DRAFT WAIVER PROJECTS AND REQUIREMENTS SUMMARY
North Central Accountable Community of Health – November 26, 2016
Based on Toolkit Pre-Draft of 11-14-2016

HCA has achieved "agreement in principle" with CMS regarding a Medicaid Waiver. Negotiations on the final terms and conditions have been under way for about a month and could go on for one or two more. In the meantime, HCA is working to develop a clear statement of Waiver activities, which has taken the form of a Waiver Projects Toolkit. The current Waiver Projects Toolkit draft is over 100 pages long (including appendix). This document attempts to highlight the key points. Quoted text in this summary is from the Toolkit draft. The draft Toolkit is available at:

http://www.hca.wa.gov/assets/program/wa-transformation-project-toolkit-draft.pdf

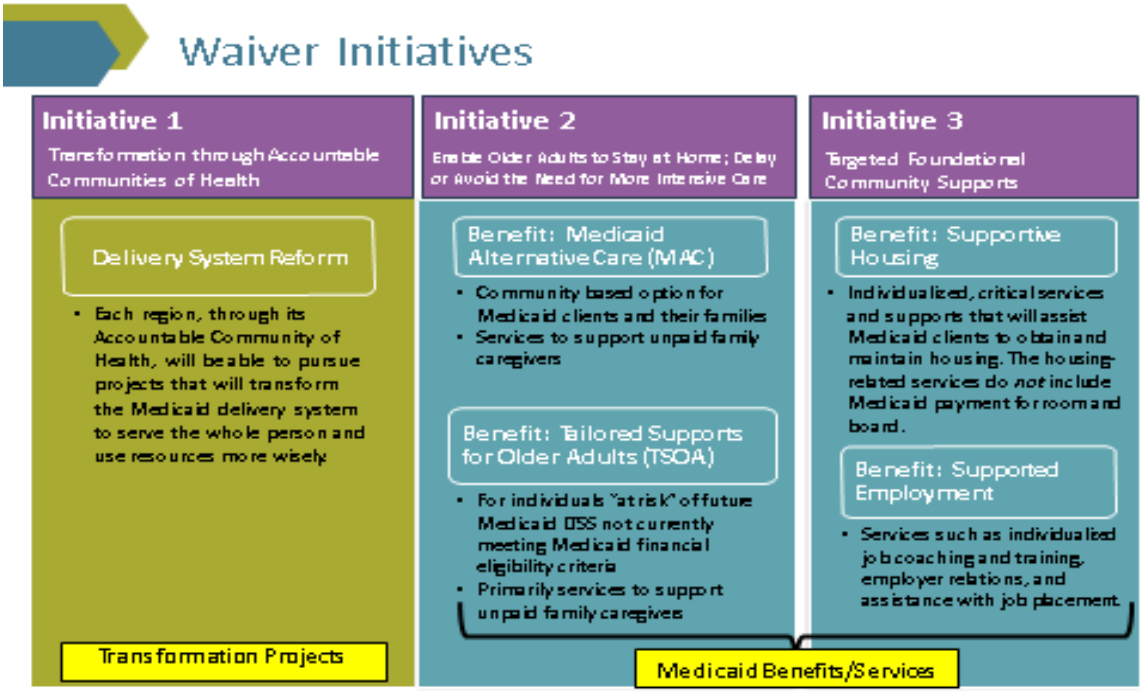
and the appendix is at:

http://www.hca.wa.gov/assets/program/medicaid-transformation-project-toolkit-appendix.pdf .

HCA will announce the process for commenting on the draft in December. There will be a webinar on Monday, December 12 from 2 to 3 p.m. to provide an update on the status of the Waiver. You can register with this link:

https://engage.vevent.com/index.jsp?eid=7198&seid=18

The proposed Medicaid Waiver includes three major initiatives. This document summarizes the Draft Toolkit for projects under Initiative #1:



It is noteworthy that North Central ACH's Whole Person Care Collaborative can provide a good framework for implementing most care transformation aspects of the Waiver projects (Domain 2), while our initial work on population health improvement (as distinct from the improvement of clinical care) are a good start on some aspects of Domain 3.

Special thanks to Aisling Fernandez and Carol Moser of Greater Columbia ACH for the initial draft of this summary.

TOOLKIT INTRODUCTION

"The Transformation Project Tookit reflects the evidence-based strategies the ACH will use to develop Medicaid transformation project plans for implementation across their regions."

Performance Measurement

System-wide measures (reported at the state and, when possible, the ACH level) and project-level measures (reported at the level of project deliverables) will be used.

Prerequisite for Project Selection and Planning: A Regional Health Needs Inventory (RHNI)

The RHNI is a vital component of the planning process, as it provides the information necessary to design the initiatives to their maximum benefit, by tailoring them to the unique needs and circumstances of the communities in which the projects will be implemented. The HCA will package and provide relevant information to the ACHs from various statewide data sets, to the fullest extent possible, to populate the RHNI. ACHs will need to fill in gaps in data using local data and complete an environmental scan. The ACH may rely on previously completed inventories or assessment to meet this requirement.

A fairly detailed outline of "minimum essential components" is provided, with two major sections: (1) Description of the region's population and health status, and; (2) Description of the current health care and community service system capacities.

Statewide Taskforces on Value Based Payment (VBP) and Workforce Development:

VBP Taskforce will have broad provider and MCO membership and will help HCA develop the roadmap for VBP introduction including a statewide readiness assessment and a "VBP provision template to be used by providers to enter VBP arrangements with MCOs." State, local and regional representatives.

Workforce Development Taskforce will include members from a broad range of health partners. Few specifics provided on this taskforce.

ACHs are expected to participate in these statewide taskforces and should convene regional or local task forces on these topics to the extent the statewide taskforces do not address local needs.

Practice Transformation Support Hub

"The HUB will convene, coordinate and develop resources to give practices the training, coaching and tools they need...." Includes BH-medical integration, VBP payment, alignment with community-based services for whole person care, and effective use of data in care and in contract negotiations. "ACHs will connect with and depend upon the Hub to support project implementation efforts."

DOMAIN 1 – HEALTH SYSTEMS AND COMMUNITY CAPACITY BUILDING

"This domain addresses the core health system capacities to be developed or enhanced.... There are three areas of focus:...value based payment, workforce, and systems for population health management. Each of these areas will need to be ***addressed progressively throughout the five-year timeline*** to directly support Domain 2 and Domain 3 transformation project success. Domain 1 does ***not outline individual projects, but three required focus areas*** to be implemented and expanded across the delivery system, inclusive of all provider types, to address the entire Medicaid population of service."

FOCUS AREA #1 (Domain 1):

Financial Sustainability through Value Based Payment

- Participate in state VBP Taskforce and convene local health system alliances and MCO/BHO partnerships; assess current level of VBP payments and VBP readiness in region; develop a Regional VBP Transformation Plan and a Regional VBP Transformation Report**;** reach VBP %benchmarks in the region (50% in 2018, 80% in 2019, etc.).

FOCUS AREA #2 (Domain 1):

Workforce

- Participate in statewide taskforce; assess current workforce situation and gaps in region in order to develop a detailed and specific action plan to address gaps, including an evaluation plan. "Develop and implement payment and compensation models to sustain the new workforce structure...aligned with VBP arrangements." Implement plan, making progress toward its "envisioned future state." Among statewide outcomes is "Expand Community Health Worker and Peer Support integration."

FOCUS AREA #3 (Domain 1):

Systems for Population Health Management

- **"**Develop interoperable health information technology (HIT) and exchange (HIE) infrastructure to capture, analyze and share population health data, including combining clinical and claims data to advance VBP models." ACHs to convene key partners for participation in developing HCA's Link4Health Clinical Data Repository (CDR) or alternatives needed in the region. Do gap analysis of HIT and HIE infrastructure, including EHR adoption, systems interoperability and HIE connectivity. Inform providers of tools to support population health management such as the HW Dashboard (CORE), PRISM and others. Create and implement a Population Health Management Capacity Transformation Plan, defining a path toward info

exchange for integrated care, with attention to projects in Domains 2 and 3. The draft is unclear which parts of this occur at the state level and which at the regional level, though ACH participation is clearly assumed at several points.

DOMAIN 2 – CARE DELIVERY REDESIGN

"Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency and effectiveness of care processes. Person-centered approaches and integrated models are emphasized. Domain 2 includes two required and two optional projects."

PROJECT 2A (Required): **Bi-Directional Integration of Care and Primary Care Transformation**

- **Overview:** This project will advance Healthier Washington's initiative to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care. Metrics to be applied are summarized in the Toolkit. Planning and implementation guidelines are provided for each option outlined below.
- **Part 1: Integrating BH into Primary Care Settings:** Select 1 of the following evidence-based approaches:
  Option 1: Patient-Centered Medical Home (PCMH)
  Option 2: Collaborative Care Model (Core Principles defined by the AIMS Center of the University of Washington)
  Option 3: Improving Mood- Providing Access to Collaborative Treatment (IMPACT) Model
- **Part 2: Integrating Primary Care into BH Settings:** Select 1 of the following approaches based on emerging evidence:
  Option 1: Off-site, Enhance Collaboration
  Option 2: Co-located, Enhanced Collaboration
  Option 3: Co-located, Integrated
  In addition to the core components of approach selected, provide: training/TA needed; shared care plans, EHRs and other technology to support integrated care; **financial resources to** offset costs of infrastructure necessary to support integrated care models**;** establish performance-based payment model to incentivize improvement.

PROJECT 2B (Required): **Community-Based Care Coordination: Pathways Community Care Coordination HUB**

- The Pathways Community Care Coordination HUB is a tested evidence-based a model for care coordination that includes adoption of standardized pathways, and establishment of centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie care coordination work products or units to payment and to outcomes. The HUB does not typically employ care coordinators, but effectively deploys the capacity of care coordinators employed by community partners. Community Health Workers often provide much of the care coordination workforce. Providers use standardized tools to assess patients' care coordination needs, and the HUB uses the results to assign patients to the evidence-based Pathways relevant to their needs. Care coordination is reimbursed on the basis of effective execution of the assigned Pathways. If properly implemented, the HUB becomes self-sustaining through the reallocation of a portion of the savings it creates, based on financial agreements established when the HUB is created. A centralized approach to care coordination is essential to avoid fragmented and ineffective care coordination of the kind typically provided now, and is critical to successful care transformation. Alternatively, the ACH may establish a "HUB-like" centralized care

coordination system that includes the core elements of the Pathways HUB model. Examples of Pathways likely to be relevant are listed in the Toolkit, as are guidelines for staged implementation of the model.

PROJECT 2C (Optional): **Transitional Care**

- This project targets "Medicaid clients in transition from intensive settings of care or institutional settings...to home or to supportive housing...." Includes transitions from prison/jail as well as from health care settings.
- The project must select from several evidence based and evidence-informed models listed, and guidelines are provided for staged implementation of each model.

PROJECT 2D (Optional): **Diversion Interventions**

- This project "provides opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services....Two types of diversion are provided under Project 2D: diversion at the point of Emergency Department (ED) presentation for a non-acute condition, and law enforcement assisted diversion (LEAD), a pre-booking approach to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution." Targets Medicaid clients in these situations.
- The project must select ED Diversion, LEAD, or both.
- Guidelines are provided for staged implementation of each model.

DOMAIN 3 – HEALTH EQUITY THROUGH PREVENTION AND HEALTH PROMOTION

"Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes three optional projects and one required project. ACH will be required to implement at least two Domain 3 projects in total."

PROJECT 3A (Optional): **Health Equity Through Chronic Disease Prevention and Control**

- Uses evidence-based approaches outlines by several resources such as CDC's Community Guide, www.improvingchroniccare.org , and several others. Although some of these resources are oriented toward primary prevention, most are oriented toward better care and identification of those already ill, and most of the metrics listed have to do with care of the sick as opposed to prevention. Still, there is room for primary prevention efforts.
- The Toolkit outlines a staged implementation process that begins with selection of clear targets and objectives based on community health data.

PROJECT 3B (Optional): **Maternal and Child Health**

- "Maternal and child health is a primary focus for the Medicaid program since it funds more than half of the births in the state and provides coverage to more than half of Washington's children. Providing first-time low-income mothers and their children with nurse home visits has been demonstrated to improve maternal and child health.... Two approaches offered under this project provide avenues for early identification of ACEs, and have the potential to reduce intergeneration transmission. First, the Nurse-Family Partnership provides first-time low-income mothers and their children with the support and

guidance of a home visit nurse. Second, the Child FIRST program is a national, evidence-based, two-generation model that works with very vulnerable young children and families, providing intensive, home-based psychotherapeutic intervention for children (birth to 6 years) and families, including expectant mothers."

- Targets Medicaid clients who are women of preconception age, pregnant women, mothers of children ages 0-2, and children ages 0-17.
- The Toolkit outlines a staged implementation process for the evidence-based intervention(s) selected.

PROJECT 3C (Optional): **Access to Oral Health Services**

- "Oral health impacts overall health and quality life, and most oral disease is preventable....While many initiatives have addressed the oral health needs of children, during crucial preventive windows, less attention has been paid to increasing access to oral health services for adults. This project focuses on providing oral health screening and assessment, intervention, and referral, in the primary care setting, or through the deployment of mobile clinics and/or portable equipment."
- The Toolkit cites two evidence-based approaches and outlines a staged implementation process for each.

PROJECT 3D (Required): **Addressing the Opioid Use Public Health Crisis**

- ACHs will support achievement of the goals outlined in Executive Order 16-09. This project aligns with the state opioid response plan and focuses on strategies under three of the plan goals, (1) Prevent opioid misuse and abuse by improving prescription practices, (2) expand access to opioid dependence treatment, and (3) intervene in opioid overdoses to prevent death.
- The Toolkit cites clinical guidelines for opioid prescription, including during pregnancy, and cites related statewide plans. It also provides staged implementation guidelines for each of the three major goals.