Update on Washington’s ACHs

Joint Select Committee on Health Care Oversight

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Today’s presentation at a glance

Accountable Community of Health (ACH) update
- 1115 Waiver overview
- ACHs and the role they play
- Medicaid Transformation priorities
- Timeline at a glance
- Three ACHs will share some successes and challenges
  - Elevate Health (Pierce County ACH)
  - Better Health Together
  - North Central
Overview of 1115 Waiver: Medicaid Transformation Project

- Delivery system transformation through ACHs and behavioral health integration
  - Achieving behavioral health integration by January 2020 is a key milestone with Centers for Medicare & Medicaid Services for continued receipt of federal funds.
- Long-term services and supports
- Supportive housing and supported employment
- Substance use disorder services in inpatient settings (IMDs)
ACHs and the role they play

- Regional organizations that work with community partners on health needs and priorities

- Address health issues by:
  - Aligning resources and activities that improve whole-person health and wellness in their community.
  - Supporting system transformation, including Medicaid Transformation.
  - Implementing projects that improve population health outcomes.

- Provide oversight on distribution of earned incentives to providers as part of Initiative 1 of the Medicaid Transformation.
Map of the ACH regions
Medicaid Transformation priorities

Integrated managed care (IMC) and whole-person care

- Advancing the integration of physical and behavioral health with managed care organizations (MCOs) and ACHs.
- To date, seven out of 10 regions have implemented IMC.
- By January 2020, all regions will fully implement IMC.
Medicaid Transformation priorities (continued)

Opioid response

► All ACHs are working on regional strategies to promote awareness, prevention, treatment, and recovery supports. They are:
  ► Providing prescribing practices and medication-assisted treatment training to hospitals, primary care providers, and behavioral health agencies.
  ► Promoting the Prescription Monitoring Program and its linkage to electronic health records (EHR) systems to increase provider participation.
  ► Established regional opioid workgroups and conducting regional opioid conferences.
Community care coordination
- Majority of factors tied to health fall outside the traditional health sector.
- Regional strategies provide continuity across organizations/providers/MCOs and ensure people have access to social supports and community resources.

Health information exchange
- Efforts are underway to ensure providers have appropriate information technology infrastructure.
- ACHs are supporting connectivity among partners to enable coordinated care.
Medicaid Transformation timeline

2017

- Partners and ACHs select strategies

Implementation plans developed

- Strategies implemented and incentive payment structures defined

Preliminary evaluation results

2023

Final performance assessment and formal evaluation
Let’s hear from some ACHs about their successes and challenges
Elevate Health (Pierce County ACH)

Care coordination

Successes

- Launched Pathways Community HUB.
- Developed Care Continuum Network for centralized and coordinated care.

Challenges

- Technology solutions
- Contracts with MCOs (silos in care coordination)
Elevate Health (continued)

IMC mid-adopter

Successes

- Diverse set of partners working toward the best care possible for clients.
- 150+ participants part of IMC adoption.
- Held real-time Open Forum for providers to talk about and work together on issues, concerns, and solutions.
- Established Primary Care Provider Network to provide assistance and resources with Western State discharges.

Challenges

- Technology: many providers launched new EHR systems during go-live.
- Delay of updated Service Encounter Reporting Instructions caused lag in providers building and testing claims systems.
- When behavioral health organization sunsetted, there was a lack of information that left gaps unaddressed until after go-live.
Elevate Health (continued)

Building capacity for system transformation and outcomes-driven innovation

► Successes
  ► Hired and trained a team of clinical improvement advisors.
  ► Created a *strategic improvement toolkit* to standardize approach to quality improvement.
  ► Led Regional Learning Collaboratives to help partners improve care delivery.
  ► Built a multi-sector Community Resiliency Fund for sustainability and community health.
  ► Building a community information exchange to track performance.

► Challenges
  ► Lack of adjudicated claims are a significant barrier to tracking performance and improving outcomes.
  ► Lack of a global consent process for patients is a barrier for data sharing.
  ► Narrow window to demonstrate success without real-time data.
Better Health Together

IMC

► Successes
  ► Supporting 32 contracted providers and 3 Tribal behavioral health partners for IMC integration in January 1, 2020.
  ► 100% of providers currently have managed care contracts in place and are getting paid.

► Challenges
  ► Behavioral health reimbursement rates are impacting our region’s ability to expand access.
  ► Continually hear from providers that community health workers/navigators make a huge difference in reducing costs and improving outcomes, but their work isn’t currently reimbursable in Washington.
Transformation projects

Successes
- 39 partnering providers, including 5 Tribal health partners, are implementing plans through pay-for-performance contracts.
  - Represents 98% of the Medicaid delivery system

Challenges
- Severe shortages in behavioral health
- Rural areas have difficulty keeping primary care positions filled.
- Lack of long-term funding mechanisms for care coordination in clinics and community.
Better Health Together (continued)

Community based care coordination

Successes

- Leveraged Medicaid $1M from Bureau of Justice grant.
- Demonstrating a model to work across sectors with cost populations.

Challenges

- Complex target population that interacts with many systems/sectors
- Sustainable funding for any type of community based care coordination
- Resources for housing and transportation to support stabilization of health
North Central ACH

IMC/whole-person care

Successes

Created a system that allows 17 primary care and behavioral health agencies to interact and learn from each other (Whole Person Care Collaborative) – more partners working together.

Quality Improvement (QI) successes: Increased technical capacity of teams through learning activities and coaching; lessons learned and tools will be shared with the region. Partners are finding significant value in regional practice facilitation.

Successfully went to Integrated Managed Care in all 4 counties.

Challenges

Lack of understanding on the different payment models (e.g. VBP, Rural Payment Model) leads to fear of making costly changes that won’t be reimbursed.

Payment (including reimbursement) is different for Rural Health Clinics & Federally Qualified Health Clinics - change to whole person care does not address those clinic structures.

Workforce Capacity & Shortages: higher turnover rates in rural positions makes it difficult to sustain QI changes.

Lack of, or inadequate, Medicaid reimbursement for transitional care management, behavioral health integration and chronic disease care coordination.
Care coordination

**Successes**

- Successfully launched Pathways HUB and have engaged Care Coordination Agencies.
- Early success has been strategically aligning the Health Home Care Coordination Organization (CCO) network with the Pathways Community HUB Care Coordination Agency (CCA) network. 33% of the new CCA network are experienced CCOs in the Health Home network.

**Challenges**

- Action Health Partners (AHP) contract negotiations with MCOs is limited due to funding restrictions created by HCA/Medicaid contracting rules restricting use of Per Member Per Month (PMPM) to pay for either of the current recognized community based care coordination models in our state.
- Washington State Duals Health Home Model is recognized as a Medicaid Provider Program. Pathways Community HUB is only considered a project and therefore not eligible to access vital data and supports that will allow strategic alignment for optimal success.
Information exchange

Successes

- Partners are exploring and implementing the Collective Medical® platform which provides real-time data to coordinate care for complex patients across settings.

Challenges

- Asset mapping: need a user-friendly, accurate and sustainable statewide solution that also integrates with care coordination IT platforms (e.g. Pathways Community HUB, Health Homes)
- Lack of standardization in EHRs across providers leads to:
  - Inconsistent methods of collecting meaningful data.
  - Inefficient, time consuming and possibly manual data extraction.
- Lack of statewide information exchange mechanisms continue to undermine MTP goals around whole person care and care coordination.
- Policy decisions need to be made if Integrated Managed Care in WA is going to be sustainable.
Questions?

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