We look forward to working with CMS to ensure any data meets the specifications of Washington State and our clients – and ensuring that we have taken any extra steps to isolate the precise population needed.

Our state evaluator, University of Washington, has a long history of running evaluations concurrently with other federal or private entities. There is an art to not getting in each

other's way; we firmly believe in collaborating with the state and federal entities and allowing for concurrent efforts and non-duplication of efforts where possible.

It is our intent to cooperate with CMS regarding any and all needs and requirements for the evaluation. We agree not to receive additional reimbursement for providing data or other information to CMS, noting that mutual negotiations may be necessary to deliver on any requests not currently funded or resourced.

3. Program Monitoring and Reporting

Project Management Structure
Oversight of program work streams and contractors

HCA has worked with a primary vendor on project management throughout the operation of the SIM grant, OTB Solutions (OTB). In tandem with additional contractors and agency project management staff, OTB provides on-site program management support. HCA meets with OTB often to discuss management strategy and monitor performance.

Frequency	What	Who
Weekly	Connect the dots between project management, operations, and program leadership. Monitor budgets. Process change requests. Discuss issues and program needs. Rapid cycle evaluation efforts of project management and operations.	Healthier Washington Connector Healthier Washington Operations Manager OTB contractor
Monthly	Review project management contract for compliance and performance. Rapid cycle evaluation efforts of project management and operations.	Healthier Washington Contracts Administrator Healthier Washington Operations Manager OTB contractor and partner
	Review OTB status report on program performance, risks, issues, and leadership escalations.	Healthier Washington Grant Coordinator Healthier Washington Deputy Grant Coordinator Healthier Washington Connector OTB contractor and partner

Our project management vendor provides weekly status reporting, helps team leads develop work plans and risk mitigation plans, reviews processes with leadership for optimization opportunities, develops quarterly progress report content and assists with the annual Operations Plan. Oversight of program work streams happens according to the Healthier Washington governance structure.

Changes in strategy to monitor existing contracts

There have been no changes in strategy to monitor existing contracts in AY2. We do not anticipate changes in AY3 as our vendors are performing to standards.

Sustainability
Please see Section E / Sustainability for a discussion on how we plan to maintain program operations beyond the SIM funded period.

4. Fraud and Abuse Prevention, Detection and Correction

HCA is nationally recognized as a leader in program and payment integrity. With ongoing emphases on data analytics, algorithms, audits, and close coordination between program integrity, policy, and technical systems, HCA maintains optimal oversight of both provider payments and quality of care.

With the goal of identifying and preventing fraud, waste, and abuse, program integrity has largely been the domain of the Office of Program Integrity (OPI), a team of more than 40 auditors, analysts, clinicians and coders dedicated to identifying and recovering improper payments and otherwise saving Medicaid dollars through prevention. In the last three biennia, OPI has saved and recovered more than $140 million in Medicaid dollars. OPI's efforts are augmented by additional, similar activities throughout the agency, including program and contract monitoring, recovering on third-party liability, and managed care oversight.

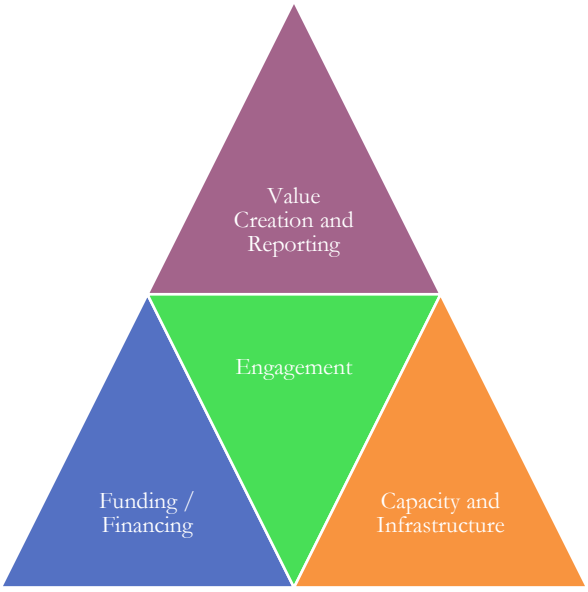
The state has realigned its operations to more appropriately and comprehensively oversee the performance of the managed care model, through which more than 80 percent of the state's Medicaid population is served. Far from posing barriers to innovation, realignment is elevating and expanding program integrity operations. Multiple divisions and offices will provide enhanced oversight in the new organization, which will increase opportunities to detect, correct, and prevent fraud, waste and abuse.

E. Plan for Sustainability

As we move into the second half of our SIM test period, we shift from planning and designing into measuring and operationalizing our work and strategies. We begin to incorporate actionable, tangible elements of sustainability planning that will help move us toward our vision of a transformed system of care. It is important to note at this stage that sustainability remains a process, one that requires careful planning, demonstration of value, and creative thinking both internally and externally – by paying attention to external market forces and initiatives. The approach to sustainability, in Healthier Washington AY3, will be focused on four strategic domains of longevity:

1. Building agency capacity and infrastructure,
2. Measuring and communicating our outcomes in order to demonstrate the value (ROI) of a transformed system,
3. Engaging a wide array of stakeholders in serious conversations about how to carry this work beyond the funding period, and
4. Funding and financing mechanisms to resource ongoing work and structures.

We have built this work into our quarterly deliverables for every investment area / driver, as a way of ensuring we are building toward our goal of a Healthier Washington that is supported and ongoing. Our goal is to begin AY4 with concrete sustainability plans for all of our investments worth sustaining.



Sustainability is a process

- In order to create lasting change, incremental work in domains of capacity, measurement, engagement and financing is key. In AY3, we will incorporate quarterly sustainability deliverables into our work plans, in order to ensure that this work moves forward and builds upon small, deliberate steps.
- In order for our stakeholders to fully engage with us to both provide needed input and begin to understand how their accountability will change as the health care

system is transformed, we need to clearly demonstrate how what we are doing is valuable. For this reason, engagement activities to promote sustainability readiness will be demonstrated by all projects in AY3. These activities include convening groups for shared learning, soliciting stakeholder feedback, fostering understanding of expectations, and engaging other state agencies and agency departments.

- In order to ensure we are doing this engagement in an organized and effective way, we will be leveraging our SIM-funded Healthier Washington customer relationship management tool (Salesforce). This tool will allow us to track communications, follow engagement by individual, organization, and project, and allow us to see if there are stakeholder groups that are not engaged so that we can adjust our tactics to bring them in.
- Another important aspect of maintaining critical relationships and demonstrating the value of our work is a strong capability for external communication. With our new hire of a Healthier Washington Communications Manager, as well as contract expectations from an outside communications vendor, we will be in a strong position to broadly communicate the nature and value of our accomplishments to the state at large, with this inclusiveness bringing in additional sectors or individuals who would not be engaged otherwise.
- We will also engage our Health Innovation Leadership Network (HILN) and accelerator committees in being accountable for communicating the value of our work. We will need trusted leaders and influencers in the community to translate our work, motivate our communities to move the work forward, and make decisions on what shape our transformed system will take within the different sectors that influence health.
- The 1115 Medicaid transformation demonstration will also have significant influence over our administrative structure, and is potentially a resource to be leveraged in order to accelerate the broad goals of Healthier Washington.
- There are many initiatives under way at the local, state, and federal levels that very much influence our work. We fully understand that it is in our best interest to be in alignment with these initiatives so that we can all be moving forward together. One of the most far reaching and important of these initiatives is the Quality Payment Program, or MACRA. As the Quality Payment Program begins, SIM work will still be under way, so we will have the opportunity to leverage SIM to align with MACRA with an eye toward practical and lasting sustainability.
- Another important part of an alignment strategy for sustainability is our role as a purchaser and influencer.
- In Grant Year 2, we executed a contract to explore the sustainability of Healthier Washington beyond SIM, with specific attention paid to financing strategies and capture and reinvestment of savings. One of the first deliverables of this contract is to define sustainability and use that definition to draft an overarching sustainability plan for the Healthier Washington initiative.

F. Appendices:

1. Driver diagram included in Section A. Project Summary

We will append a PDF to our submission so that you may read our driver diagram in detail.

2. Core Progress Metrics and Accountability Targets

Healthier Washington's Portfolio of Reporting Metrics captures model participation and core outcomes metrics with accountability targets. This portfolio of metrics will assist in tracking progress toward SIM goals, identify trends in progress, and identify gaps and barriers to implementation over the three-year test.

The model participation metrics are intended to capture data on the participation of providers and provider organizations in SIM as well as the number of beneficiaries impacted. Through the SIM grant, we are testing four payment models. Model participation metrics will be reported quarterly by individual payment model, in addition to an aggregated total, demonstrating progress and adoption of value-based payment strategies by providers, provider organizations, and beneficiaries impacted. All model participation metrics were defined by the CMMI SIM program. Information captured by each model participation metric, by individual payment test model, is as follows:

- Metric Area
- Metric Title
- Metric Definition/Description
- Numerator Definition
- Denominator Definition
- Notes
- Payment Taxonomy (category 2-4)
- Baseline Value
- Accountability Target

Payment taxonomy was categorized by the guidance outlined by CMMI:

Category 1: Fee for Service-No Link to Quality
Category 2: Fee for Service-Link to Quality
Category 3: Alternative Payment Models on Fee-for Service Architecture
Category 4: Population-Based Payment

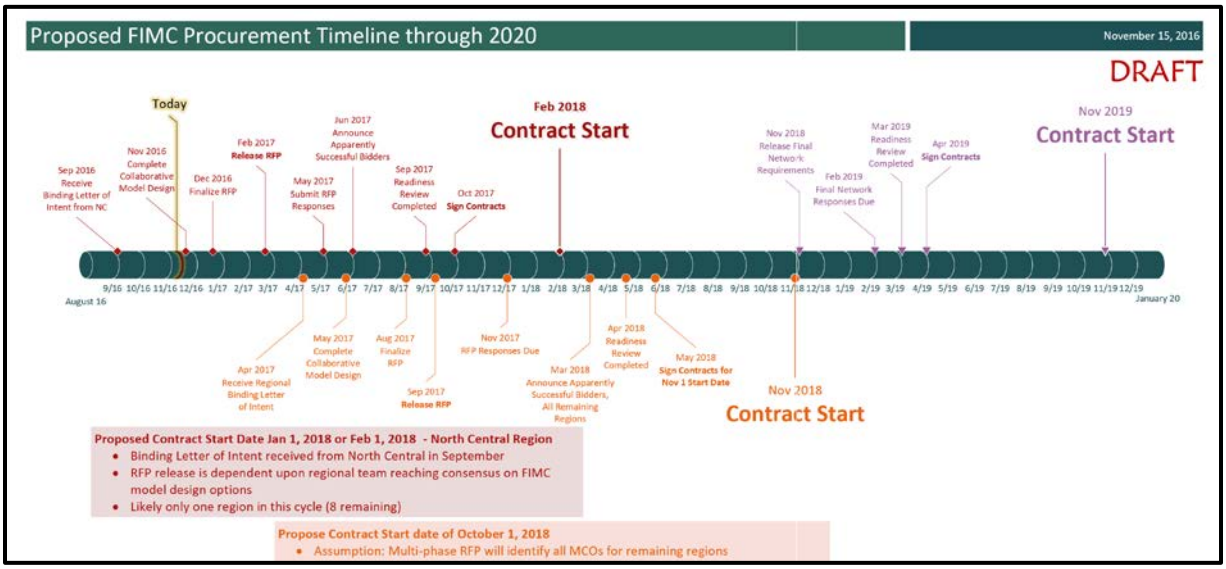
The model participation metrics will allow us to better identify, track, and understand provider, beneficiary, and payer participation.

3. ACH Roster / Providers and Community Stakeholders

Healthier Washington's ACHs vary in composition and governance structure across the state. This list is just a sample of the types of provider partners involved, specifically physicians. This list is not meant to represent the broader array of sectors/partners, all of which are essential to the ACH convening.

Coalition	Physicians
Better Health Together	Jeffrey Liles, MD Joel McCullough, MD
Cascade Pacific Action Alliance / CHOICE Regional Health Network	Phyllis Cavens, MD Kevin Haughton, MD
Greater Columbia ACH	Dale Hoekema, MD Wassim Khawandi, MD Venkataraman Smabasivan, MD
King County ACH	Lydia Chwastiak, MD Jeff Duchin, MD David Fleming, MD Chad Krilich, MD Emily Transue, MD Maria Yang, MD
North Central Health Partnership	Peter Rutherford, MD Douglas L. Wilson, MD
North Sound ACH	Federico Cruz-Uribe, MD Connie Davis, MD Gary Goldbaum, MD
Olympic Community of Health	Michael D. Anderson, MD Thomas H. Locke, MD Susan Turner MD, MPH, MS
Pierce County Health Innovation Partnership	Anthony Chen, MD Federico Cruz-Uribe, MD Paul D. Schneider, MD Andrew R. Wiesen, MD, MPH
Southwest WA Regional Health Alliance	Sharon Crowell, MD Federico Cruz-Uribe, MD Lawrence H. Neville, MD Alan Melnick, MD

4. Draft Timeline of Integrated Financing for Medicaid by 2020



Healthier Washington Metrics and Driver Diagram

Triple AIM. Better Health. Better Care. Lower Costs.

AIM

What are you trying to accomplish? What will be improved-by how much or how many and by when?

By 2019, Washington's health care system will be one where:

90% of Washington Residents and their communities will be healthier.

All people with physical and behavioral (mental) health/substance abuse comorbidities will receive high quality care.

Washington's annual health care cost growth will be 2% less than the national health expenditure trend.

Quality Outcome Targets

- Behavioral Health: Percent of adults reporting 14 or more days of poor mental health
- Tobacco: percent of adults who smoke cigarettes
- Plan readmission rate by all-causes
- Child and adolescents' access to primary care practitioners
- Mental health treatment penetration
- Personal care provider
- Chronic care engagement with personal care provider
- First trimester care
- Psychiatric hospitalization readmission rate
- Potentially avoidable emergency department visits
- Adult access to preventive/ ambulatory health services
- Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Childhood immunization status
- Patient Experience: provider communication (CG-CAHPS)
- Patient Experience: Communication about medications and discharge instructions (HCAHPS)
- Well-child visits
- Annual per-capita state purchased health care spending growth relative to state GDP
- Medicaid spending per enrollee

Investment Area / Primary Drivers

What do you predict it will take to accomplish this aim?

Community Empowerment and Accountability

- Accountable Communities of Health (ACHs)
- Plan for Improving Population Health

Practice Transformation

- Practice Transformation Support Hub
- Shared Decision Making
- Workforce/Community Health Workers (CHWs)

Payment Redesign

- Payment Test Model 1: Early Adopter: Integration of Physical and Behavioral Health Purchasing
- Payment Test Model 2: Encounter-based to Value-based for cost based reimbursements
- Payment Test Model 3: Public Employee Benefits Accountable Care Program (ACP)
- Payment Test Model 4: Greater Washington Multi-Payer Data Aggregation Solution

Secondary Drivers

What will be required for this to occur?

Accountable Communities of Health (ACHs)

- Define vision, build foundation for ACHs to collaborate in region
- Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities
- Participate in broader Healthier Washington activities, including delivery system transformation

Plan for Improving Population Health

- Develop and strengthen regional partnerships so collaboration leads to complementary and collective health improvement activities

Practice Transformation Support Hub

- Understand the practice transformation training and technical assistance needs of providers to inform HUB services
- Make tools and resources available online
- Refer small and medium sized practices to training, technical assistance and facilitation services
- Develop comprehensive dashboard showing progress on statewide adoption of Bree Collaborative recommendations

Shared Decision Making

- Provide training and practice coaching opportunities on shared decision making implementation
- Promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice
- Develop a multi-state Shared Decision Making Innovation Network

Workforce/Community Health Workers (CHWs)

- Engage community health workers
- Survey the health care industry and make targeted investments to address identified workforce needs

Payment Test Model 1: Early Adopter: Integration of Physical and Behavioral Health Purchasing

- Integrate Medicaid purchasing of physical and behavioral health services within accountable managed care organization (MCO)
- Create internal MCO processes and structures
- Improve service delivery process to increase access to integrated services

Payment Test Model 2: Encounter-based to Value-based for cost based reimbursements

- Introduce a value-based alternative payment methodology in Medicaid for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Pursue flexibility in delivery and financial incentives for participating Critical Access Hospitals (CAHs).
- Test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams.

Payment Test Model 3: Public Employee Benefits Accountable Care Program (ACP)

- Enrollment/participation in ACP options, January 2016
- Expansion of ACP to larger population of public employees, 2017
- Purchaser engagement to spread and scale model and value-based purchasing strategies

Payment Test Model 4: Greater Washington Multi-Payer Data Aggregation Solution

- Secure lead organization to convene payers and providers to advance an integrated multi-payer data aggregation solution and increase adoption of value-based payment strategies
- Align the data aggregation solution with clinical and financial accountability (from Payment Test Model 3) centered on the Washington Statewide Common Measure Set
- Leverage and expand existing data aggregation solution that includes at least one or more payers and/or provider group
- Provide resources and state-purchased health care data to accelerate building common infrastructure of integrated claims-based and clinical data

Metrics

What data will be used to track progress (how much and by when)?

Accountable Communities of Health (ACHs)

- Number of technical assistance summits to address priority topics

Plan for Improving Population Health

- Number of times the advisory board meets
- Toolkit available for distribution

Practice Transformation Support Hub

- Number of sessions by type of stakeholders involved
- Website analytics and user satisfaction
- Number of training; satisfaction with trainings
- Bree Collaborative implementation roadmaps. Dashboard developed.

Shared Decision Making

- Proportion of eligible practices receiving training
- Number of certified decision aids
- SDM Innovation Network formed

Workforce/Community Health Workers (CHWs)

- Initial survey implemented through portals, results shared.

Payment Test Model 1: Early Adopter: Integration of Physical and Behavioral Health Purchasing

- Percentage of population impacted by Payment Test Model
- Number of providers participating by Payment Test Model
- Number of provider organizations participating by Payment Test Model

Payment Test Model 2: Encounter-based to Value-based for cost based reimbursements

- Percentage of population impacted by Payment Test Model
- Number of providers participating by Payment Test Model
- Number of provider organizations participating by Payment Test Model

Payment Test Model 3: Public Employee Benefits Accountable Care Program (ACP)

- Percentage of population impacted by Payment Test Model
- Number of providers participating by Payment Test Model
- Number of provider organizations participating by Payment Test Model

Payment Test Model 4: Greater Washington Multi-Payer Data Aggregation Solution

- Percentage of population impacted by Payment Test Model
- Number of providers participating by Payment Test Model
- Number of provider organizations participating by Payment Test Model

Analytics, Interoperability and Measurement (AIM)
(Development of data infrastructure for the operational and evaluation functions of Healthier Washington)

Healthier WASHINGTON

HCA 82-026 (12/16)