

Baseline Findings on Washington's Medicaid Transformation Project

In 2017, the State of Washington launched the Medicaid Transformation Project (MTP), a five-year effort to transform health care delivery and payment for Medicaid members.

MTP is an ambitious effort to transform care and improve health for Washington's Medicaid members. MTP is aimed at integrating physical and behavioral health care, increasing the use of value-based payment, helping health care providers adopt new health care delivery and payment models, improving population health and health equity, and addressing the needs of the state's aging population and key social determinants of health. It will provide up to \$1.5 billion for these goals from 2017 through 2021.

MTP supports Washington State's Accountable Communities of Health (ACHs), partnerships among organizations concerned with community health in nine regions of the state. ACHs work on building the capacity of their partners and implementing health improvement projects in their regions. MTP also provides new supportive services for people who need long-term care, housing, and employment, as well as new resources to support substance use disorder care.

The Center for Health Systems Effectiveness is evaluating MTP on behalf of the Washington State Health Care Authority. This brief presents highlights from our Baseline Evaluation Report, which describes the performance of Washington State's Medicaid system and its readiness for transformation as of 2019. Recommendations from the report may improve the potential for the State to meet its goals.

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

[Access to full report](#)

RECOMMENDATIONS

- Provide clarity on sustainability and expectations for ACHs beyond 2021.
- Provide ACHs with specific strategies and guidance on health information exchange and community information exchange.
- Clarify the role of ACHs in meeting workforce needs.
- Evaluate ways to connect MTP's initiatives and facilitate connections.
- Enhance value-based payment reporting to track dollars directly tied to quality and efficiency.



Washington State's Medicaid Transformation Project

In 2017, the State of Washington launched the Medicaid Transformation Project (MTP), a five-year effort to transform health care delivery and payment for Medicaid members. MTP has the following goals:

- Integrate physical and behavioral health care
- Increase the percentage of dollars paid to health care providers through value-based payment arrangements
- Help health care providers adopt new health care delivery and payment models
- Improve population health and health equity
- Provide services that address the needs of the state's aging populations and key social determinants of health

MTP will provide up to \$1.5 billion for these goals from 2017 through 2021.

The Center for Health Systems Effectiveness is evaluating MTP on behalf of the Washington State Health Care Authority. This brief presents highlights from our Baseline Evaluation Report, which describes the performance of Washington State's Medicaid system and its readiness for transformation as of 2019. The report presents analyses of State administrative data, results from a specialized survey of primary care practices, information from interviews with State and ACH leaders, and other data. It provides baseline information for contextualizing and measuring MTP's impacts in the future.

The Baseline Report was prepared just before the COVID-19 outbreak in Washington State. Future reports will incorporate information about the effect of COVID-19 on MTP and the ways in which the program has responded.

MTP consists of four initiatives:

Initiative 1: Delivery System Reform Incentive Payment Program

Initiative 1 supports Washington State's Accountable Communities of Health (ACHs), partnerships among organizations concerned with health in nine regions of the state. (Exhibit 1) ACHs bring together a variety of organizations—including health care providers and hospitals, public health districts, and community-based organizations, such as social service providers—and align their efforts toward common goals. Initiative 1 requires ACHs to work with their partners toward the following goals:

- **Increase Participation in Value-Based Payment Arrangements:** Value-based payment (VBP) rewards health care providers based on health care quality, service use, or cost, rather than the volume of services they provide. Washington State has set goals for the percentage of Medicaid dollars paid to providers through VBP.
- **Build Health Care Workforce Capacity:** MTP directs ACHs to help address regional workforce gaps and training needs.
- **Increase the Use of Health Information Technology:** Health information technology (HIT) includes electronic health records (EHRs) and other tools to help track patients' needs and coordinate care. It also includes health information exchange (HIE) and community information exchange (CIE), which allow health care providers and community-based organizations to exchange information about a patient's health care and social service needs.
- **Carry Out Health Improvement Projects:** MTP requires ACHs to implement regional health improvement projects in two domains: Care Delivery Redesign, and Prevention and Health Promotion. ACHs receive incentive payments for planning projects, reporting on project milestones, and improving performance metrics associated with each project.

Initiative 2: Medicaid Alternative Care and Tailored Supports for Older Adults

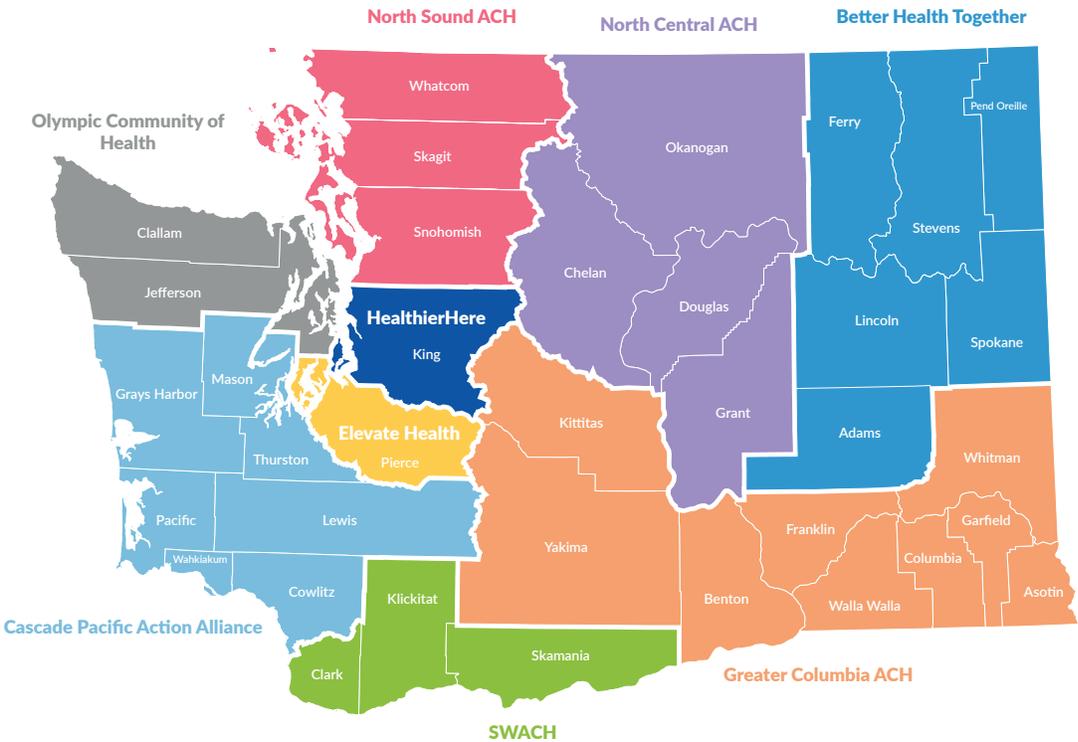
Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) are new supportive services for people who need long-term care but who are not yet using long-term care paid for by Medicaid. MAC is for people who meet financial eligibility requirements for Medicaid, while TSOA is for people who do not yet meet the financial eligibility requirements but who are at risk of spending down their financial assets to become Medicaid-eligible. Both programs provide supportive services for unpaid family caregivers, such as training and education, counseling on adapting to the role of a caregiver, and caregiver assistance services, including respite care or home-delivered meals. In addition, TSOA provides some assistance with everyday activities for people without an unpaid family caregiver. By supporting people who need long-term care and their caregivers, MAC and TSOA are intended to delay or avoid a later need for more intensive and costly Medicaid-funded

long-term care, such as care in a nursing facility or other residential setting.

Initiative 3: Foundational Community Supports

Foundational Community Supports (FCS) provides supportive services to help Medicaid members with specific risk factors and health needs gain and keep housing and employment. Examples of groups that may be served include people experiencing chronic homelessness, people with physical and behavioral health conditions that create barriers to employment, and vulnerable youth and young adults. Services are administered by Amerigroup, one of Washington State's managed care organizations, and delivered by a network of providers across the state. FCS was included in MTP due to the well-recognized connections between housing, employment, and health outcomes.

Exhibit 1. Washington State's Accountable Communities of Health



Initiative 4: Substance Use Disorder Waiver Amendment

In 2018, Washington State received an amendment to its Medicaid 1115 demonstration waiver that provides federal financial support for extended substance use disorder (SUD) treatment in residential settings. The amendment also establishes important milestones in care delivery and treatment for people with SUD. Because Initiative 4 began later than other MTP initiatives, information about its impacts will be presented in future reports.

Medicaid System Performance

Using State Medicaid data, we analyzed Washington State's performance on 45 metrics, categorized into 10 domains, in 2017 and 2018. (Exhibit 2) Where possible,

we compared the state's performance to a national benchmark.

Washington State generally performed well in three domains: Mental Health Care, Substance Use Disorder Care, and Opioid Prescribing and Opioid Use Disorder Treatment. Most metrics in these domains were above national benchmarks or increased from 2017 to 2018.

Overall, metrics in four domains changed little from 2017 to 2018: Social Determinants of Health, Access to Primary and Preventive Care, Reproductive and Maternal Health Care, and Oral Health Care. National benchmarks were unavailable for most metrics in these domains.

Exhibit 2. Measurement Domains and Example Metrics

Domain	Example
SOCIAL DETERMINANTS OF HEALTH	Homelessness: Percentage of members who were homeless at least one month in the year
ACCESS TO PRIMARY AND PREVENTIVE CARE	Children and Adolescents' Access to Primary Care: Percentage of children and adolescents who had at least one primary care visit
REPRODUCTIVE AND MATERNAL HEALTH CARE	Timely Prenatal Care: Percentage of deliveries with a prenatal care visit in the first trimester
PREVENTION AND WELLNESS	Cervical Cancer Screening: Percentage of women age 21 to 74 who were screened for cervical cancer
MENTAL HEALTH CARE	Mental Health Treatment Penetration: Percentage of members with a mental health treatment need who received at least one mental health service
ORAL HEALTH CARE	Topical Fluoride at a Medical Visit: Percentage of children age five and younger who received topical fluoride at a medical visit
CARE FOR PEOPLE WITH CHRONIC CONDITIONS	HbA1c Testing for People with Diabetes: Percentage of members age 18 to 75 with diabetes who received a hemoglobin A1c test
ED, HOSPITAL, AND INSTITUTIONAL CARE USE	Emergency Department (ED) Visit Rate: Number of ED visits per 1,000 months of enrollment
SUBSTANCE USE DISORDER CARE	Alcohol or Other Drug (AOD) Treatment Initiation: Percentage of members with AOD dependence who received treatment within 14 days of diagnosis
OPIOID PRESCRIBING AND OPIOID USE DISORDER TREATMENT	Opioid Use Disorder (OUD) Treatment Penetration: Percentage of members with opioid use disorder who received medication-assisted or medication-only OUD treatment

Performance was mixed in three domains:

Prevention and Wellness; Care for People with Chronic Conditions; and Emergency Department, Hospital, and Institutional Care Use. In these domains, at least half of metrics were below national benchmarks or worsened from 2017 to 2018.

Across most domains, Black and American Indian/Alaska Native Medicaid members experienced worse outcomes than the average Washington State Medicaid member.

Progress on Value-Based Payment

To measure VBP adoption, we administered a specialized survey to a sample of primary care practices across Washington State. We interviewed State agency and ACH representatives to understand factors that facilitated and impeded VBP adoption.

Among Washington State's primary care practices, participation in VBP was widespread in 2018. For example, 72 percent of practices participated in fee-for-service contracts with rewards for quality goals and 55 percent participated in contracts where they could share in savings from meeting cost or service use targets. However, practices reported a low proportion of Medicaid revenue tied to quality goals: 70 percent of practices said they received less than one-fifth of their revenue from payments linked to quality. This apparent discrepancy may exist because incentive payments or penalties under VBP contracts are relatively small compared to overall revenue.

ACHs are looking for State leadership on VBP. ACHs provided training and technical assistance on VBP to their partners and facilitated collection of VBP data from health care providers. However, ACH leaders expressed the need to clarify ACHs' role on VBP. Some barriers to greater VBP adoption—such as the capacity of smaller providers to assume financial risk—may be difficult for ACHs to address.

MTP's Impact on Health Care Workforce Capacity

To assess Washington State's health care workforce capacity, we asked primary care practices whether they needed—but had difficulty hiring or retaining—specific types of health care workers. We interviewed State agency and ACH representatives to understand factors that facilitated and impeded workforce capacity.

Primary care practices reported widespread staffing shortages in 2018: More than half reported shortages of medical assistants, registered nurses, primary care physicians, and psychiatrists. A majority of practices expressed concerns that staffing shortages would result in suboptimal outcomes for people with severe mental illness, co-occurring behavioral and medical conditions, and substance use disorder, which are focus populations for MTP.

Barriers exist to expanding specific workforces needed for MTP. These workforces include behavioral health care providers, community health workers and peer counselors, and physicians who provide medications for substance use disorder treatment. Barriers included licensing and credentialing regulations, billing regulations, and concerns about sustaining funding for staff after MTP ends.

ACH leaders expressed concerns that the State had not clearly defined ACHs' role in meeting workforce needs. During the design phase of MTP, leaders acknowledged the importance of building workforce capacity, but there was no consensus on how best to address it. Without clear guidance, ACHs desired clarification on their role addressing workforce shortages.

MTP's Impact on Health Information Technology Use

To assess HIT use, we asked primary care practices whether clinicians used EHRs to

accomplish specific tasks that are important for patient care, and whether they used EHRs to communicate with certain kinds of provider organizations outside their own organization or health system. We interviewed State agency and ACH representatives about their efforts to increase HIT use.

Among primary care practices, EHRs were widely used to accomplish important tasks and exchange information with outside outpatient clinics and hospitals. However, use of EHRs to view information about patients' health-related social needs or exchange information with long-term care providers or social service organizations was less common.

ACHs focused their HIT investments on filling HIT gaps among behavioral health care providers and gaps in providers' ability to store and share information about patients' health-related social needs. However, ACHs did not make extensive efforts to establish regional HIEs or connect providers to OneHealthPort, the State's designated lead HIE.

ACH informants expressed a desire for a statewide approach to HIE and CIE. They articulated that coordination from a central authority is needed to work toward these goals efficiently. HIEs or CIEs that connect providers solely within ACH regions would not enable providers in different ACH regions to exchange information.

Impact of ACH Health Improvement Projects

MTP requires ACHs to implement regional health improvement projects in the domains of Care Delivery Redesign and Prevention and Health Promotion. Each ACH must carry out one required project and select at least one other project in each domain. (Exhibit 3) ACHs focused on project planning starting in 2017 and began implementing projects in 2019.

Through interviews with ACH leaders, we learned about ACHs' approaches to their projects and emerging challenges in MTP's first three years.

Exhibit 3. Health Improvement Projects

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

ACHs executed contracts with a variety of partners to implement their projects.

These include health care providers, such as primary care providers and hospitals; social service providers; local government entities, including a city fire department, a city housing authority, and a county sheriff; and tribal nations. Some ACHs prioritized contracting based on a potential partner's ability to implement projects and improve performance metrics, while others allocated resources to a wider variety of partners.

The extent to which ACHs set uniform requirements across projects varied among ACHs.

For example, some ACHs required their partners to follow change plans with activities and outcomes specified by the ACH, while others allowed their partners more flexibility to choose activities and outcomes for their projects.

ACHs often used common approaches across projects.

Examples included using a common intervention or model, identifying shared target populations, and engaging common partners. In this way, ACHs aimed to reduce duplication of efforts, minimize burden for partners, and maximize efficiency.

We identified the following emerging challenges.

These may affect ACHs' ability to meet MTP's goals and sustain projects after MTP ends.

- **Assessing project performance and making course corrections:** ACH informants described challenges obtaining data to assess project performance and make course corrections. This feedback may reflect the limitations of health care claims data available to ACHs, as these data generally cannot be used to track people who were served by specific projects.
- **Focus on clinical determinants of health:** The ACH model, which incorporates health care and community partners, is well-suited to address social and community-

level determinants of health beyond the medical system. However, several aspects of MTP's design have focused ACHs on establishing partnerships with clinical providers and improving health care processes. There is a risk that ACHs will continue to prioritize clinical improvement and forego investment to improve non-medical determinants and health.

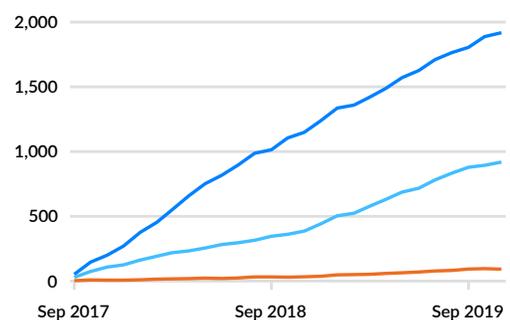
- **Sustainability:** ACHs have begun to implement a variety of delivery system reforms. However, there does not appear to be a statewide strategy or explicit funding to sustain these investments after MTP ends in 2021.

Implementation and Impacts of MAC and TSOA

Nearly 2,000 individuals and nearly 1,000 pairs of caregivers and care receivers were enrolled in TSOA by September 2019, two years after the program began enrolling participants. In contrast, fewer than 100 caregiver and care receiver pairs were enrolled in MAC. (Exhibit 4) Informants reported challenges reaching caregivers because many unpaid family caregivers do not identify as caregivers and may be unaccustomed to seeking help. They believe there are more eligible caregivers whom they have not yet engaged and enrolled.

Exhibit 4. MAC and TSOA enrollment, September 2017 to September 2019

Number of **individuals enrolled in TSOA, caregiver and care recipient pairs enrolled in TSOA,** and **caregiver and care receiver pairs enrolled in MAC**



Source: Aggregated MAC and TSOA enrollment data from Washington State Department of Social and Health Services.

Among a sample of TSOA participants who received services through the program, 80 percent thought TSOA services would help keep them from moving to a nursing home or adult family home. Strong majorities also expressed satisfaction with the program and the application process.

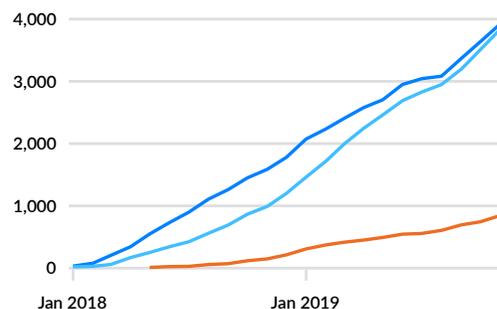
Few connections existed between Initiative 2 and other MTP initiatives. Informants described how ACHs could leverage the expertise of Washington State’s Area Agencies on Aging, which play key roles in Initiative 2, to raise awareness of MAC and TSOA and help achieve MTP’s goals.

Implementation and Impacts of FCS

FCS began enrolling participants in January 2018. Enrollment increased steadily, reaching 6,914 participants in November 2019. (Exhibit 5)

Exhibit 5. FCS enrollment, January 2018 to November 2019

Number of individuals enrolled in **supported employment**, **supportive housing**, and **both services**



Source: Aggregated FCS enrollment data from Washington State Department of Social and Health Services.

Despite the increase in enrollment, informants described several challenges with the program:

- Limited availability of service providers in rural areas
- Challenges for service providers with adapting to becoming Medicaid providers

- Lack of affordable housing in many areas of the state

FCS services could potentially be used to help ACHs achieve goals for some health improvement projects.

For example, supportive housing services could be used to help Medicaid members transition between care settings or provide the stability needed to manage chronic conditions, thereby helping ACHs improve performance metrics for several projects. However, ACHs informants were largely unaware of regional activity surrounding FCS or how they could connect to FCS services.

Recommendations

Based on data and findings from the initial years of MTP, the following actions may improve the potential for the State to meet its goals:

- 1 Provide clarity on sustainability and expectations for ACHs beyond 2021.** Large-scale health care delivery and payment reform may take longer than the five-year MTP timeframe. Concerns about ACHs’ ability to sustain themselves after 2021 may inhibit ongoing efforts. To realize the potential of the ACH model, the State may need to demonstrate commitment to the model and provide clarity on ways in which ACHs will be expected to sustain themselves after 2021.
- 2 Provide ACHs with specific strategies and guidance on HIE and CIE.** ACHs expressed a desire for a statewide approach to HIE and CIE. Guidance and clarity from the state, in addition to consideration of a uniform approach to HIE and CIE, may avoid unnecessary fragmentation and investments in the future.
- 3 Clarify the role of ACHs in meeting workforce needs.** ACHs have primarily focused on meeting MTP’s workforce needs by training new workers, but

they may be poorly positioned to lead on creating new workers or addressing state-level regulations that restrict the expansion of workforces needed for MTP. The State should clarify the intended role of ACHs in meeting workforce needs.

4 Evaluate ways to connect MTP's initiatives and facilitate connections.

ACHs may be able to leverage benefits provided under Initiatives 2 and 3 to help achieve MTP's goals. The Washington State Health Care Authority and Department of Social and Health Services should evaluate the value of connecting the initiatives and facilitate potentially valuable connections.

5 Enhance VBP reporting to track dollars directly tied to quality and efficiency.

To monitor VBP adoption, the State currently reports the percentage of dollars paid to providers through managed care contracts with any VBP component. However, more detailed reporting on VBP arrangements may be needed to determine if provider

incentives in these contracts are strong enough to motivate efforts to improve quality and efficiency. The State could supplement current reporting to include dollars at risk based on quality or service use goals, such as the maximum value of bonus payments providers could earn or penalties that providers would pay under a contract with rewards and penalties for performance. Dollars at risk could be reported as a percentage of total contract dollars in order to gauge the strength of VBP incentives.

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

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