

Washington State Health Care Innovation Plan



The Washington Way



JANUARY 2014

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JAY INSLEE
Governor



STATE OF WASHINGTON
Office of the Governor

January 29, 2014

Mr. Richard Jensen, Project Officer
Mr. Gabriel Nah, Grants Management Specialist
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244-1849

Dear Mr. Jensen and Mr. Nah:

It is my pleasure to submit the enclosed Washington State Health Care Innovation Plan, as fulfillment of the final deliverable for the State Innovation Models: Funding for Model Design grant awarded to the state, 1G1CMS331184-01-00. I am pleased to fully endorse this plan.

The support provided by the SIM pre-testing grant has catalyzed a bold initiative that builds upon and reinforces Washington State's reputation for innovation. The resulting Innovation Plan charts a bold course for transformative change in Washington State that links clinical and community factors that support health, spreads effective and integrated value-based payment and care delivery models, and has the potential to generate more than \$730 million return on investment over the next three to five years.

Washington State's Health Care Innovation Plan builds on efforts already initiated in the state by private and public organizations and creates a framework for spreading that work in order to achieve system-wide change. The development of this plan was deeply informed by hundreds of thought leaders from across the health sector and broad leadership through my Cabinet—ranging from public health and human services to education and commerce. This extensive engagement has resulted in a uniquely Washington plan that ensures support from across the state as it continues on its path toward health system transformation.

With the Innovation Plan in place, Washington is taking action to ensure its success. I proposed \$2.7 million in my supplemental budget to begin implementation of the five-year plan. Additionally, at my request and with support from legislators and advocates, a bill was introduced this month in the State House of Representatives that lays the foundation for implementation of the plan. Similarly, the private sector is making commitments to core elements of the Innovation Plan, including transparency and community collaboration to improve health and value. These foundations position Washington to maximize future resources in support of the Innovation Plan and provide the basis for transformation of the state's current system to one that ensures health, quality and value.



Mr. Richard Jensen
Mr. Gabriel Nah
January 29, 2014
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Thank you for this opportunity to accelerate health system transformation in Washington State.

Very truly yours,



Jay Inslee
Governor

Enclosure

cc: Karen Murphy, Director, State Innovations Group, Center for Medicare and Medicaid Innovation
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Richard Onizuka, Executive Director, Washington Health Benefit Exchange

Testimonials: Washington State's Innovation Plan

"This is exactly the right moment to take a fresh look at our state's current health care delivery and financing systems and to examine new ideas capable of improving the health of all Washington residents. UW Medicine supports the Innovation Plan taken as a whole, and in particular SHCIP's commitment to the further integration of care provided to individuals with multiple healthcare needs: physical health, behavioral health, substance abuse and community services. Our mission at UW Medicine is to improve the health of the public, and we look forward to our continued partnership in creating and executing this new vision for improving the health of the residents of our state."

— Paul G. Ramsey, MD, CEO
UW Medicine

"Virginia Mason is a proud supporter of Washington's Innovation Plan. The Innovation Plan is a necessary road map to more accountable, higher quality, patient-centered health and health care in Washington State. Virginia Mason was an active participant in the planning process, and looks forward to working with Washington state and other health care stakeholders toward better health, better care, at lower costs."

— Gary S. Kaplan, MD, Chairman and CEO
Virginia Mason Medical Center

"As a major insurer and delivery system in Washington State and contractor for Washington's Public Employee Benefits program, we support the Public/Private Transformation Action Strategy. We look forward to working collaboratively with the state to refine the details and with our payer, provider and purchaser partners to make further strides on value-based payment reform, transparency of quality and cost, common performance measures and innovative consumer engagement strategies. Alignment of payment and delivery system reform strategies across stakeholders is critical to achieving meaningful transformation in health care, and we look forward to doing our part."

— Scott Armstrong, President and CEO
Group Health Cooperative

"Legacy Health looks forward to working with fellow health systems and payer organizations to take the innovation plan and its key transformative elements from theory to practice in Southwest Washington. We strongly support movement toward more accountable delivery systems with community involvement and greatly appreciate the plan's focus on integrating physical and behavioral health, at a financing and delivery system level."

— George Brown, MD, CEO
Legacy Health

"PeaceHealth supports the concept of regional purchasing for Medicaid that promotes greater collaboration and community accountability for health outcomes. The Public/Private Transformation Action Strategy provides a clear roadmap for innovation and we are committed to working with the state toward achieving a high-performing, accountable health delivery system in SW Washington."

— Alan Yordy, President & Chief Mission Officer
PeaceHealth

"The Plan's core strategy for the State to take a lead role as 'first mover' is vitally important to creating a strong primary care system, which is needed as the foundation for accountable care."

— Cindy Robertson, President
RHCAW, Northshore-Medical Group & Rural Health Clinic Association of Washington (RHCAW)

“As a large hospital system serving Washington State, Providence Health & Systems applauds Washington’s Innovation Planning effort. We look forward to partnering with the State on strategies that will move the needle on creating better value and a more accountable delivery system. We also look forward to collaborating with providers, payers, and purchasers on additional strategies that will improve quality and reduce costs for the entire community.”

— Joseph Gifford, MD, CEO

ACO of Washington, Providence Health and Systems

“Integrating physical and behavioral health and addressing social determinants of health (including Adverse Childhood Experiences) are components of the plan that the WA Chapter of the American Academy of Pediatrics strongly supports. We believe that aligning the SHCIP with other initiatives in WA State, such as the Early Learning Plan and Frontiers of Innovation, is a smart strategy that will maximize the potential of all of these efforts. Further, the plan recognizes the need to focus on payment models, outcomes, and health disparities, all complex issues, in order to achieve the Triple Aim. We appreciate the hard work and vision so apparent in the plan.”

— Washington Chapter

American Academy of Pediatrics

“Thank you again for seeking to address the needs for health care reform in such a comprehensive manner. While developing a final plan will be challenging, the draft’s prioritization of remedying health inequities, addressing the social determinants of health, and integrating physical and behavioral health with LTSS give Washington a real opportunity for broad-based improvements in community health to benefit all residents.”

— Children’s Alliance, Neighborhood House, and Northwest Health Law Advocates (NoHLA)

“The formation of the regional Accountable Communities of Health (ACH) as a key strategy for fostering cooperative action for improvements in health, care and costs is of key interest to us. We welcome the opportunity to come to the table with other community health partners to plan, act, evaluate and learn together.”

— Randall H. Russell, CEO

Lifelong AIDS Alliance

“Mental health and chemical dependency services need to become better integrated with each other; any further separation would be a step backwards. These service systems should be integrated in a single payment and management structure. More effective service coordination is also needed with physical healthcare, through bi-directional integration approaches and care coordination.”

— Ann Christian, CEO

Washington Community Mental Health Council

“The Washington State Hospital Association is pleased the state is moving forward on integrating care for individuals with physical and behavioral health co-morbidities, a group currently not well served by our system. We have appreciated being part of the innovation planning process and look forward to continued collaboration as we move toward implementation.”

— Claudia Sanders, Senior Vice President, Policy Development

Washington State Hospital Association

"At the Washington State Medical Association our vision is to make Washington the best place to receive care and to practice medicine. The goals outlined in the state's innovation grant are bold steps toward achieving that vision. There is much to be done to transform our state's health care system to better achieve the triple aim of improved care, improved health and lower per capita costs. We look forward to working with our state's leaders as they continue to refine their plans to better serve our state's patients."

— Dale P. Reisner, MD, President
Washington State Medical Association

"Community health centers welcome the goal of integrating behavioral health into the Medicaid contracts and anticipate that integration will better meet our patient needs and improve health outcomes."

— Mary Looker, CEO
Washington Association of Community & Migrant Health Centers

"Public hospital districts cover over 75% of the state and are charged by statute with providing hospital and other health care services to the residents of those communities. We believe the only way to maintain community health and ensure access to essential care is through effective coordination of services. We, therefore, applaud the state's efforts to create a more integrated local service delivery system and we look forward to continued partnership with the state at the policy level and with other community serving groups at the local level where care is delivered."

— Ben Lindekugel, Executive Director
Association of Washington Public Hospital Districts

"The Vancouver Clinic appreciates the clear assessment of the state of health care in Washington state and the broad aims outlined in the plan are consistent with our organization's mission to serve the people of SW WA. The plan builds its core, transformative strategies on the foundation of primary care and we believe this is essential toward achieving the triple aim in our health care delivery system."

— Duane Lucas-Roberts, CEO
The Vancouver Clinic

"'The fog has lifted' reported a middle age man with severe schizophrenia who now closely attends to his diabetes through glucose monitoring, diet and exercise, and credits the provision of whole person care by Kitsap Mental Health Services. This integration of behavioral and primary health care creates a higher quality of life by making the critical connection of the head to the rest of the body. Kitsap Mental Health Services is now able to actually provide the right services, at the right time and at the right place. The cost/benefit of this model is exceptionally encouraging and it will require continued state innovation and support to take this model to scalability and ultimately spread throughout our region, the state and beyond."

— Joe Roszak, Executive Director
Kitsap Mental Health Services

"The emphasis on care coordination and integration of primary care and behavioral healthcare services is most important to us because it recognizes the person-centered, whole health needs of the clients we serve."

— Janet St. Clair, Deputy Director
Asian Counseling and Referral Service

“The Washington Association of Alcoholism & Addictions Programs (AAP) membership really aligns with the plan's emphasis on the integration of chemical dependency with managed health plans for the many individuals that make up the non-disabled Medicaid expansion population. We believe this will go a long way in realizing the promise of the Affordable Care Act with regard to appropriate access and healthcare savings. Persons suffering from addiction can and do recover every day.”

— Cheryl Strange, Vice President & President
Pioneer Human Services, Alcoholism & Addictions Programs

“We appreciate the phased approach for behavioral health and physical health integration, allowing each region to determine its level of readiness for implementation.”

— Connie Mom-Chhing, CEO
Southwest Washington Behavioral Health

“We endorse the overall direction of the Vision for Health System Transformation and applaud Washington's plan to implement payment reform and practice transformation, as well as moving to activate and engage individuals and families in their own health and wellness.”

— Cheri Dolezal, RN, MBA, Executive Director
OptumHealth, Pierce County RSN

“We believe transparency is a critical component of payment reform. When used properly, it allows all stakeholders to benchmark performance and value, which will hopefully lead to better results and wiser buying.”

**— Richard Cooper, Forum Board Chair, and
Richard D. Rubin, Executive Director**
Washington Healthcare Forum

“Washington's State Innovation Plan sets us on the right path toward a health care system based on value, and care focused on prevention, so we can build healthy communities. As a large purchaser of health care, a public health department, and a human services agency, King County is truly excited to be an active partner and participant throughout all phases of the plan.”

— Dow Constantine, Executive
King County

“Washington's Innovation Plan is comprehensive and sets us on the right course for health, transforming the delivery and financing of health care in Washington State. We were privileged to participate in the formative stages of the Plan, and look forward to supporting and aligning with the many stakeholders in our state as we drive value-based purchasing to become the standard across Washington.”

— Larry McNutt, Administrator
Carpenters Trusts of Western WA

“This year, Washington State will take great strides forward toward ensuring everyone has access to meaningful health insurance. But our work is not done. Next we must focus on the future improvements—promoting better quality and value in our health-care system through increased transparency, focusing on outcomes and building smarter, more efficient delivery models. Washington's Innovation Plan is a critical step to help us meet these goals and will help us make innovations in state-purchased health care that will set the pace for the commercial insurance market in years to come.”

— Mike Kreidler, Commissioner
Washington State Office of the Insurance Commissioner

“Amerigroup applauds Washington State’s efforts to drive toward better health and better care at lower costs. As a partner in the Medicaid delivery system, we are pleased to work with the state on value-based purchasing, better integration of services, common measures of performance, health information exchange and increased transparency on cost and quality.”

– Daryl Edmonds, Health Plan President
Amerigroup Washington

“Community Health Plan of Washington (CHPW) appreciates Washington State's efforts to integrate behavioral health into Medicaid managed care contracts. As a partner in the Medicaid delivery system, we are ready to help demonstrate that financial integration and integration in the delivery system can reduce costs and improve health outcomes, as we have already demonstrated with a subset of Medicaid enrollees.”

– Lance Husinger, President & CEO
Community Health Plan of Washington

“Columbia United Providers is deeply committed to collaboration with providers who live and work in the same community we do, who care for the same patients we work to keep insured. The state’s Public/Private Transformation Action Strategy is built on these same principles, and is focused on locally organized care delivery, significant community engagement, and supporting trusted relationships across the health care spectrum.”

– Ann Wheelock, CEO
Columbia United Providers

“As a long-time partner of the state of Washington, Molina Healthcare applauds these efforts to improve health outcomes while also being a responsible steward of tax payer dollars. With over 30 years of experience in the Medicaid delivery system, we have seen the significant impact that can come from coordinating patients’ care through better performance measures, transparency and ongoing exchange of health information. We will continue to collaborate with the state, health care providers and community organizations to improve our members’ care.”

– Bela M. Biro, President
Molina Healthcare of Washington

“As a major insurer in Washington State and contractor for Washington's Public Employee Benefits program, we support the broad goals of the evolving State Health Care Innovation Plan. We look forward to continuing the work we have already initiated with our provider and purchaser partners to make further strides on value-based payment reform and innovative consumer engagement strategies. Incentivizing strategic innovation pathways while reducing unnecessary regulatory burdens is critical to achieving meaningful transformation in health care, and we look forward to doing our part.”

– Beth Johnson, Vice President
Network Management and Contract Strategy, Regence BlueShield

“It's time to find solutions for our health care system. INHS supports the Innovation Plan and looks forward to working with Washington State and health care stakeholders to reform health care for the betterment of patient care and outcomes.”

– Tom Fritz, CEO
Inland Northwest Health Services

"The transformative elements in the plan have inspired much discussion within our community and give us great hope for what the delivery system could look like five years from today. With a five-year strategy now in place, Community Choice is willing to lead North Central Washington's discussion on the next steps toward making this health transformation a reality."

— Jesus Hernandez, Executive Director
Community Choice Healthcare Network

"The Whatcom Alliance of Health Advancement applauds both our State government's process in preparing (the Innovation Plan) as well as the major aims and strategies it articulates. These are well thought out and offer promise of moving all of our communities closer to the triple aim of improved quality, higher satisfaction, and moderated costs."

— Larry A. Thompson, Executive Director
Whatcom Alliance of Health Advancement

"We are extremely encouraged to see the focus on the use of the life-course framework for early intervention service, and the Innovation Plan's emphasis on substantive connections and collaborations among such systems as early learning, housing, education, nutrition and food security, built environment, and economic development. The Accountable Communities of Health (ACH) have great potential to facilitate this, particularly as we focus together on building out the critical role of local health jurisdictions and enable these organizations to develop organically to be responsive to the needs of their local communities. Thank you for the work you and others have done to make this a strong collaborative effort between not only key community partners, but also among the key state agencies. We look forward to seeing this work move forward in Washington state."

— Anne Tan Piazza, President of the Board
Washington State Public Health Association

"Public Health-Seattle & King County commends Washington State for the vision and strategies outlined in the State Health Care Innovation Plan. Overall, they are highly aligned with King County's recent health and human services transformation work. Both plans share a vision of moving from a 'sick care' system to one focused on prevention, well-being and equity. Both drive toward the effective integration of physical and behavioral health. And, both plans call for working collectively with other partners in ways that better integrate the healthcare delivery system with community-based systems that are outside healthcare but that greatly influence health such as social services, housing, education and public health. We look forward to partnering in transformation to achieve our mutually shared vision and aims."

— David Fleming, MD, Director and Medical Officer
Public Health – Seattle & King County

"We endorse a model that includes a true integration of behavioral health and primary care beyond a single funding system. Any such effort must preserve the unique clinical approaches that behavioral health brings and ensure that the medical model not be the determining theoretical framework for service delivery. We believe the plan has great promise, and we look forward to being full participants in co-creating a more healthy future for the people of Washington State."

— Carlos Carreon, LICSW, ACSW, BCD, HMHI Director
Health & Human Services, Cowlitz County Health Department

“The Tribes of Washington and Urban Indian Organizations appreciate the opportunity to partner with Washington State to improve reimbursement and health care delivery models. It is important to recognize the complexities of the Indian Health Care delivery system, and we have appreciated the government to government consultation process in the development of the policy. It is critical to maintain this framework as we move down the path of implementation.”

— Marilyn M. Scott, Whe-Che-Litsa
Vice Chairman, Upper Skagit Indian Tribe
Chair, American Indian Health Commission

“Empire Health Foundation has been an investor in Washington State’s innovation plan from the beginning and we consider the plan that has been developed to be an adaptive and innovative testing ground for achieving the triple aim in Washington State; something that was missing until now. We are highly supportive of key elements of the implementation plan that includes the integration of behavioral and oral health with primary care and the phased creation of regional Accountable Communities of Health that builds off of what already exists locally and allows for appropriate customization throughout the state to achieve results. This a shovel-ready business plan private philanthropy can co-invest in.”

— Kristen West, Vice President
Empire Health Foundation

“At the Bill & Melinda Gates Foundation, we are acutely aware of the important connections between implementation of the Affordable Care Act and promoting community well-being rooted in a deep understanding and responsiveness to key social indicators of health. Our priorities here in Washington State, which focus on developing community capacities, promoting housing stability and ending homelessness, and ensuring kindergarten readiness, school success and college completion, are all highly relevant, connected to and part of a holistic, community-based approach to core health indicators which are the foundation of success for our region’s most vulnerable populations.”

—David M. Wertheimer, M.S.W., M.Div., Deputy Director
Pacific Northwest Initiative, U.S. Program, Bill & Melinda Gates Foundation



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Executive Summary

Washington's Health Care Innovation Plan

Washington's State Innovation Models grant from the federal Center for Medicare and Medicaid Innovation (CMMI) has catalyzed a bold initiative. The CMMI planning grant enabled extensive and rapid cross-community and cross-sector engagement on broadly defined health and health care system change. The resulting Innovation Planning initiative created a framework for health system transformation that is significantly more far reaching than the testing grant application submitted by the state in 2012.¹ The State Health Care Innovation Plan forms the basis of a future application for a multiple-year State Innovation Models testing grant. More importantly, it charts a bold course for transformative change in Washington state that links clinical and community factors that support health, spreads effective payment and care delivery models, and has the potential to generate more than \$730 million in return on investment.

Washington is home to some of the most innovative and transformational efforts in the nation to improve health and health care and lower costs, which have only been strengthened by an infusion of energy and resources upon passage of the Affordable Care Act. Washington's purchasers, labor organizations, providers, quality improvement organizations, local jurisdictions, and health plans are leaders in performance measurement, clinical practice transformation, and innovative payment and delivery methods, ensuring focus on value rather than volume. In his first year, Governor Jay Inslee has set ambitious health and health care goals for the state, including a vision for full integration of mental health, chemical dependency, and physical health care. Innovative local jurisdictions and communities throughout the state already have leveraged collaboration and engagement across sectors to work toward healthier people in their communities and are poised to do much more.

The State embraces and applauds its deserved reputation for innovation, but recognizes it must reach higher and transform faster to ensure Washingtonians are healthy and consistently receive high quality, affordable care. The Innovation Plan builds on Washington's unique blend of entrepreneurship and collaboration. It seeks to channel health plan and provider competition toward value without dictating lockstep adherence to specific payment or delivery system

¹ Washington's 2012 State Innovation Models testing grant application proposed implementation and testing of a model for improving maternal/infant care and managing chronic conditions through a multi-payer approach. See https://www.statereforum.org/system/files/wa_sim_project_narrative.pdf for the original project narrative.

models. In order to achieve results through competition, the State must focus on the fundamentals necessary to consistently define, demand and incentivize value, measure it consistently, and act on what is measured. For this reason, the Washington plan emphasizes greater purchaser leadership and the importance of transparency and deploying high-value measures, drawn as much as possible from nationally standardized measure sets.



The Innovation Plan also focuses on creating capacity and modest infrastructure to support enhanced cooperation where a competitive model will not suffice. Caring for the state's most vulnerable; engaging individuals in their own health; addressing the needs of rural and underserved communities; and preventing illness, injury, and disease often demands coordinated planning and response among multiple private actors, various governments, public health, not-for-profit service providers, and philanthropy. Maximizing the potential for collective impact does not demand a great deal of infrastructure nor does it call for top-down regulation. It does require that communities have support and a voice in defining mutual state and regional aims, greater local control, and more consistency and clarity from their State governmental partners. New thinking and financing tools to support health are required, particularly when investments by one party or sector yield return in others.

The collaborative and inclusive state Innovation Planning process recognized the importance of the contributions of and commitment from all state actors. As such, the Innovation Plan is intended to be viewed as a comprehensive *state* plan, and not just the State or Governor's plan. It will require action on multiple levels and strong public-private partnership, particularly as Washington bridges from planning to implementation.

The Innovation Plan is organized along two major axes: (1) three strategic focus areas, which include multiple targeted health system and payment reforms, and (2) seven foundational building blocks, which directly support the three strategies and also enhance overall system performance.

Strategies for Better Health, Better Care, and Lower Cost

The Innovation Plan is built to achieve three ultimate aims: better health, better care, and lower costs. Three broad strategies drive progress toward these interrelated aims.

Strategy 1

Drive value-based purchasing across the community, starting with the State as “first mover”

The Innovation Plan emphasizes leadership from Washington’s public and private major purchasers to jointly catalyze payment and delivery system transformation. Washington will move away from a largely fee-for-service reimbursement system to an outcomes-based payment system that delivers better health and better care at lower costs. Specifically, within five years, Washington aims to move 80 percent of its State-financed health care to outcomes-based payment and work in tandem with other major purchasers to move at least 50 percent of the commercial market to outcomes-based payment. Key action steps include:

- Requiring all providers of State-financed health care to collect and report common measures, implement evidence-based guidelines, and enable use of patient-decision aids.
- Implementing accountable care organization models, reference pricing, and tiered/narrowed networks for State-financed health care.
- Aligning public and private purchasing expectations with flexible benefit design efforts.
- Generating actionable commitments in support of a well-defined strategy that will align payment and delivery system transformation across multiple payers, purchasers, and providers.

Strategy 2

Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course

Ensuring better health, better care, and lower costs requires Washington to close the gaps between prevention, primary care, physical and behavioral health care, public health, social and human services, early learning/education, and community development systems. It also requires better alignment at the state and community levels. To invest in the success of healthy communities, the State will leverage its leadership role to shape and align policies that provide the opportunity and space to develop healthy physical and social environments that foster resilient and connected communities. Key action steps include:

- Leveraging community-based, public-private collaboratives to bring together key stakeholders to link, align, and act on achieving health improvement goals, support local innovation, and enable cross-sector resource sharing, development, and investment.
- Amplifying a Health in All Policies approach across State agencies and within communities, with a focus on healthy behaviors, healthy starts for children, prevention and mitigation of adverse childhood experiences, clinical-community linkages, and social determinants of health.
- Using geographic information systems-mapping and hot-spotting resources to drive community decisions.
- Designing a toolkit for communities seeking to finance innovative regional projects.

Strategy 3

Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities

Needlessly complex health care and benefit systems are major obstacles to prevention and effective management of chronic disease. These obstacles can be particularly challenging for people with both physical and behavioral health issues. Effectively integrating mental health, substance abuse, and primary health care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs. Key action steps include:

- Spreading adoption of the Chronic Care Model.
- Supporting the integration of physical and behavioral health care at the delivery level through expanded data accessibility and resources, practice transformation support, increased workforce capabilities, and reduction of administrative and funding silos on a phased basis.
- Restructuring Medicaid procurement into regional service areas to support integrated physical and behavioral health care and linkages to community resources.

Foundational Building Blocks

These building blocks address fundamental capabilities and supports that must be in place to realize the Innovation Plan, and for health and health care transformation to succeed on a system-wide basis. The goal of these building blocks is to enable Washington to harness and channel competition, and accelerate change at the delivery system and community level.

FOUNDATIONAL BUILDING BLOCK 1

Build a culture of robust quality and price transparency

The State will actively lead in the development of broad price and quality transparency infrastructure to help individuals and providers make informed choices, enable providers and communities to benchmark their performance against that of others, and enable purchasers and payers to reward improvements in quality and efficiency.

FOUNDATIONAL BUILDING BLOCK 2

Activate and engage individuals and families in their health and health care

Washington will implement and promote evidence-based wellness programs, flexible benefit design, and tools, and provide a suite of new resources and training to help individuals and providers in shared decision making.

FOUNDATIONAL BUILDING BLOCK 3

Regionalize transformation efforts

Recognizing that health and health care are influenced by local needs, the State and regional leaders (including counties) will work together to determine regional service areas that drive increased collaboration between clinical and population health efforts. These regional service areas also will define Medicaid purchasing boundaries and make it easier to support health improvement and prevention at the local and regional levels. Most importantly, this regional approach will empower local entities, such as counties and public health jurisdictions, to shape

a health and social services system tailored to the needs of their communities and aligned with key statewide priorities.

FOUNDATIONAL BUILDING BLOCK 4

Create Accountable Communities of Health

The Innovation Plan leverages innovation and collaboration already occurring in local communities by formalizing regionally governed public-private collaboratives to address shared health goals. These new partnership organizations will support communities, sectors, and systems in their regional service areas, and implement health improvement plans primarily focused on prevention strategies. Accountable Communities of Health also will help structure and oversee Medicaid purchasing. They will partner with the State to bring order and synergy to programs, initiatives, and activities based on unique regional and local characteristics.

FOUNDATIONAL BUILDING BLOCK 5

Leverage and align state data capabilities

Washington agencies will partner with one another and the private sector to address the longer-term needs for clinical health data management solutions, services, and tools to support case management and treatment decisions at the point of care, and new methods of paying for value versus volume. Washington will partner with the Institute for Health Metrics and Evaluation and local public health to develop new data capabilities and technical assistance to support community population health management.

FOUNDATIONAL BUILDING BLOCK 6

Provide practice transformation support

To align and amplify the array of exemplary public and private learning collaborative programs currently providing practice and community transformation support, the State will create a Transformation Support Regional Extension Service that operates at the state and community levels. This entity will ensure providers receive the necessary support in Washington's rapidly changing health care environment.

FOUNDATIONAL BUILDING BLOCK 7

Increase workforce capacity and flexibility

Washington will prepare its health workforce to care for the whole person and to work in teams to engage individuals and families and provide care effectively for those with complex and chronic conditions.

In addition to these seven building blocks, Washington has existing health information technology and information exchange transformation plans in place that address uptake and spread of health technologies. These are linked to and supportive of the Innovation Plan's strategies.

Ultimately, implementation of Washington's plan will impact nearly every health consumer and taxpayer in the state and is conservatively estimated to yield a \$730 million return on investment over the next three years. Innovation Plan initiatives will continue to drive greater returns in later years as delivery and payment reform initiatives take root. Washington's prevention investments will save money as fewer people suffer from preventable illness and untimely death, and will reduce the toll of illness in the state's workforce, schools, and communities.



■ SECTION 1

Vision and Goals

Health System Transformation

■ Washington's Vision

The passage of the Patient Protection and Affordable Care Act in 2010 presented an unrivaled opportunity for progress in Washington. The state embraced the Medicaid expansion and launched a fully operational Health Benefit Exchange in October 2013. These efforts alone are expected to enroll nearly 325,000 new Medicaid clients and more than 400,000 individuals and families in the insurance marketplace by the end of 2017.¹

Additionally, nearly two dozen public and private entities across Washington have partnered with the Center for Medicare and Medicaid Innovation to test new payment and service delivery models, adopt best practices, and transform primary care—building upon the state's many existing pioneering efforts.

Improved access to insurance coverage and incremental progress toward better health, better care, and lower costs are not enough. When health care services cost a family of four as much as a house payment and the services fail to efficiently and effectively resolve health needs, there's a problem. Too many state residents continue to suffer from Washington's costly and inefficient system, plagued by fragmentation, wasteful care delivery and payment models, and unaligned silos within the public and private sectors. These are barriers to the health and well-being of individuals, and their holistic treatment when they do enter the health care system.

Perhaps the largest barrier to capitalizing on this unprecedented environment for improvement and innovation in health and health care is the lack of a strong, comprehensive action plan that more effectively uses the forces of competition *and* collaboration. Washington is home to a myriad of highly skilled public and private organizations that individually and collectively have the ability to drive delivery system and overall health systems transformation, align financing and incentives, and share performance measures and tools necessary to support provider and community transformation. Even as Washington seeks to nurture entrepreneurship, state actors acknowledge the need to act together to create a system that can reduce total health costs

¹ Buettgens, Matthew, et al. "The ACA Medicaid Expansion in Washington." The Urban Institute, 2012. <<http://www.urban.org/UploadedPDF/412581-The-ACA-Medicaid-Expansion-in-Washington.pdf>>

while achieving better outcomes for the people of Washington. Unified action toward health transformation is the opportunity presented by the State Health Care Innovation Plan.

Washington has room to improve with regard to better health and health care, lower costs, and health care delivery system and community linkages...

- *The state's obesity rate has increased by 8 percent since 2000. Nearly 27 percent of Washingtonians are now considered obese. Rural areas have consistently higher rates of both obesity and smoking.²*
- *Washington residents with serious mental illness die eight to 25 years earlier than the rest of the population, and most of these premature deaths are caused by preventable chronic illnesses such as heart disease.*
- *Personal health care expenditures per capita in Washington have grown from \$2,358 in 1991 to \$6,782 in 2009.*

This Innovation Plan builds upon initiatives already occurring across the state by providers, health plans, employers and labor organizations, State agencies, consumer groups, local jurisdictions, community collaboratives, and more. Innovations such as physical and behavioral health delivery integration, public/private performance measurement and transparency collaboratives, quality improvement, shared decision making and technology assessment programs, value-based payment initiatives, and efforts by pioneering regional health improvement collaboratives are Washington strengths upon which the Innovation Plan is built. The plan provides a roadmap with common goals, focused strategies, and a build out of critical infrastructure to align, take to scale, and spread these and other foundational and promising practices statewide. It provides the leadership, direction, and supports essential to moving the needle on improved health, quality health care, and lower costs.

The Innovation Plan's core strategy is for the State to take a lead role as "first mover" in transforming State purchasing for public employees and Medicaid to achieve high-value, integrated, and whole person care; creating regionally-centered organizations that support necessary linkages and alignment around community health improvement and cross-sector resource sharing; fundamentally reorienting payment toward value rather than volume; incentivizing care delivery redesign; creating a robust culture of transparency; and continuing to build upon health information technology and data exchange infrastructure throughout the state. Through strategic leadership and collaborative partnership, Washington will:

- **Lead by example as a purchaser and market organizer.** The State will transform how it purchases care and services in State-purchased insurance programs, and engage multiple payers and purchasers in community-wide adoption of common adult and pediatric measures and value-based payment and benefit design strategies. Person-centered primary care and behavioral health will be strengthened and integrated at the site of care and service delivery, and better supported through phased in changes to Medicaid purchasing. Public employees will experience enhanced benefit design and wellness programs. Through new expectations for State-financed health care that includes increased transparency and evidence-based care, as well as alignment with private purchasers, Washington will move away from a largely fee-for-service system to an outcomes-based system that delivers better health and better care at lower costs.
- **Coordinate and integrate the delivery system with community services, education, social services, and public health.** Health is significantly influenced by factors outside the

² Washington State Department of Health Behavioral Risk Factor Surveillance Survey, 2000-2011.
<<https://fortress.wa.gov/doh/brfss/BRFSSHome.aspx>>

health care system, and achieving better health requires collaborative action on multiple fronts. The Innovation Plan therefore creates locally governed public-private collaboratives to support communities, sectors, and systems in newly designated regional service areas that also will serve as new Medicaid procurement areas. These Accountable Communities of Health will address state and community health priorities, encourage cross-sector resource sharing, test new funding strategies, and ensure organizations that contract to provide physical and behavioral health services are responsive to the communities they serve. Innovative funding resources will support cross-sector initiatives to improve population health and foster community learning laboratories to support, evaluate, and spread regional innovations throughout the state.

- **Align and focus state priorities and provide community practice transformation support to achieve state goals.** To align and amplify Washington’s array of exemplary public and private learning collaborative programs currently providing practice and community transformation support, the State will create a Transformation Support Regional Extension Service that operates at the state and community levels. As a statewide transformation “hub,” the Extension Service will serve as a clearinghouse of tools and augmented resources and act as a convener and aligner of the state’s many transformation efforts. At the regional level, the “spokes” of the Extension Service will provide local infrastructure support for practice transformation, increased and efficient workforce capacity, and community collaboration to achieve common goals.
- **Enhance data and information infrastructure.** The State will build upon current performance measurement and price transparency initiatives through an all-payer claims database, common performance measures, and expanded health information exchange capacity. Washington’s Innovation Plan also leverages “big data” geographic information system mapping and hot spotting to provide detailed community level information, better enabling regional leaders to address health inequities through targeted initiatives aimed to improve the health of those most in need, and effectively measure progress over time.
- **Expand successful Washington payment and delivery models.** The State will move to support and spread successful bi-directional collaborative care models of physical and behavioral health at the delivery level, and value-based benefit design strategies that promote consumer incentives and price transparency, such as reference pricing, an accountable care organization option for public employees and Medicaid beneficiaries, and tiered/narrowed networks selected on ability to deliver better outcomes and value. These efforts will be enabled by aligned practice transformation support, increased workforce capacity and flexibility, and data sharing and monitoring.
- **Activate and engage individuals and families in their health and health care.** Washington residents will have better tools to be informed consumers of care and in control of their own health. Washington is investing in customized wellness programs, an enhanced community workforce to educate and communicate with individuals and their families, and new evidence-based and technology enabled resources to help individuals make informed, shared decisions about care with their providers.

Beyond the specific actions, partnerships, and supports identified within the Innovation Plan, culture change based on unprecedented transparency around costs and outcomes is a foundational element to ensuring Washington’s health and health care system is among the best in the country. This Innovation Plan and its implementation over the following five years aims to capitalize on and further build leadership commitment to drive transformative change and ensure:

By 2019, the people of Washington will be healthier because the state has collectively shifted from a costly and inefficient system for health care to aligned, person-centered primary care health systems approaches focused on achieving common targets for better health, better care, improved quality, lower costs, improved person and family experience, prevention, and reduction of disparities.

Washington's Opportunity

■ The Current Landscape

Washington has many of the building blocks to lead the nation in improved health, better care and lower costs. Washington is known for practice transformation, evidence-based medicine, and person and family engagement. Washington also is home to high-performing health organizations and best-in-class quality improvement initiatives, health information deployment, regional entrepreneurship, community collaboration, and innovative use of data. There is no lack of exemplary work underway across the state, including new payment and service delivery model initiatives, care coordination, disease management and utilization efforts, and primary care and community transformation. For example:

- Washington communities are engaged in a wide array of workforce-related initiatives. Efforts include: integrating fire, emergency services, nurses, community health and care workers to provide community based and transitional support for individuals; engaging a broader base of professional, allied and community based workers to assess and serve across traditional physical and behavioral health silos; and increasing workforce capacity through integration of skilled military veterans.
- The state is at the forefront of medical technology and research, with a booming biotech sector and innovative approaches to expanding evidence-based medicine and its spread.
- Washington is a national leader in supportive housing, an evidence-based practice that offers voluntary, flexible supports for those with psychiatric disabilities, allowing housing that is safe, affordable, and integrated into the community. This model has decreased costs in the Medicaid program and improved the lives of chronically homeless people with serious mental illness.

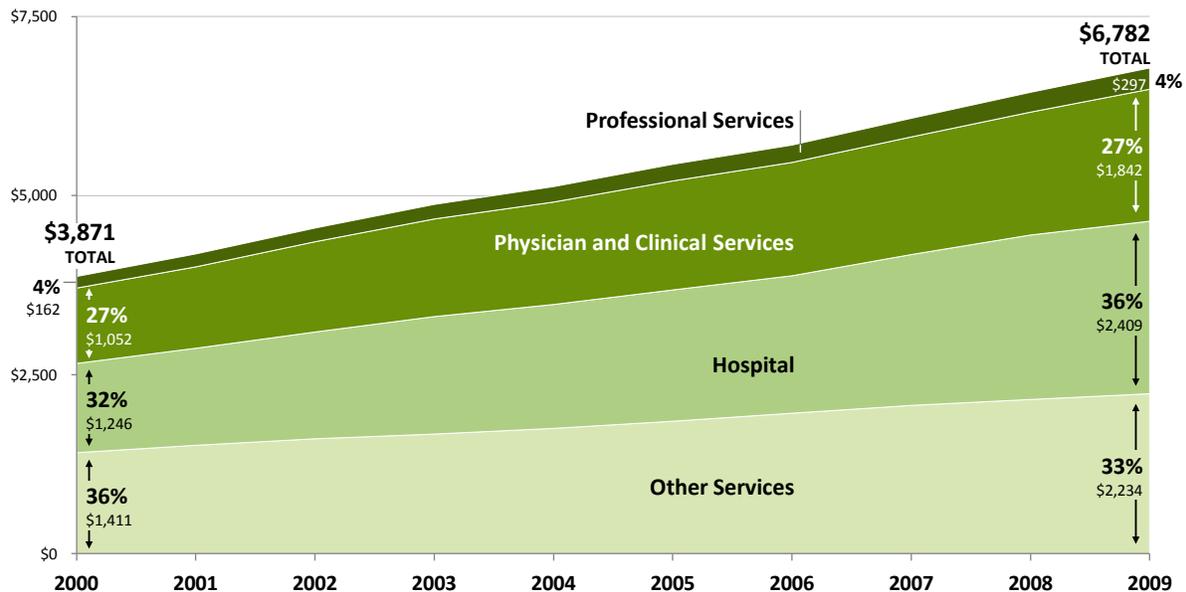
Despite these advantages, the present realities and trends in Washington are concerning.

- Personal health care expenditures in the state have grown from \$3.8 billion in 1980 (7.3 percent GDP) to \$45.4 billion in 2009 (13.6 percent GDP). Comparatively, national personal health care expenditures have grown from \$217.1 billion (8.0 percent GDP) to \$2.1 trillion in 2009 (15.1 percent GDP) and are approaching a projected 18 percent of the GDP. Washington's 7.3 percent average annual growth in health care expenditures is higher than the national average at 6.5 percent.³
- Consistent with national rates, Washington residents with serious mental illness die roughly eight to 25 years earlier than the rest of the population, and most of these premature deaths are caused by preventable chronic illnesses such as heart disease.

³ "Average Annual Percent of Growth in Health Care Expenditures." *State Health Facts*. The Henry J. Kaiser Family Foundation, 2 Nov 2013. Web. 3 Dec 2013. <<http://kff.org/other/state-indicator/avg-annual-growth-2/>>

- Washington’s leading underlying causes of premature death for residents younger than 65 years are primarily attributable to causes that are preventable and treatable.
- Washington has 375,000 children living in households with at least two adverse childhood experiences.⁴
- Washingtonians with fewer economic resources are at a higher risk for infant mortality, pre-term birth, suicide, coronary heart disease, hypertension, asthma, diabetes and smoking.
- Washingtonians with less education are more likely to have high cholesterol, insufficient nutrition, be smokers, and be obese.

Health spending per person by type of service, SFY 2000-2009



Source and Notes: CMS Office of the Actuary, Health Expenditures by State of Residence. Other Services includes the following: Dental Services; Home Health Care; Prescription Drugs; Durable Medical Products; Nursing Home Care; Other Health, Residential, and Personal Care. Other health professionals include non-physician providers such as nurse practitioners and physician assistants.

While there are many factors driving poor outcomes and increased health care costs in Washington, those with the most significant impact include the growing prevalence of chronic disease and obesity, unnecessary or overuse of certain procedures, use of more expensive treatment options, use of more expensive locations and types of providers for care delivery, and rate of treatment versus non-treatment.

Addressing areas of unmet need are a strong part of the value equation. Doing more of what existing evidence shows works for prevention and mitigation of disease will have enormous benefit for everyone and particularly for the state’s most vulnerable residents. Federal, State, and local community budgets benefit as well, particularly as many more individuals will be served via a combination of Medicare and Medicaid throughout their lifespans. Better health and lower cost opportunities are rife.

⁴ CDC, Morbidity and Mortality Weekly Report. Adverse Childhood Experiences Reported by Adults --- Five States, 2009. December 17, 2010 / 59(49);1609-1613 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5949a1.htm>).

Opportunities to address cost drivers—including using information to target higher-risk individuals; improving outpatient and community based prevention and management; improving price transparency; expanding the use of shared decision-making resources; encouraging the use of higher-value locations, providers and treatments; and improving access to high quality, affordable patient-centered primary care—will contribute to lowering costs or slowing the cost trend for everyone while improving quality and outcomes.

However, these opportunities face significant barriers that impede the progress of health care delivery system transformation. Many barriers are complex and deeply engrained, and must be addressed together in a more coordinated, systematic fashion.

Silos and Fragmentation

Washington’s current health system runs along multiple fault lines. The system remains largely siloed, with significant gaps in coordination between and among primary care and specialty practices; between and among ambulatory and hospital settings; and between and among primary care and behavioral health. Seamlessness of care for individuals with physical health, mental health, and/or substance abuse issues is widely recognized as desirable, but is often stymied by administrative, financing, and regulatory systems that have developed over many years when the essential interconnectedness of physical and behavioral health and well-being were not recognized.

Physical and Behavioral Health One Person, Multiple Administering Entities, Siloed Services

Administering Entity	Medicaid Benefits
Health Care Authority (HCA)/ State Medicaid Agency	<ul style="list-style-type: none"> Physical health Limited mental health (12/20 visits, will change post Jan. 1, 2014) Prescription drugs (excl. opiate substitution) Targeted health home services (high cost/high risk)
Department of Social and Health Services (DSHS)/ Division of Behavioral Health and Recovery (DBHR)	<ul style="list-style-type: none"> Chemical dependency (inpatient and outpatient) Mental health for people with serious mental illness (SMI), through Regional Support Networks
Department of Social and Health Services (DSHS)	<ul style="list-style-type: none"> Long-term services and supports Supports for people with developmental disabilities Targeted health home services (high cost/high risk)
Counties (under contract with DSHS/DBHR)	<ul style="list-style-type: none"> Regional Support Networks (as single counties or county partnerships) Outpatient chemical dependency
Tribes	<ul style="list-style-type: none"> Outpatient physical health Outpatient mental health Outpatient chemical dependency (under contract with DSHS/DBHR)

Similarly, oral health, long-term care, intellectual and developmental disability services and supports, and human services are not consistently connected to one another or to the physical or behavioral health systems.

Despite a host of innovative initiatives and programs, many providers and programs manage a distinct element of a person's or community's health, and are paid separately or not paid for at all. Many but not all systems have developed performance outcomes and goals that make sense within each sphere, but typically do not hold providers accountable for influencing overall health outcomes or expenditures. Broad gaps in measurement and accountability for the whole person create unclear expectations, ambiguous responsibilities with the delivery system, and uneven success in meeting the needs of individuals, families, and communities.

Too often individuals receive services from different State agencies and local providers with less than optimal coordination of care, supporting services, or recognition of the role of the community. State payment often is tied to the provision of distinct services, treatments, or interventions and therefore is not consistently oriented to prevention or performance-based outcomes. While Washington has made strides on these fronts, the efforts are at times duplicative or suffer from lack of a consistent approach and the infrastructure needed to effectively drive and measure improvement.

Broad gaps in measurement and accountability for the whole person create unclear expectations, ambiguous responsibilities with the delivery system, and uneven success in meeting the needs of individuals, families, and communities.

Savings in one silo or funding stream caused by intervention by another cannot easily be moved or shared to provide incentives to produce the outcomes desired. As such, there are few incentives for actors within the system to work collaboratively to meet complex needs. This unnecessarily frustrates individuals and families as they try to navigate in and across systems of care and social supports—and, more critically, can result in missed opportunities to prevent complications and unnecessary deaths.

These silos persist despite mounting evidence that the greatest expenditures and most preventable adverse health outcomes are associated with poor care coordination for individuals and families who have complex needs that cut across disciplines and are engaged with multiple systems.

They also create barriers to enabling lifelong health and recovery approaches to prevention and the larger social determinants of health. Health care systems have not yet consistently and fully embraced or adequately funded population health that promotes proactive, preventive health care—although this emphasis is emerging in many regional health organizations that are in various stages of development across the state, and has long been a hallmark of public health. Despite evidence supporting the benefit of prevention and community linkages, Washington does not yet have a health system that adequately considers social determinants—nutrition, environment, education, and housing, for instance—that impact overall health.

Finally, Washington's health care market is inundated with pilot programs and various one-off efforts that are not always well coordinated with one another. Many promising efforts are in early stages, not yet fully systematized, and do not have a clear path to sustainability or expansion. Aligned approaches that drive sustained and large-scale delivery system change have been slow to arrive. Washington's major commercial health carriers—while responsible for key innovations around payment—are fiercely competitive. The resulting diversity of payment methods, priorities, and performance measures perpetuate the silos dominant across the state's

health systems. In the face of such diversity, providers outside of fully integrated financing and service settings face difficulty in focusing on a common set of outcomes and moving toward outcomes-based payment systems—even where there is desire and a variety of incentives in place to do so. This marketplace diversity also leads to higher administrative costs for providers.

Dominant Payment and Benefit Design Models

Despite Washington’s reputation for innovation, the use of alternative payment models is not as prevalent in Washington as it is in other pioneering states. Individual payers have efforts under way—some more robust than others—to test aligning payment with value. But dominant payment methodologies used by health plans in Medicaid, Medicare, State-purchased, and commercial populations continue to be built on a foundation of fee-for-service reimbursement. Traditional fee-for-service payment provides little incentive for optimal prevention, efficiency, care delivery in lower-cost settings, population-based health strategies, or coordination activities that can lower costs or support improved health outcomes. As health care organizations continue to consolidate, fee-for-service payment systems dominate, and in some cases have become even more prominent.

Many large employers including King County, Boeing, and the State of Washington are leaders in working with their respective carriers and third-party administrators (TPAs) to improve value in health care. Their plans are beginning to feature episode-based payments, and contract incentives to reduce higher than desirable use of certain types of procedures, tests, or non-generic drugs. They also are rolling out new forms of payments to primary care and multispecialty groups that represent attempts to move away from what is largely a fee-for-service payment environment across the state.

Just as traditional payment models dominate Washington’s market, so do traditional approaches to benefit design. Individually, purchasers have begun to implement alternative, value-based approaches, but overall adoption is relatively slow and not fully capitalizing on the potential to engage individuals through benefit design. More commonly used benefit design models include reductions in premium or cost sharing for participation in wellness programs, value-based cost sharing for pharmaceuticals, and high-deductible health plans.

Washington as a whole is not characterized by the type of dominant and consistent purchaser leadership in driving collective or aligned benefit design changes, as is the case in some states. However, the Washington Health Alliance (formerly the Puget Sound Health Alliance) convenes its purchaser members regularly, through a group called the Purchaser Affinity Group, to identify innovative value-based purchasing strategies and how to implement them in the marketplace.

Health Information Infrastructure Supports

With the assistance of federal grants, Washington has made progress over the last several years in building a solid health information technology (HIT) and health information exchange (HIE) foundation. The rate of electronic health records (EHR) adoption among Medicaid providers has increased significantly, and EHR adoption by the entire system is above average compared to the nation as a whole—with 75 percent of Washington office-based practices adopting EHRs versus 57 percent nationally. However, as providers strive to meet the second stage of Meaningful Use requirements, broader HIE capacity to support interoperability is becoming increasingly important.

Health Information Exchange (HIE)

In Washington, the primary focus of HIE activities is support of direct delivery of services. Washington's HIE effort supports four core improvement elements:

- **Care coordination.** Deliver information needed by care team members at the point of service to effectively treat individual patients who receive services from a number of different providers.
- **Care management.** Deliver information to individuals and organizations responsible for managing the ongoing process of care over time.
- **Public health monitoring and surveillance.** Deliver to public health officials the information needed to monitor public health trends and events.
- **Consumer activation.** Deliver information to consumers about their care and the care of others they may be responsible for that allows them to be more effective partners in the care received.

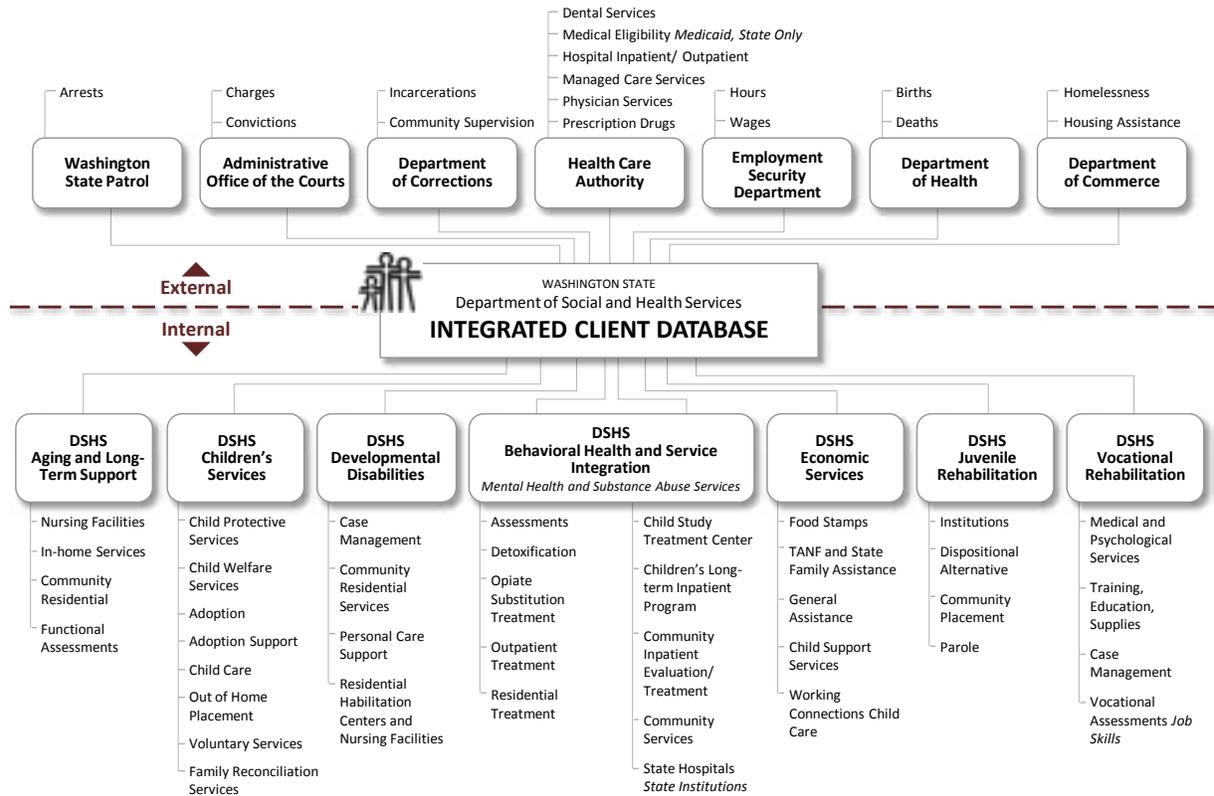
Washington's rapidly changing and diverse HIE environment ranges from providers with high-functioning EHR capabilities and their own clinical data repositories to providers still using paper. The state currently is engaged in efforts focused on expanding the tool set and a "data first" strategy.

- **Expand the tool set.** To complement the secure exchange infrastructure the HIE currently operates, Health Care Authority (HCA) and OneHealthPort, which manages the statewide HIE, are engaged in an exploration of a significant enhancement to the HIE. The two organizations are seriously considering acquiring a new HIE platform. This platform would add a clinical data repository, care management tools, a less resource-reliant EHR, and a patient portal to the current HIE capabilities.
- **Data First.** In considering whether to prioritize the deployment of care management tools or the collection of clinical data, OneHealthPort and HCA are considering a "data first" strategy. This thinking derives from 1) the precedence clinical data has over clinical data tools, and 2) the existing critical mass of clinical information infrastructure in the Washington market. The aspirational goal is that within three years every Medicaid encounter will result in a continuity of care document being sent to the HCA clinical data repository. Over time, the maturing of the clinical data repository will greatly enhance the ability of all parties to coordinate care, manage care and activate patients.

Electronic clinical information exchange is not yet a mature capability. Today, most parties are challenged to extract, exchange, and aggregate clinical information. The operating rules for this space are still very much in development. However, considerable progress has been made and there is a significant impetus to accelerate progress based on numerous investments and incentives arising from the private and public sector. The imperative is to start now, learn the hard lessons, mature the capability, and move forward. Washington will work to harness both traditional industry sources and more innovative solution providers in the quest to transform the health care marketplace.

Integrated Client Database

Washington is one of a few states in the nation with an integrated social service client database. This means Washington can use claims and encounter data to identify costs, risks and outcomes for individuals receiving services across State-funded social and health programs. The database already informs internal and external decisions, and is linked to other sources of information, such as crime, incarceration, and school and employment data.



Washington's advanced analytic capabilities are now being deployed using both Medicaid and Medicare claims data to monitor, track, and analyze health service utilization, medical expenditures, morbidity/mortality outcomes, and social service impact outcomes. The data (Medicaid and Medicare) are used to support cost-benefit and cost offset analyses, program evaluations, operational program decisions, geographical analyses, and in-depth research. Strict client confidentiality standards are in place to ensure protection of personal client information, in full compliance with HIPAA. Population estimates are available at many different levels of geography, including state, counties, cities, legislative districts, school districts, and census tracts. The information can be used to generate use rates by age, race, gender, and poverty levels for multiple geographic areas, enhancing the ability to make regional and local comparisons for policy purposes.

These capabilities must be further leveraged with the addition of real-time clinical information. New data efforts that incorporate the financial and clinical side of care will improve care management capacity in the community on a more real-time basis. As the state strives to pay for value over volume, with new payment methodologies that move off of unit-based, fee-for-service reimbursement, the need for better information around clinical encounters and outcomes associated is even more essential.

All-Payer Claims Database

Washington recently was awarded a federal grant to build an all-payer claims database (APCD). The grant funding will be used to improve and expand upon the Washington Health Alliance existing multi-payer claims database for collection and analysis of medical claims data, and reporting on the quality and cost of health care in Washington.

Since 2006, the Washington Health Alliance has published the WA Community Checkup, a community-wide—soon to be statewide—report on quality. Using nationally-endorsed quality measures, the Community Checkup compares medical groups and clinics on certain aspects of effective care, including for people with chronic conditions such as diabetes, heart disease and depression. Scores are drawn from the Alliance's large multi-payer database of claims data supplied by commercial and a few Medicaid health plans and self-insured purchasers, and represents about 2.5 million covered lives.

The new APCD will provide significant additional benefits to all stakeholders—consumers, purchasers, state agencies, and providers.

■ **Consumers:**

- Access to health care pricing and quality data for personal health care decision making.

■ **Purchasers:**

- Access to data for use in designing benefit plans and provider networks to drive higher value care.
- Benchmark provider performance to inform discussions and negotiations with providers.

■ **State agencies:**

- Better understand cost drivers of health care.
- Improve analyses of geographic variation.
- Improve analyses of access to care.
- Ability to analyze utilization by payer type.
- Payment reform and delivery system design for accountable care.
- Evaluate Qualified Health Plan rates.

■ **Providers:**

- Information for community-wide efforts to reform payment and delivery.
- Common source of metrics for “one source of truth” about provider performance.

With the addition of cost information, the APCD will become a community resource of comprehensive health care claims data from multiple sources, including Medicare, that informs improvements in the quality and cost of health care in Washington.

Washington plans to work with health care stakeholders to secure the necessary cost data, and will pursue regulatory and legislative action in 2014 and 2015 as necessary. By September 2015, new infrastructure for expanded access and reporting will be in place and public reporting will begin.

Infrastructure for data-informed clinical-community initiatives

While there have been great strides to integrate and utilize inter-agency data to inform care, including the aforementioned integrated client database, there is limited use of or access to data informing the provider of their patients’ physical and social environments that contribute to health. As Washington strives to cultivate a system able to improve health, it can benefit from information and data from across sectors, such as the Department of Health’s risk-based survey data, the Office of Financial Management’s Educational Research and Data Center, and community based data.

Competition and Collaboration

Washington’s health care market generally is competitive, particularly among delivery systems and public and private payers. Larger health care organizations have been moving to position themselves for longer-term success in an environment of more constrained resources and greater expectations, and in the shorter term, to maximize their revenues in light of anticipated reduction of historic fee-for-service and cost-based payment streams. Actions by these health care organizations include acquisitions of primary care practices, moving physicians into salaried positions, tying compensation to performance, and formation of integrated delivery networks and inter-organizational alliances designed to take advantage of economies of scale, enhance referrals, and capture market share. Washington is seeing increasing use of hospitalists and intensivists. Additionally, smaller, independent practices in urban centers are merging into larger health centers.

On the payer side, 61 insurance carriers are licensed or registered to sell health coverage in Washington. However, across public and private large, small, and individual commercial markets, Premera Blue Cross, Regence Blue Shield, and Group Health Cooperative and their subsidiaries are the dominant carriers, with approximately 80 percent of the commercial market collectively. In addition to the “big three” commercial carriers, Aetna, UnitedHealth Group, and Cigna are the major insurance plans.

Profile of Major Payers in Washington, in 2011

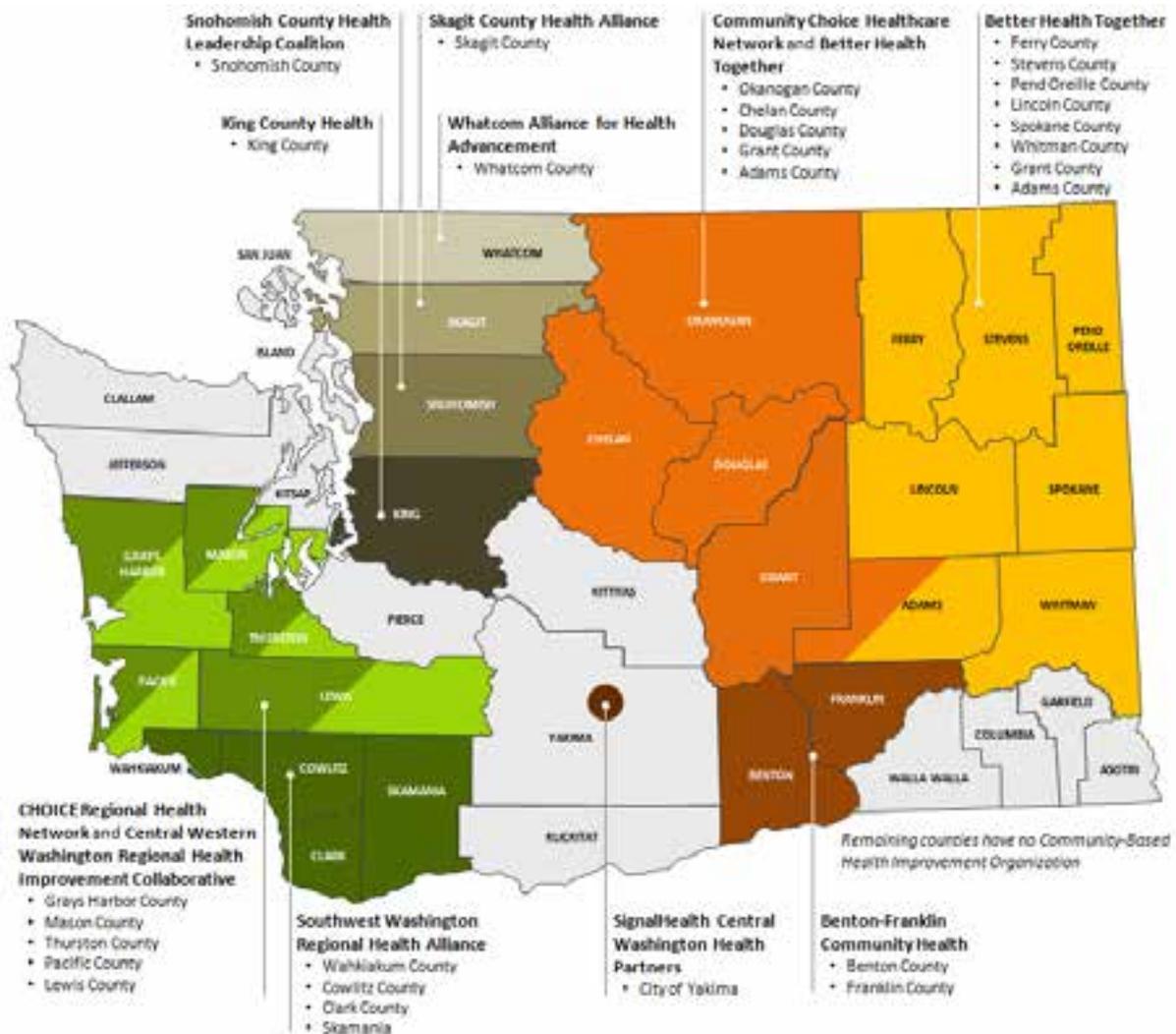
Plan	Enrolled Members				Utilization		Premiums
	Total	Commercial	Medicaid	Other	Ambulatory Encounters	Hospital Days	
Premera Blue Cross	660,917	402,855	—	258,062	4,206,230	100,759	\$1,912,321,823
Regence Blue Shield	548,970	366,671	—	182,299	10,239,603	96,339	\$1,621,840,694
Molina Healthcare of WA	411,206	27,819	377,347	6,040	2,371,047	77,296	\$ 753,893,764
Group Health Cooperative	335,826	218,799	—	117,027	1,344,313	83,723	\$1,590,759,500
Community Health Plan of WA	325,766	35,257	270,887	19,622	1,047,467	57,113	\$ 628,233,267
Group Health Options	208,023	204,262	—	3,761	681,559	30,183	\$ 757,184,129
LifeWise Health Plan of WA	112,459	112,459	—	—	811,843	13,058	\$ 244,727,670
UnitedHealthcare of WA	84,509	1,281	30,067	53,161	365,387	11,638	\$ 398,245,170
Asuris Northwest Health	63,301	48,312	—	14,989	956,423	9,783	\$ 186,777,286

Source: Annual statements from the Office of the Insurance Commissioner (09/12)

Amid a culture of competition, Washington boasts many respected collaborative efforts around evidence-based practice, quality and transparency, and community health. Entities such as the Dr. Robert Bree Collaborative, Washington Health Alliance, Foundation for Health Care Quality, Qualis Health, University of Washington AIMS (Advancing Integrated Mental Health Solutions) Center, the Health Technology Assessment program, as well as community collaboratives and Washington’s hospital, medical, and other professional associations are well positioned to better align with one another and provide a foundation for collaborative improvement across the state.

Already in place throughout most of Washington are community based health improvement organizations—ranging from formal regional health improvement collaboratives to developing community alliances—involving a wide range of interests and local entities beyond simply health care. These organizations often serve as platforms for cooperative efforts aimed at achieving better health, better care, and lower costs at the local level, and have records of accomplishment suggesting considerable capacity and willingness to support the transformation of Washington’s health system statewide.

Washington State Health Care Innovation Planning and Community-Based Organizations



The state's current community based organizations vary significantly and emerged largely as a result of local interest and initiative, using local funding, staff, and expertise. Historically, they have been connected to the state to fulfill specific programmatic needs. Many such community based organizations are interested in an evolved and strengthened relationship with the State, but emphasize that maintaining local identity, control, and the ability to set local priorities are key to any new partnership.

Washington's Opportunity

■ The Future State

Washington's State Health Care Innovation Plan will change how care is purchased, financed, delivered, and linked to communities. The plan also aims to align health systems with community transformation initiatives, and support the underpinnings of lifelong health. Throughout the Innovation Planning process and across stakeholder groups, there was agreement on two major points:

1. Washington must move away from a largely fee-for-service system that pays for activity to an outcomes-based system much more focused on delivering the best outcomes at the lowest possible cost; and
2. The state must focus on more than health care delivery. Eighty percent of health is determined by physical environment, health behaviors, and socioeconomic factors.⁵

High-quality, affordable, person-centered primary care is foundational. The plan has a strong focus on building cross-cutting infrastructure and deploying the strategies needed to foster strong and efficient primary care and preventive community systems, move care to less costly settings or methods while maintaining or improving health outcomes, reduce unwarranted variation and waste, support effective care management, and better integrate physical and behavioral health services. The focus on transparency, supportive systems, infrastructure, and performance measurement also will facilitate innovative approaches to the integration of oral health, long-term care, and disability services in the future.

The Innovation Plan recognizes health is a complex interplay of physical health; behavioral health; basic needs such as food, housing, education and employment; personal and family supports; welcoming communities; and quality of life—beginning at birth. Health and recovery services, without a strong foundation of equitable system supports and community services geared to sustain health, do not serve individuals as whole people. Additionally, without supports, such as payment models that incentivize outcomes, the system responsible for health cannot effectively deliver it. There are many interdependencies that lack a clear solution, and that are not the responsibility of any single organization or State agency. These complex problems require a new way of doing business that reaches across organizational silos. Washington's communities are ready to drive improvement. Synergistic health and recovery services, systems supports, and community services will be achievable on a much broader scale through implementation of the Innovation Plan.

⁵ Magnan, Sanne, et al. "Achieving Accountability for Health and Health Care." State Quality Improvement Institute, 2012. <https://www.icsi.org/_asset/hkt4a4/Accountable-Health-Communities-White-Paper.pdf>



In order to achieve effective interplay between systems and supports and reach across silos to achieve health and well-being for the whole person, Washington will pursue solutions that address broad populations and drive, reward, and measure a working health and health care system. Washington also will support innovation and market solutions that drive toward better health and better care at lower costs, using regulation only when necessary.



■ SECTION 2

Health System Design

Washington's Health Care Innovation Plan ■ System Design and Performance Objectives

Ultimately, Washington aims to broadly improve health and health care and lower costs. Within the context of the five-year Innovation Plan, the state's aims, primary drivers, and key actions are intentionally more focused and specific.

In order to achieve the aims, multiple payers, purchasers, providers, communities, and governments must act in complementary ways. The implementation of any one strategy by any one sector in isolation will not achieve transformative change. The Innovation Plan also recognizes it must build on where Washington is today, and with the state's unique environment and market in mind.

Strategies and Key Actions to Drive Progress

Washington will drive transformation through three primary drivers—or strategies:

- Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course. (See page 49)
- Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities. (See page 56)
- Drive value-based purchasing across the community, starting with the State as “first mover.” (See page 42)

Washington's Five-Year Plan for Health Care Innovation

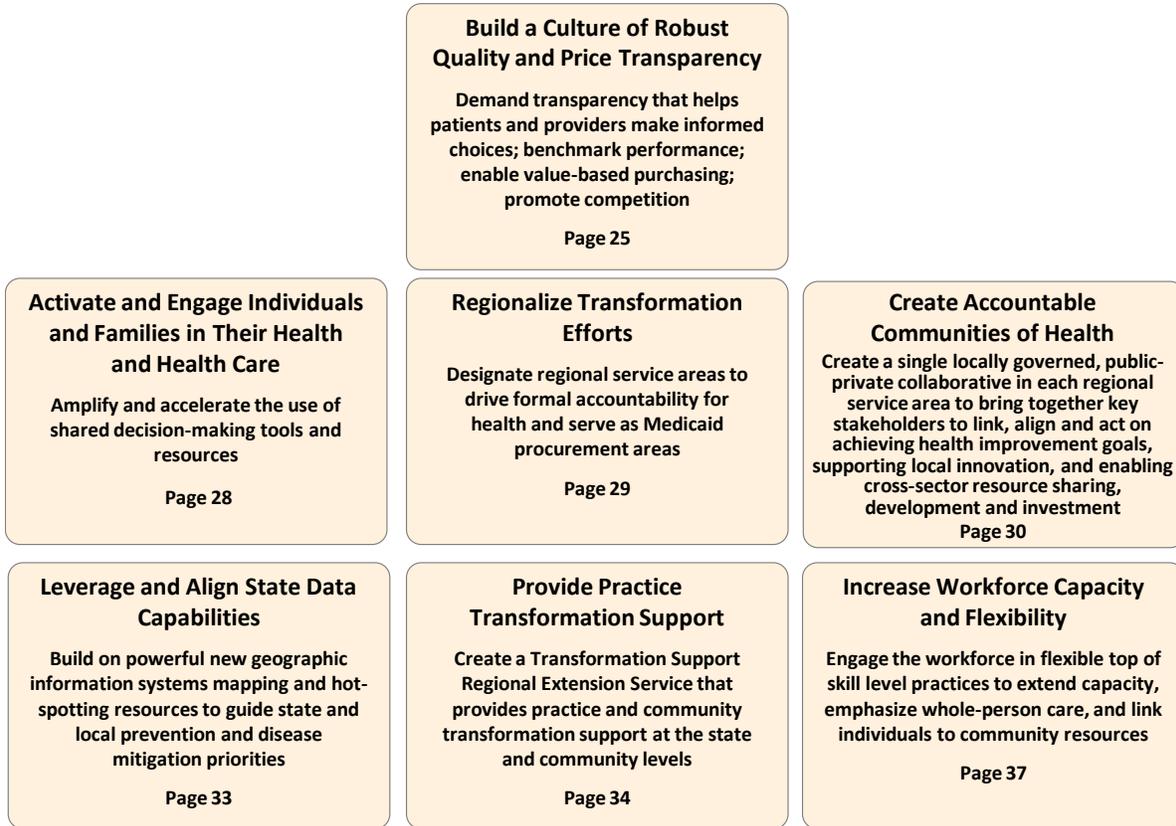


Measure Concepts

Healthier Residents and Communities	Physical-Behavioral Care	Cost Growth
<ul style="list-style-type: none"> Report good health Community resiliency scale Youth quality of life scale Children/adults at healthy weight Access to primary care Preventive care Children receiving vaccinations AHRQ Clinical-Community Relationship measures House Bill 1519 guidelines 	<ul style="list-style-type: none"> Reduction in mortality Tobacco/smoking cessation (all settings) Behavioral health assessment (all settings) Oral health assessment (all settings) Diabetes care Heart care Appropriate treatment for chronic conditions Mental health consumers receiving services after discharge Care transitions ED utilization House Bill 1519 guidelines 	<ul style="list-style-type: none"> Health expenditure trend Per capita health care costs Consumer affordability index Unwarranted diagnostic/medical/surgical procedures Inappropriate/unwanted nonpalliative services at end of life Use of generic prescription drugs Appropriate use of services

Specific key actions fall under each of these strategies, which rely on the creation and amplification of cross-cutting infrastructure and systems supports—the building blocks of Washington’s improved system.

Foundational Building Blocks for Transformation



The Innovation Plan’s core strategy is for the State to take a leadership role as a major purchaser and market organizer to drive transformation. In order to lead and link arms in partnership with private purchasers and organized labor, communities, providers, health plans, and others, Washington is using a variety of levers. While many of the Innovation Plan’s strategies center on non-regulatory strategies and incentives, the State is prepared to explore regulatory approaches should its initial market-based and collaborative tactics be less successful than expected.

Measuring Progress

Tracking, evaluating, and incentivizing progress toward the Innovation Plan’s five-year aims will depend upon measurement of both ultimate outcomes and intermediate proxies. The plan will bridge from measure concept to specific measures that evaluate not only ultimate impact, but continuously measure the effect of specific strategies and key actions through its program evaluation and implementation processes. This will allow for continuous, real-time learning at the state and community levels, as well as enable regular checking and adjusting.

Measure identification for evaluating the Innovation Plan will dovetail with the state’s initiative to hone the statewide measure set for use across key stakeholders. Final selection criteria for the latter will include preference for nationally endorsed measures, focus on overall system performance to the greatest extent possible, and mutually inform developing measure

frameworks, such as state health benefit exchange measures and House Bill 1519¹ requirements. Development also will address refinements for rural areas and diverse and low-income populations served within the Medicaid program. Importantly, as a strategic vision for health system transformation in the state, all Innovation Plan-related measurement—whether the statewide measure set or impact evaluation of the Innovation Plan—will inform and accelerate Governor Inslee’s goals and associated measurement² (see page 51).

In addition to health system impact measures, progress toward the Innovation Plan’s aims will be evaluated through process and operational metrics. These will build from the key milestones identified throughout the plan and presented in full in Washington’s Roadmap for Health System Transformation.

Innovation Plan Guiding Principles

Inclusive of the broader theme of alignment and connections between health and recovery services, systems supports, and community services, several major guiding principles underpin the Innovation Plan’s strategies in support of better health, better care, and lower costs.

- **Improve health equity.** Eliminating health and health care disparities will drive improved health outcomes and reduce costs. Broader coverage afforded through the Medicaid expansion and other health reforms is a necessary but insufficient step toward ensuring equitable access to care and other services. The strategies and infrastructure supports outlined in the Innovation Plan are directed to areas of particular inequity and anticipate resources devoted to monitoring access and outcomes for diverse individuals and populations across the state.
- **Encourage individual responsibility for maintaining and improving health.** Leading a healthy lifestyle greatly reduces a person’s risk for developing disease, can slow the progression of disease, and reduces the costs of treatment. The Innovation Plan’s strategies encourage and support activated individuals and families and ensure community supports, payment, and delivery mechanisms for health and prevention. Ultimately, individuals and families must play their part in maintaining a healthy lifestyle and obtaining appropriate preventive care needed to support health.
- **Acknowledge delivery challenges and opportunities in different geographic areas and for different population subgroups.** While the Innovation Plan addresses opportunities for broad population health improvement and significant cost and quality drivers, special attention is needed to address the specific challenges in different geographic areas of the state and for population subgroups. This may include tailored approaches for rural areas, small providers, and providers with unique needs to transform their care delivery systems and bolster community linkages. Additionally, Washington Tribes and tribal members, as sovereign governments and with unique access issues, require independent attention as plan strategies relate to their health systems and specific needs are implemented.
- **Recognize and encourage existing efforts to continue—but in a more aligned fashion.** While the Innovation Plan aims to fundamentally change certain elements of Washington’s current system, it encourages existing efforts, such as initiatives of community collaboratives and efforts to identify and use performance measures linking health and community.

¹ “Accountability Measures” (320, 28 July 2013)

² “Results Washington.” Washington State. Web. 3 Dec. 2013. <<http://www.results.wa.gov/>>.

- **Focus on building infrastructure and sustainability.** The Innovation Planning process allowed Washington the opportunity to be bold, aspirational, and innovative. The State is committed to addressing the barriers and pursuing the goals outlined in the plan. Transforming Washington’s payment and delivery system will improve health outcomes and therefore contain health care costs. But the plan recognizes that creating the system supports necessary to achieve this transformation requires substantial financial and in-kind investment. As such, the State must and will pursue funding and partnership opportunities—from federal grants to philanthropic endeavors—to deploy the strategies outlined in the Innovation Plan and develop mechanisms to sustain them.
- **Balance immediate and longer-term priorities and returns.** The Innovation Plan proposes goals and strategies that are achievable in three to five years, as well as those that will yield longer-term returns in population health and community vitality. Washington must take advantage of immediate opportunities to apply existing knowledge to ensure care is coordinated and appropriate, while encouraging ongoing innovation and investment for the future.
- **The Innovation Plan is a first step.** The Innovation Plan is simply a point in Washington’s innovation journey. While it provides a vision and five-year aims to transform the state’s health system, specific tactics to implement the plan are still being determined and honed. Washington will look to its partners at the local, county, regional, and state levels to help turn this vision into a reality.

Key Innovation Plan Terms

As with any transformative effort, the Innovation Plan introduces new concepts and designations. Many of the following terms function to consistently describe key concepts, and are subject to change as the Innovation Plan bridges to implementation. See Appendix B for a full glossary of terms.

Accountable Communities of Health (ACHs)

- An Accountable Community of Health (ACH) is a regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations.

Accountable Risk Bearing Entities (ARBES)

- Managed care plans, risk-bearing public-private entities, county governmental organizations, or other community-based organizations with a risk-bearing partner or the direct capacity to assume full financial risk (for physical and/or behavioral health). This term is used specifically in reference to future Medicaid procurement.

Behavioral Health

- This term is used to refer to both mental health and substance abuse.

Bi-Directional Integration

- Physical-behavioral health services integration and delivery. “Bi-Directional” refers to inclusion of behavioral health services in primary care settings, and physical health services in behavioral health settings.

Geo-Mapping or GIS Mapping

- In the health care context, a computerized and typically real-time geographic information system that is used to show on a map where and what health events or conditions occur in a

geographic area. It provides tools and applications to place and display items on a map with alternative ways to filter or amplify objects or conditions and view changes over time. This technology provides local contextually relevant information and can help support planning and interventions, identify potential health threats and trends, and be a valuable tool for collaborative health ventures.

Reference Pricing

- An innovative payment/benefit design element successfully used by several major purchasers including CalPERS and Intel. It is similar to a reverse deductible with the insurer paying the first part of the total allowed charge, and the enrollee paying the remainder. This requires price transparency to the enrollee. Typically used where there is significant variation in cost in the same markets without a difference in quality, and with procedures that can be scheduled.

Social Determinants of Health

- The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

Tiered Networks

- A health plan delivery system and benefit design structure through which purchasers can continue to offer a larger health plan network to enrollees, but out-of-pocket costs will vary based on the ability of the chosen facility or service provider to deliver value (better outcomes and lower costs).

Transformation Support Regional Extension Service

- The convener and coordinator of practice transformation services and clearinghouse of tools and resources modeled after the “primary care extension program” outlined in section 5405 of the Affordable Care Act. The extension service design envisions a central coordinating “hub,” and community-based “spokes.” Local extension agents will provide supports required for practice transformation through facilitating and providing assistance for implementing quality improvement or system redesign necessary for high-quality, cost-effective, efficient, and safe person-centered care.

Value-Based Payment

- Value-Based Payment (VBP) is a broad class of strategies used by purchasers, payers, and providers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to health outcomes. Examples of such payments include pay-for-performance programs that reward improvements in quality metrics; bundled payments that reduce avoidable complications; global arrangements that tie upside and downside payments to specific quality targets, in addition to actual to-target-cost trend rate. VBP programs share a common objective of slowing the increase in the total cost of care by encouraging a reduction in the reported 30 percent of wasted health care dollars.



■ SECTION 3

Washington's Innovation Model

Foundational Building Blocks and Transformative Strategies

Washington is committed to achieving better health, better care, and lower costs for its residents, employers and communities. The State will lead and strategically partner with public and private entities to fundamentally reorient payment toward value rather than volume, incentivize care delivery redesign, and enable regionally centered organizations that support necessary linkages and alignment around prevention and community health improvement and cross-sector resource sharing.

To achieve the five-year aims of the Innovation Plan, the state will deploy three interrelated and transformative strategies:

1. Drive value-based purchasing across the community, starting with the State as “first mover.”
2. Improve health overall by building healthy communities and people by prioritizing prevention and early mitigation of disease throughout the life course.
3. Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities.

The State will enter a new era of health care purchasing with greater levels of accountability through a phased regional Medicaid procurement that incentivizes patient-centered primary care and delivery systems to serve the whole person, as well as statewide progression of traditional fee-for-service models toward outcomes-based purchasing. Additionally, Washington will shift from a “sick-care” system that permeates much of the country to a system focused on prevention of disease and strong linkages between communities, public health and the delivery system.

The three strategies will rely on the creation and amplification of cross-cutting infrastructure and systems supports—the “building blocks” of Washington’s improved system. The three transformative strategies, bolstered by these seven building blocks, will drive re-engineering of health care purchasing, financing, delivery, and links to community resources. As a result, Washington will move toward an equitable, efficient, and person-centered health system.

Intersection of Innovation Plan Strategies and Foundational Building Blocks

Dot size and shade indicates anticipated level of building block impact on achieving strategy

		STRATEGY 3 Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities		
		STRATEGY 2 Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course		
		STRATEGY 1 Drive value-based purchasing across the community, starting with the State as “first mover”		
SEVEN BUILDING BLOCKS	Quality and price transparency			
	Individual and family engagement			
	Regionalize transformation			
	Create Accountable Communities of Health			
	Leverage and align state data			
	Practice transformation support			
	Workforce capacity and flexibility			

Seven Foundational Building Blocks

Transformation depends upon the development and strengthening of fundamental capabilities and supports across Washington’s health system. Washington’s seven foundational building blocks enable Washington to realize its three transformative strategies to accelerate change at the delivery system and community level.

Foundational Building Block 1 Build a Culture of Robust Transparency

Health transformation requires significantly greater transparency. Value-based payment rests firmly on a foundation of transparent, accessible data and accurate measurement. It can help inform benefit and network design, and consumer choice of plan and provider. It is an essential element of clinical performance improvement. Population-level data is foundational for community-wide improvement of population health and reduction of disparities. Performance transparency ensures that all participants understand how they and the overall system are doing. Washington’s plan demands a new level of transparency that:

- Helps patients and providers make informed choices about care.
- Enables providers and communities to learn and improve by benchmarking their performance against that of others and by shining the light on best practices.
- Enables purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time.
- Promotes competition based on outcomes.

Washington’s transparency initiative heavily emphasizes development, accurate measurement and reporting of common measures around quality and value, while making this information accessible and understandable to providers, purchasers and consumers.

Develop a statewide measure set. Washington is continuing its initiative to hone the high-value performance measures that will be included in a state-wide measure set for use across key stakeholders to evaluate performance and progress. The common measure set builds from the measure specifications identified in the Public/Private Transformation Action Strategy (Appendix C) and will include dimensions of prevention, effective management of chronic disease, and use of the lowest-cost, highest-quality care for acute conditions. The measure set will:

- Be of manageable size.
- Give preference to nationally endorsed measures (e.g., National Quality Forum).
- Be based on claims data initially, progressively adding measures based on clinical data.
- Focus on the overall performance of the system (e.g., outcomes, functionality and total cost) to the greatest extent possible.
- Be aligned with Washington State’s Health Benefit Exchange measures, Governor Inslee’s performance management system measures, and common measure requirements specific to Medicaid delivery systems under recently passed Washington State House Bill 1519.
- Consider the needs of different stakeholders, the populations they serve, including challenges of low census in some diverse communities, smaller sites of care, and rural areas.

- Be used broadly by multiple payers, providers, and purchasers, as well as communities where applicable, as part of health improvement, care improvement, provider payment systems, and benefit design.

Potential Statewide Clinical Measure Set, Measure Concepts

Prevention and Screening	Chronic Conditions	Acute Conditions
<ol style="list-style-type: none"> 1. Proportion of adults with a healthy weight 2. Proportion of adults with healthy blood pressure 3. Proportion of children with a healthy weight 4. Proportion of the state population <ul style="list-style-type: none"> • That is tobacco-free • With no substance abuse • Current on evidence-based immunizations • Screened for serious infectious disease (HIV, Hepatitis C) • Screened for behavioral health issues • Assessed for oral health problems • Current on evidence-based cancer screening • With a designated primary care provider 5. Infant mortality rate 6. Incidence rates of newly diagnosed advanced stage cancer 7. Death rate from cervical, breast, colon, and lung cancer 8. Death rate from drug and alcohol abuse 9. Death rate from suicide 10. Projected life expectancy and quality of life 11. Per capita spending on treatment of preventable conditions 	<ol style="list-style-type: none"> 1. Proportion of individuals with one or more chronic conditions whose health care is being well managed 2. Proportion of individuals with a chronic condition who have a medical/health care home 3. Proportion of individuals with depression, mental illness, or chemical dependency participating in a treatment program 4. Rate of avoidable emergency room usage for individuals with chronic conditions 5. Rate of avoidable hospitalizations for individuals with chronic conditions 6. Rate of avoidable hospital readmissions for individuals with chronic conditions 7. Ratings by individuals of their experience with the care they have received 8. Use of palliative care vs. treatment at end of life 9. Ratings by individuals with chronic conditions of their health and ability to function 10. Activation (patient engagement) level of individuals with chronic conditions 11. Total cost of care for individuals with chronic conditions, risk adjusted 	<ol style="list-style-type: none"> 1. Rate of ER usage for non-urgent conditions 2. Proportion of generic drugs prescribed (when generic alternatives exist) 3. Proportion of initial births delivered vaginally 4. Proportion of babies born full term and at normal birth weight 5. Rate of high-tech diagnostic imaging, particularly for conditions such as low back pain 6. Proportion of patients <ul style="list-style-type: none"> • Reporting good outcomes from procedures • Who die following major procedures 7. Proportion of providers with published episode prices for common procedures 8. Total spending (by purchaser and by patient) per episode on common procedures, risk adjusted 9. Variation in total risk-adjusted spending by provider organization (cost of care) per episode on common procedures 10. Per capita rate of procedures, risk adjusted, for procedures where evidence exists that there is overuse nationally 11. Per capita spending on most common acute conditions, risk adjusted

Source: Public/Private Transformation Action Strategy. See Appendix C.

Collect and report statewide data. To drive *system-wide* improvement in quality and lower cost, public and private payers alike must actively use the statewide measure set, contribute cost and quality data to Washington’s planned all-payer claims database, and support public reporting on

common performance measures. Data will be more readily accessible to stakeholders for measurement and analysis of progress toward goals while supporting continuous improvement and elimination of unwarranted variation. The data collection mechanisms will be chosen with consideration for the time and cost involved in data collection and the benefits to be achieved from measurement. Implementing legislation is under development.

Make quality and cost of providers and services transparent for all stakeholders. Individuals, purchasers, providers, payers, and communities will have access to reliable and comparable information about variation in quality and price using a core, statewide set of high-value measures. In some instances, this will require a common definition of procedures and services covered in “episodes or bundles of care,” and methods of attributing care to providers and provider organizations. Cost and quality reports for consumers will be culturally appropriate, in plain language, and at a summary level. Analyses will be conducted and shared to:

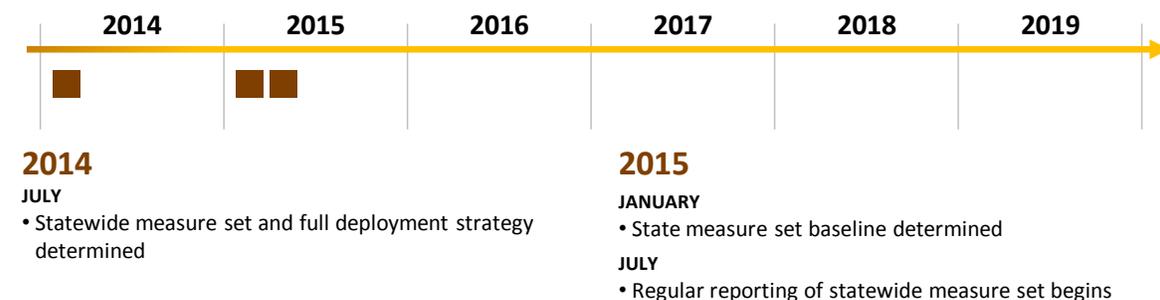
- Identify and recognize providers and health systems delivering efficient, high-quality care, and enable purchasers and consumers to direct business to these systems.
- Identify unnecessary variation in care and other opportunities to improve quality of care and reduce cost.

Wherever possible with the data available, measures will be stratified by demography, income, language, health status, and geography to identify both disparities in care and successful efforts to reduce disparities. All data with patient-specific information will be stored and used in ways that protect patient privacy.

Develop innovative methods for consumers to access and understand information. An all-payer claims database, disease registries, and other mechanisms will enable more sophisticated users to access and interpret data. Much of this information is also important for individuals and families, yet often hard to digest for lay audiences. This will be addressed through specific requirements for health plan cost calculators in State procurement contracts, and planned development of a common major purchaser RFP outlining this requirement. Using the Consumer Rating System in the Washington Health Benefit Exchange, qualified health plans will voluntarily submit quality information for display in the Washington Healthplanfinder beginning in October 2015. Other factors could be collected around value-based payment methods, additional quality measures or other factors, should the Exchange’s board choose to expand the Consumer Rating System.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Transparency Milestones



Foundational Building Block 2: Activate and Engage Individuals and Families in Their Health and Health Care

Washington will create and support resources, tools, and wellness programs to ensure state residents are activated and informed consumers of care and in control of their own health. A key strategy is to build upon Washington’s pioneering work in shared decision making. The first focus will be on shared decision making in maternity care. Washington will be among the initial users of the first national maternity care shared decision-making initiative, aimed to give women and their providers evidence-based and personalized support to help women make informed decisions about their care, including decisions about elective induction and cesarean section.¹ The anticipated continued build out includes state certification, and development and use of decision aids in other preference-sensitive areas. Strong consideration will be given to current and future focus areas of the Dr. Robert Bree Collaborative, including joint replacement and end-of-life care and preferences. As part of this initiative, health care providers will be offered practical online, self-paced training in shared decision making.

While amplified shared decision making is a key component of Washington’s individual and family engagement strategy, other patient activation approaches include:

- Developing methods for consumers to access and understand quality and price information. This includes requiring contractors of state-financed health care to provide consumer cost calculators and using the Consumer Rating System in the Washington Health Benefit Exchange to access quality data.
- Encouraging and supporting the use of Choosing Wisely² information and tools by professionals and employers. This might include the adoption of employee materials such as the National Business Group on Health’s What to Reject When You’re Expecting,³ or local development of similar evidence-based materials, drawing on state and national resources and expertise.
- Supporting the ability for individuals and families to make the easy choice the healthy choice by supporting communities in developing healthy social and physical environments.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION Key Individual and Family Engagement Milestones



¹ "Maternity Care Shared Decision Making Initiative." Informed Medical Decisions Foundation. Web. 3 Dec 2013. <<http://www.informedmedicaldecisions.org/shared-decision-making-in-practice/maternity-care-shared-decision-making-initiative/>>.

² "Choosing Wisely." ABIM Foundation, n.d. Web. 2 Dec. 2013. <<http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx>>.

³ "What to Reject When You're Expecting: 10 Procedures to Think Twice About During Your Pregnancy." *Consumer Reports*. Feb 2013. Web. 2 Dec. 2013. <<http://www.consumerreports.org/cro/2012/05/what-to-reject-when-you-re-expecting/index.htm>>.

Foundational Building Block 3 Regionalize Transformation Efforts

At present, regional service areas are different for many State-financed health care, social supports, and other essential State services. For example, the Health Care Authority, the Department of Social and Health Services, the Department of Health, the Department of Labor and Industries, and the Department of Early Learning all use different service areas for varying programs and purposes that affect health and/or health care delivery. Some boundaries are important to preserve and are the province of local government (such as local health jurisdictions), but others deserve re-examination with an eye toward creating more alignment and synergy across the state.

Washington will designate no more than nine regional service areas to drive increased coherence within naturally occurring communities of health. These regional service areas will drive accountability for health by defining the structure for health and community linkages, be a foundational component of a State “Health in All Policies” approach, and serve as new Medicaid service areas for physical and behavioral health. Over time, Washington will consider using a similar construct for other health and human services programs.

This approach recognizes health care is local and aims to empower local and county entities to develop bottom-up approaches to transformation that apply to community priorities and environments, guided and supported by state goals and supporting resources. Given this critical role for regional stakeholders, including counties, health collaboratives, public health jurisdictions, and providers, the process for determining regional service areas will be highly collaborative and consensus driven. This process will be a first priority of Innovation Plan implementation as it will provide an essential framework for Medicaid procurement and strategies related to clinical-community linkages through Accountable Communities of Health.

Seven-Region Straw Man for Future Dialogue



SOURCE: Health Home Network Coverage Areas: Health Care Authority, DSHS Aging and Long-Term Support Administration.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Regionalization Milestones



2014

JANUARY

- Begin regional service area designation process, with high priority on engagement from counties, community entities, providers and other key stakeholders, as well as tribes

SEPTEMBER

- Regional service areas defined

NOVEMBER

- Key State agencies ensure alignment with regions

Foundational Building Block 4: Create Accountable Communities of Health

Ensuring individuals and families have person-centered, coordinated health and social services and addressing the determinants of health requires a collaborative community approach. Each element demands cross-sector focus on shared outcomes, wise resource use, and upstream investment. An Accountable Community of Health (ACH) provides the forum and organizational support to achieve transformative results through collaboration.

What is an Accountable Community of Health?

An ACH is a regionally governed, public-private collaborative or structure that supports mutually agreed-upon, aligned actions across sectors and systems. ACH participants are envisioned to include public health, health, housing, and social service providers; risk-bearing entities; county and local government; education; philanthropy partners; consumers; Tribes; and other critical actors within a region. These members link, plan, and act on achieving health improvement goals and cross-sector resource sharing, development, and investment. The precise organizational and governance structures will not be dictated at the State level, because they should be determined in collaboration with parties in the region. As a general principle, however, no single entity or sector may dominate the agenda or have majority control. Additional key principles for the formation and governance of ACHs are discussed in Appendix E, which outlines next steps in development including broad stakeholder engagement.

The ACH is **not** intended to:

- Be a one-size-fits-all approach.
- Add “approval” layers or act as a regulatory body.
- Supplant government entities, such as local public health jurisdictions.
- Divert state general funds otherwise going to local entities.

What are the Accountable Community of Health Responsibilities?

Partner in Medicaid Purchasing

- The Medicaid program, particularly as it moves to support whole-person care and a growing number of adults and families, will demand greater partnership among State and local government, health care, and community-based organizations. Today’s behavioral health systems and supports are particularly interdependent, and these interdependencies

must be reflected in procurement design, assessment, and subsequent oversight. Medicaid procurement therefore will be reorganized into regional service areas that correspond with boundaries defined by ACHs. This regionalization will enable direct ACH representative engagement in development of statewide procurement objectives to ensure they address regional needs and perspectives, including those of local government, public health, providers, and communities. Washington also envisions engaging the ACH in assessment of accountable risk-bearing entity (ARBE) RFP responses for its specific region to inform the State's decisions around which ARBEs best meet the needs of the community. Additionally, the plan envisions that each ACH will be a meaningful partner with the State in providing on-going oversight of the effectiveness of the ARBEs in its communities to address gaps in service and quality of care.

- This expanded role for the ACHs will require thoughtful development and application of strict conflict of interest policies to exclude any potential bidder involvement, or the potential for self-dealing. While Washington's new procurement approach is built upon community engagement, the State retains ultimate responsibility for selection and oversight in the procurement and bears legal and financial responsibility.

Develop a Region-Wide Health Assessment and Regional Health Improvement Plan

- ACHs will be expected to complete a region-wide health assessment and planning process. The ACH framework envisions that this process will be led by the participating local health jurisdictions but will draw upon and reflect the strengths and insights of other ACH participants. Ideally, these assessments would also satisfy requirements for non-profit community benefit needs assessments and public health jurisdiction accreditation in a streamlined approach. The regional health assessments provide the basis for Regional Health Improvement Plans that align with state priorities and identify community health priorities.

Drive Accountability for Results through Voluntary Compacts

- The Regional Health Improvement Plan as envisioned will focus on outcomes outside the direct control of any one service provider or funder. The parties therefore will mutually recognize what actions they agree to take. Working together in this way is often referred to as a "compact," where each party has voluntarily aligned its actions. The ACH is envisioned to function as the primary regional vehicle for developing and coordinating this type of "compact" accountability. ACHs as non-regulatory entities must embody the following collective impact principles: common agenda development; mutually reinforcing, individually differentiated activities; shared measurement of progress; consistent and open communication; and backbone support through adequate staffing.⁴ The Collective Impact model is discussed in Appendix E.

Act as a Forum for Harmonizing Payment Models, Performance Measures, and Investments

Using a collective impact approach, ACHs potentially can work with all partners to:

- Strategize how to reduce existing and future administrative burdens and duplication and streamline regional activities.
- Accelerate implementation of new, innovative delivery and payment models that will aid provider groups in achieving better health for the region in partnership with community partners that align with the goals of the Innovation Plan.

⁴ Hanleybrown, F., Kania, J., & Kramer M. *Channeling Change: Making Collective Impact Work*, Stanford Social Innovation Review. (January 2012) Collective Impact Model; John and Mark Kramer, *Embracing Emergence: How Collective Impact Addresses Complexity*, Stanford Social Review <http://www.fsg.org/tabid/191/ArticleId/837/Default.aspx?srpush=true>

- Review and understand data to address health and community needs, and continuously improve quality as well as inform process for alignment and partnership at the ACH level. The ACH also can help mobilize and communicate the analysis of the data out to communities and other interested parties that could directly or indirectly impact health.
- Be the forum in which strategic cross-sector investments are negotiated. If savings are anticipated, the ACH can play a role in negotiating how savings will be distributed and perhaps reinvested. This might include opportunities resulting from agreements with ARBEs or innovative funding mechanisms that enable cross-sector investment in projects such as supportive housing with anticipated future return on investment
- Work to integrate health information exchange (HIE) efforts. In some cases, the ACH may be the organizer of a regional HIE, if necessary. ACHs can be the agent that moves forward HIE adoption as a community standard, especially around a shared care plan for high-risk individuals.

Health Coordination and Workforce Development

- When feasible to effectively support local community resource needs, an ACH could identify and facilitate shared workforce resources to build effective pathways for those community members most at risk. Examples include but are not limited to shared intensive case management, care coordination, and community health workers. The ACH also could serve as a forum to assure a continuum of crisis outreach, diversion, and involuntary commitment services is in place across the region to improve delivery of the services and reduce duplication or gaps in service.

“As a long-time Medicaid partner of the State of Washington, we applaud these efforts to improve health outcomes while also being a responsible steward of taxpayer dollars. ...We have seen the significant impact that can come from coordinating patients’ care through better performance measures, transparency, and ongoing exchange of health information.”

— Bela M. Biro, President
Molina Healthcare of Washington

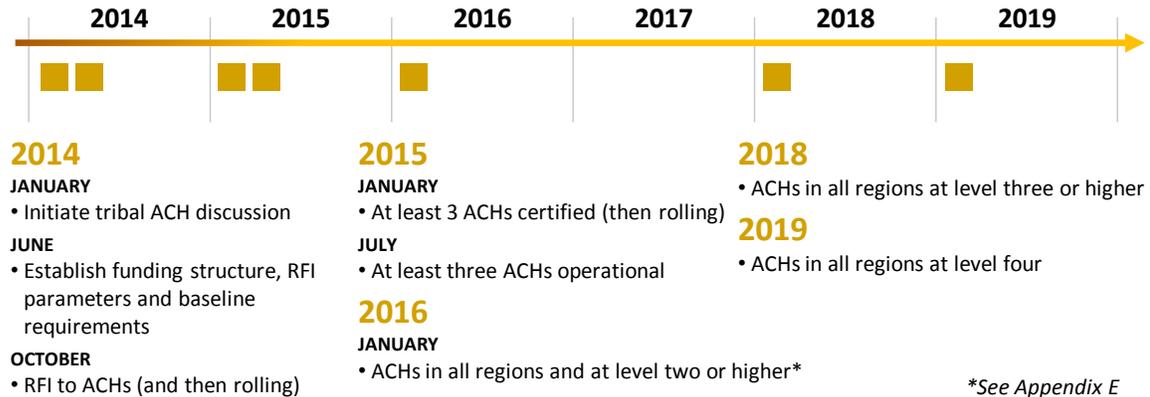
What are the State’s Responsibilities to ACHs?

Improved cross-sector results at the local and regional level demands adequate funding, aligned State policies, a more collaborative and supportive approach to Medicaid procurement, actionable data and transformation support, and investment vehicles for high value innovation initiatives. To better enable the ACHs to drive health improvement in a region, the State proposes to:

- Invest in the ACHs by providing funding and technical support for organizational development and maturation.
- Amplify its “Health in All Policies” approach to drive consistent health priorities across multiple State agency policies, and better align agency activity across the regions.
- Engage ACHs in Medicaid procurement design, assessment, and meaningful oversight as described above.
- Ensure the Washington Health Mapping Partnership (Appendix F) is designed with local public health and community leaders, and provides data and tools needed to support community hot-spotting efforts and cross-sector policy decisions.
- Cultivate and provide access to “best in class” transformation support tools through a combination of regional and statewide resources and learning collaboratives that encourage the capturing, sharing, and spread of best practices.
- Explore new financing tools and seed funding for cross-sector innovation in partnership with regional partners.
- Check and adjust as experience is gained, in collaboration with stakeholders and government partners.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Accountable Communities of Health Milestones



Foundational Building Block 5

Leverage and Align State Data Capabilities— Washington’s Health Mapping Partnership

Washington’s ACHs will serve two linked objectives: improving health and outcomes, particularly for those with complex health needs, and supporting regional and local capacity to improve the community features that shape the health and well-being of Washington residents. The strategies to achieve both of these objectives must be informed and guided by user friendly data. Success will flow in part from the ability to hone and target initiatives to make the best use of available resources.

Washington has significant capabilities when it comes to data and analytics related to state-provided health and social services. Washington proposes to leverage these capabilities by:

1. Partnering with world renowned experts at the University of Washington and local public health leaders to develop a new toolbox of data, capabilities, and technical assistance in support of the ACHs and local communities, and
2. Continuing to deepen the state’s underlying data pool and analytic capacity.

$$\text{Sophisticated Data Analytics + World Renowned Health Mapping} = \text{New Insight + Targeted Community Approaches}$$

The Institute for Health Metrics and Evaluation (IHME), based at the University of Washington, has agreed in principle to partner in this initiative. IHME has worked with the World Bank and other global and national policymakers to develop and deploy new data-driven tools and techniques to measure population health status and disease burden, and enable targeted and successful interventions. It has pioneered methods to pinpoint the specialized needs of local communities by creating new ways of measuring health challenges in small areas. The IHME Geographic Information System (GIS) combines powerful data sources, methodologies, and mapping capabilities. GIS mapping provides new ways of “seeing” and improving health outcomes in targeted areas with poor health and social indicators.

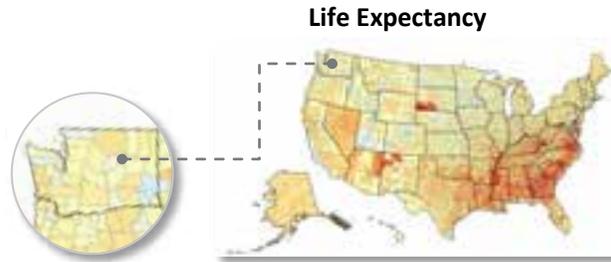
Washington’s strategy for transformation fuses these mapping capabilities with a further build-out of data resources to develop a statewide baseline and deepen the local toolbox for population health improvement. These resources will strengthen existing data-analytics capabilities at the regional level. They will provide local public health and community leaders

with tailored support in achieving state and local health objectives, recognizing that underlying local analytical resources and capabilities vary across the state. In some regions, an analytics role is well established within local health jurisdictions that already brings together currently available state data with other relevant data sets at the regional/local level. Examples include Homeless Management Information System (HMIS) data, jail health data, crisis system data, emergency medical services data, and housing data. In other regions, the partnership offers not only enhanced mapping tools and augmented data, but can also provide consultation and technical assistance to help build and develop needed capacity and analytics. See Appendix F for more on Washington’s Health Mapping Partnership.

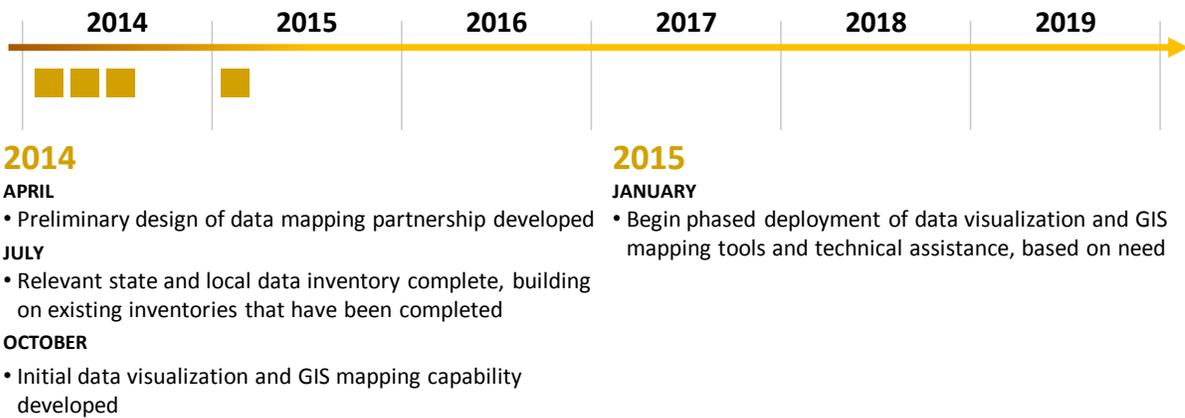
Washington State Specific Detail

Innovation Plan will permit mapping of data by census tract/small areas to illustrate prevalence, hot spotting, and regional trends

Screen shots captured for purposes of illustration only from the IHME website:
<http://www.healthmetricsandevaluation.org/tools/data-visualizations>



**ROADMAP FOR HEALTH SYSTEM TRANSFORMATION
 Key Mapping Partnership Milestones**



**Foundational Building Block 6
 Provide Practice Transformation Support**

Washington has an array of exemplary public and private entities and organizations that currently provide practice and community transformation support. These initiatives are at times duplicative, do not address all high-impact priority needs, and many must either build or make do without “boots on the ground” capabilities across the state. To align and amplify the many programs currently providing support, the State will create the Transformation Support Regional Extension Service, operating at the state and community levels. The extension service model is an evidence-based approach, outlined in the Affordable Care Act.⁵

As a statewide transformation “hub,” the Transformation Support Regional Extension Service will be well connected to the state and national pulse. It will serve as a convener and coordinator of the state’s Innovation Plan transformation support initiatives and clearinghouse

⁵ “Patient Protection and Affordable Care Act” (PL 111-148, 23 March 2010)

of tools and resources. At the community level, the “spokes,” or Transformation Support Regional Extension Agents housed within Accountable Communities of Health, will provide supports required for practice transformation. This will be achieved through facilitating and providing assistance for implementing quality improvement or system redesign necessary for high-quality, cost-effective, efficient and safe person-centered care.

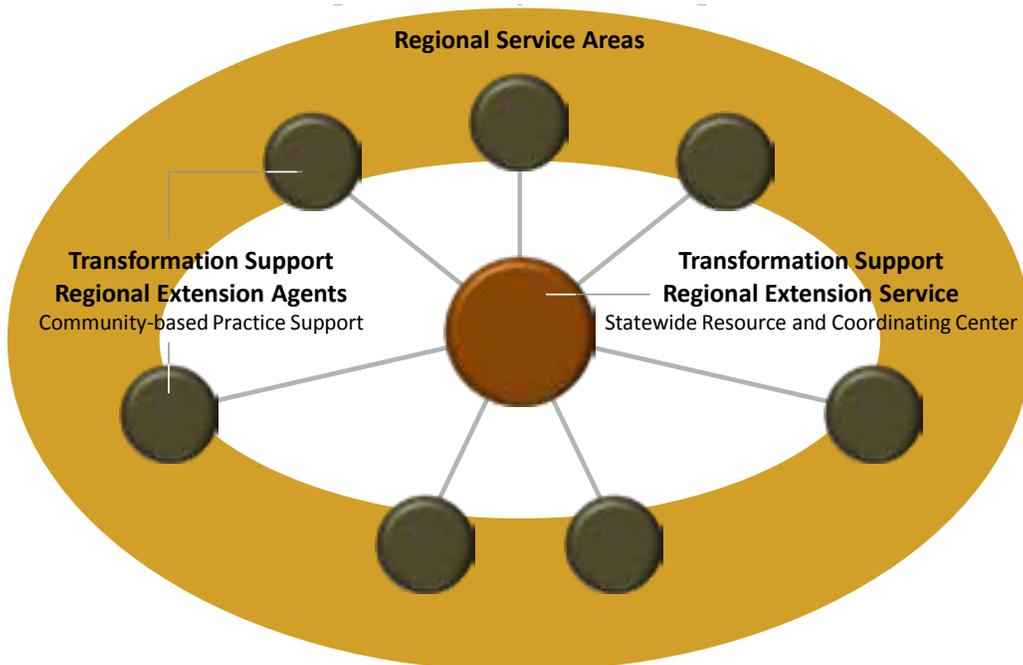
The initial priorities of the Transformation Support Regional Extension Service will be as follows:

- Assemble and make available a strong portfolio of transformation support programs, tools, and resources, drawing from best in class state and national transformation support entities. These may include resources and information around shared decision making, physical-behavioral health integration, delivery of oral health preventive services in primary care settings, or common statewide performance measures.
- Enable community-based practice support around health information exchange utilization and data-driven quality improvement.

In addition to the initial efforts at the state level and in every community “spoke,” the Extension Service may use one of its spokes to test practice transformation in a more challenging, but critical area of support, such as team-based clinical improvement and information sharing across physical and behavioral health. Learnings from this early model would be spread as more of the “spokes” take on these challenging areas.

As proof of concept is established and capacity increases, the Extension Service will be positioned to expand its scope to address evolving needs of the state or priorities of individual communities (e.g., grant application training and capacity building; resources and support for community entities that wish to assume risk) as determined by Regional Health Improvement Plans or otherwise.

See Appendix G for more information on the Transformation Support Regional Extension Service.

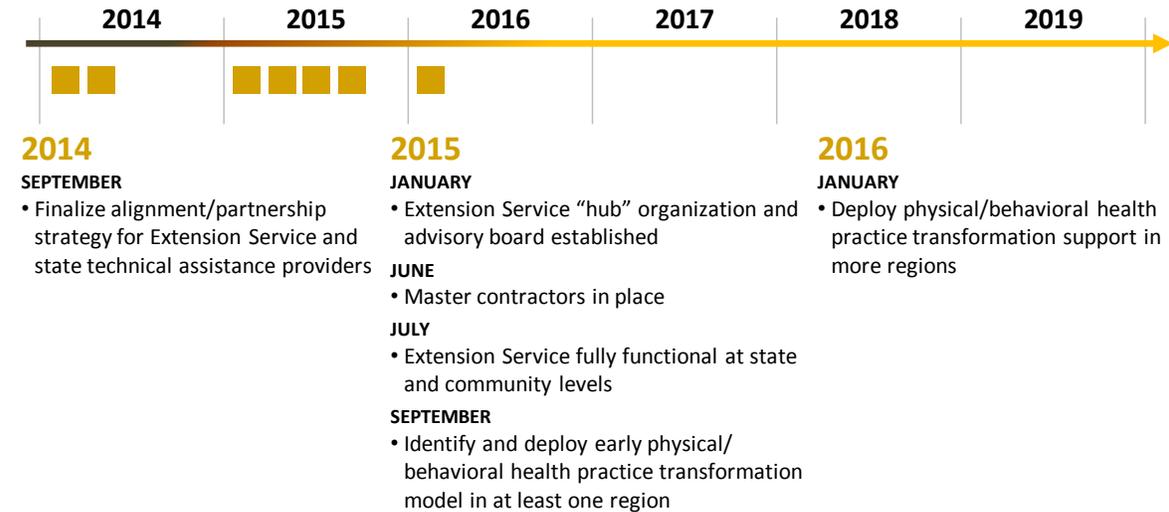


Data & Metrics Support

Separate function informing Regional Extension Service. Extension Service and Agents serve supportive role in clinical achievement of performance measure targets.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Transformation Support Milestones



Program concept ...

Transformation Support Regional Extension Service

The extension service concept builds upon the USDA’s highly effective Cooperative Extension, which has resulted in significant, positive effects on increased agricultural production and profits. In 2009, the Hawaii Department of Agriculture reported a 32 percent return on investment for its Cooperative Extension program. Leaders in health care have pushed for nearly a decade for a similar resource in health care. Although no funding was allocated through the Affordable Care Act for an extension program, learnings can be gleaned from initiatives here and in other states, for example the Infrastructure for Maintaining Primary Care Transformation (IMPACT), Health Extension Rural Office (HERO) program coordinated by the University of New Mexico, and the Vermont Blueprint for Health.

Significant return on investment has been found in programs that facilitate primary care practice improvement. For example: primary care practices are 2.76 times more likely to adopt evidence-based guidelines through practice facilitation; a 2005 study of practice facilitation in Canada found net savings of \$3,687 per physician and \$63,911 per outreach facilitator and the same study estimated a 40 percent return on intervention investment and delivery of appropriate preventive care; and a review of 27 randomized trials found that practice coaching improved chronic and preventive care and increased willingness to implement changes, and that the effect was improved with increased intensity and duration of coaching.⁶

⁶ Phillips, Robert, et al. “The Primary Care Extension Program: A Catalyst for Change.” *Annals of Family Medicine*. 11.2:2013: 173-78. Web. 1 Dec. 2013. <<http://annfammed.org/content/11/2/173.full>>.

Foundational Building Block 7

Increase Workforce Capacity and Flexibility

Realizing Washington’s transformation vision and goals depends upon the availability and readiness of the state’s health workforce.⁷ Washington’s workforce must meet rising demand stemming from coverage expansions, gain skills in team-based care, address the needs of an aging population, effectively prevent and treat the multiple co-morbidities of those who are at greatest risk of poor health outcomes, be able to promote health as well as diagnose and treat illness and injury, and have the technical skills and tools to fully leverage practice-extending health information technologies. Most areas of rural Washington also face problems of workforce mal-distribution that are likely to worsen after 2014, with some of the biggest challenges in the areas of primary care and behavioral health.

Moving forward, Washington needs to engage the full spectrum of its workforce in flexible *top of skill level* practices, and extend and retain workforce capacity. Washington has many strengths on which to build. It has a strong history of workforce partnerships between labor, employers, and Washington State. The Washington State Workforce Training & Education Coordinating Board’s Health Care Personnel Shortage Task Force, the Washington State Board for Community & Technical Colleges, and industry actors are exemplars of workforce transformation. Washington has a strong and vital nursing workforce practicing on the front lines of health delivery.

Washington’s Transformation Support Regional Extension Service will provide considerable practice transformation support, training, and assistance for those already in practice across the state. However, systematically preparing Washington’s workforce requires acceleration of upstream initiatives already under way to meet the demand for a transformed and transformative workforce.

A detailed strategic roadmap for workforce development must build upon the following key recommendations, which were outlined during the 2013 Health Workforce Leader Summit⁸. Throughout the development of the Innovation Plan, these recommendations were echoed by labor, health care employers, academic experts, and consumer advocates, and will form the backbone of workforce roadmap development for Washington.

Make Value Based Payment a Workforce Change Prerequisite. One of the more striking outcomes from the Innovation Plan Workforce Leader Summit was the near-universally expressed view that the most important drivers of workforce transformation are what we pay for and how we pay for it. Put quite simply, workforce change is driven by workforce demand. Moving away from fee for service and toward value-based payment was Summit leaders’ number one strategy for accelerating workforce transformation.

⁷ The workforce under consideration includes but is not limited to primary care providers such as physicians, advanced nurse practitioners, and physician assistants. Workforce also includes registered nurses, licensed practical nurses, certified nursing assistants, psychiatrists, psychologists, pharmacists, certified chemical dependency professionals and peer counselors, home care and personal care workers, medical assistants, dentists, dental hygienists and assistants, community health workers, physical therapists and physical therapy aides, and paramedics and emergency medical technicians.

⁸ “Health Workforce Leader Summit Summary.” *Proceedings of the Health Workforce Leader Summit – Washington*, Seatac, Washington, Sept. 5, 2013. Washington State Health Care Authority: 2013.
<http://www.hca.wa.gov/shcip/Documents/sept_5_health_workforce_leader_summit_summary.pdf>

Encourage workforce capacity for the transformed system by building educational and career progression opportunities. Providing progression opportunities for today's workers enhances the ability to responsively serve Washington residents by increasing health access while reducing cultural and geographic barriers. Washington has demonstrated significant leadership in this area. For example, SEIU Healthcare 775NW and SEIU Healthcare 1199NW have partnered with delivery system actors to develop career pathways that help workers move between long-term care and acute care professions. These innovations help recruit and retain a quality workforce. Further development will focus on:

- Strategies to incentivize the current overall workforce to learn new skills, and welcoming and integrating those transitioning from military health provider experience to help fill provider shortages in both physical and behavioral health care arenas.
- Using training and career ladder opportunities to better reflect Washington's diverse population and enhance cultural competency in care and service delivery.

Partners in Innovation ...

The Community Health College and Innovation Center at Pacific Tower

Washington State recently entered into an agreement with the Pacific Hospital Preservation and Development Authority that creates an exciting model for health care training, service innovation, and community impact. The *Community Health College and Innovation Center at Pacific Tower* includes two components which align closely with Innovation Plan priorities. The Center will be anchored by Seattle Community College (SCC) programs designed to meet the emerging need for health care workers through classroom training, apprenticeships, and community partnerships. SCC is accelerating two new certificate programs that create career ladders in the health care field, and a distance learning component for its allied health sciences program. The Center will also be a hub for service innovation, with a mix of co-located community health, education, and social service non-profits. These include Neighborcare Health, Seattle Indian Health Board, NW Regional Primary Care Association, Cross Cultural Health Care Program, Building Changes, Fare Start, and many other non-profit organizations.

Expand model testing sites and build on successful methods for Community Health Workers. Successful engagement of Community Health Workers (CHWs) has helped chronically ill individuals maintain or improve their health while reducing cost of care. CHWs typically have a relationship with and understanding of the community in which they serve, often belonging to the same culture, speaking the same language, and having similar life experiences as the individuals they support. As a result, they often successfully engage the individuals medical providers have difficulty reaching. In order to better utilize and deploy CHWs, Washington will convene a specific workforce team to focus on CHWs and develop a timeline outlining the steps each stakeholder must take to establish an effective CHW workforce for Washington State. The task force will include key stakeholders from public and private sectors and engage CHWs.

- In the short term, Washington also will build upon an existing Department of Health training program to enhance skills of CHWs. Washington proposes to encourage additional training sites in consultation with Accountable Communities of Health or their precursor communities.
- Washington will draw on existing experience to provide implementation, practice, and evaluation support to local communities that wish to develop, implement, and evaluate CHW programs and models. As the number and scope of CHW programs increases, the value of their work will become increasingly apparent, and the State will have a better sense of which programs are most effective with different clientele. The development of CHW networks and sites will build a foundation for the state to develop effective guidelines on CHWs scope of practice, qualifications, and reimbursement methods.

Provide education and practice support for team-based and coordinated care, and extend workforce capacity through telehealth and telemonitoring.

Advanced medical homes and collaborative care models of physical and behavioral health integration are foundational elements of care delivery in the Innovation Plan. Inter-professional teams are integral to success, as is a grounding in population health. One key to preparation for inter-professional care is to train future caregivers together. Models already exist in Washington in both academic and practice/residency settings. Washington will explore acceleration of interprofessional education using shared courses and simulation of team-based care.

Washington also can help alleviate provider shortages and expand the benefits of team-based, coordinated care through increased use of and reimbursement for telehealth-enabled care and emerging technology for home telemonitoring, as well as increasing the use of technology enabled shared care planning. For example, clinical experts based at a hospital in Spokane use computer systems there to operate a “robot” that is based nearly 40 miles away in Davenport, Wash., at Lincoln Hospital. From Spokane, clinicians are able to turn on and “drive” the robot within Lincoln Hospital to where patients are and interact with patients via the computer screen that serves as the robot’s head and displays the clinicians face. The robot screen also can display various images and test results, like CT, to both the clinician and the patient, to assist the clinician in diagnosis and discussion with the patient. This type of technology is critical when every minute can make the difference between a life and death, and life with or without major disabilities. Additionally, individuals at Lincoln Hospital no longer need to be transported 45 minutes to Spokane in order to be “seen” by a specialist.

Curriculum must also focus increasingly on skill development to enable the health workforce to appropriately access and use client electronic health records and telemedicine tools for consultation and more effective virtual access to clients. Washington will further accelerate:

- Skill development to use client electronic health record, telemedicine, and effective virtual access to clients.
- Provide support for telemedicine technology, build upon existing telehealth behavioral health consultation services for adults and children, and encourage local telemedicine strategies within rural regions.

Train primary care and behavioral health providers to address the needs of whole person.

In primary care settings, recognizing and effectively addressing depression and delivering evidence-based oral health preventive services expand the prevention and chronic disease management skill set, as well as the opportunity for improving health outcomes and reducing the cost of care. Primary care providers also need better preparation to not only recognize somatic presentations of psychiatric illness by individuals not previously identified as needing behavioral health support, but also to properly investigate the medical concerns expressed by patients who are known to have serious behavioral health issues. Psychiatrists and advanced registered nurse practitioners (ARNPs) working in specialty behavioral health settings must be prepared to assume general medical oversight of their patients, particularly for the problems caused by psychiatric medications that carry with them a significant cardio-metabolic risk. This calls for enhanced curriculum development in academic settings, as well as skills enhancements among those already practicing. This will be a strong focus area for the Transformation Support Regional Extension Service. Workforce development elements will focus on development and deployment of curriculum components/enhancements for whole-person care.

Build and Expand Primary Care Residencies in Washington. State workforce experts are interested in exploring development of a startup revolving fund to community hospitals to start primary care residencies, and continue to attract new and innovative residencies that address the needs of diverse communities.

Partners in Innovation ...

Puyallup Tribe Medical Residency Program

The Puyallup Tribe has initiated a unique medical residency program. The Puyallup Takopid Family Medicine is the first osteopathic family medicine residency in the country to have a Native American focus. The Tribe started with two Doctor of Osteopathic Medicine residency participants in 2012, and now has approval for an additional four residents per year (four started in 2013 and four more in 2014; at full capacity the program will have 12 residents).

The program is affiliated with Tacoma General Hospital and Tacoma Family Medicine faculty. The residency program investment helps build a strong ongoing primary care provider workforce for Indian country, increase awareness of tribal customs and healthy practices in the coming years, and will reflect the whole-person approach supported by the Tribe.

Leverage Washington State’s Progressive Scope of Practice Laws to Improve Patient Management and Mitigate the Shortage of Primary Care Providers. Washington has led in scope of practice innovation in several disciplines, providing additional opportunity for meeting the needs of a growing and changing population. For example, Washington is one of 18 states that grant independent practice and full prescriptive authority to ARNPs. Many of the Washington’s 5,200 ARNPs provide primary care, and also focus on geriatric, pediatric, women’s health, and behavioral health care. Washington also leads by reimbursing ARNPs for Medicaid services at the same rate as physicians, providing the incentive to care for the influx of patients newly accessing care through the ACA. Similarly, Washington State’s progressive pharmacy practice laws position the state to take full advantage of integrating pharmacists into patient care teams. Pharmacists in Washington may use physician-approved, evidence-based protocols to adjust medication regimens for patients with chronic conditions such as hypertension, diabetes and asthma. Pharmacists may also provide immunizations without an individual physician order. As Washington looks to the future, nurses also can be deployed to greater affect in transformative ways across many fields, such as coordinating and integrating the delivery system with community services, education, social services, and public health. Roadmap focus areas will include:

- Enhancing the supply of ARNPs as well as other primary care providers, including physician assistants.
- Developing innovative ways of paying for non-dispensing pharmacy services in order to more broadly integrate pharmacists into ambulatory practice. This focus area would extend to other practitioners (e.g., physical therapists).
- Deploying registered nurses to their full potential.

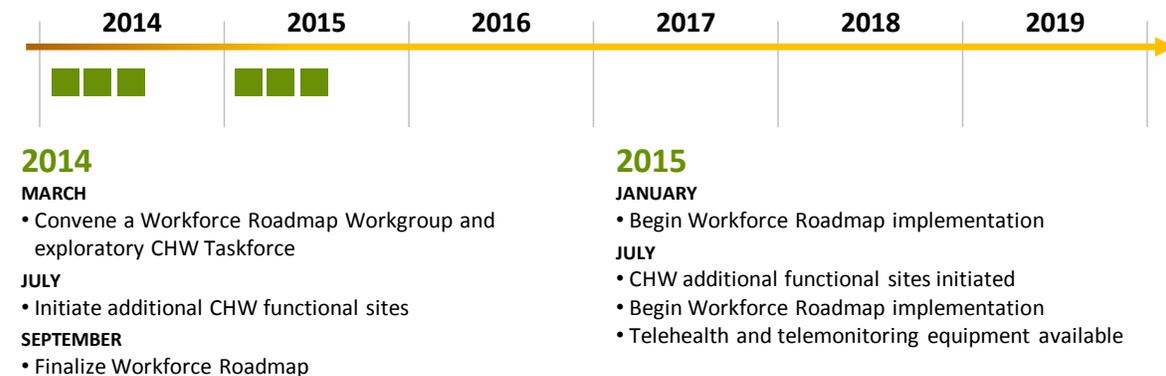
Identify Professional Loan Repayment Options. Some of the Summit recommendations will yield long-term return but require further policy and business case development. Workforce Summit leaders, for example, advocated for the need to reinvigorate the State Health Professional Loan Repayment Program as a means to address workforce shortages and better meet the needs of rural and underserved communities. The program historically has provided loan repayment assistance of up to \$35,000 per year for a minimum of two years, plus \$30,000 for each additional year, but is based on funds available. Eligible provider types include: physicians (MD and DO), physician assistants, nurse practitioners, pharmacists, certified nurse

midwives, dentists, dental hygienists, and registered nurses. In the 2011-13 budget cycle, funding was suspended due to State budget considerations.

Address the impact of a move from fee for service on Graduate Medical Education (GME) funding. GME funding is currently embedded in Medicaid fee-for-service payments to hospitals. Next steps must identify options to preserve an adequate level of funding for GME without further state general fund commitment, while accelerating movement away from fee for service.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Workforce Transformation Milestones



Three Transformative Strategies

- A**s described, the state will achieve transformation through three strategies:
1. Drive value-based purchasing across the community, starting with the State as “first mover.”
 2. Improve health overall by building healthy communities and people by prioritizing prevention and early mitigation of disease throughout the life course.
 3. Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities.

Each of these strategies is supported by the seven building blocks just discussed. Together, these strategies and building blocks are the foundation for attaining the ultimate goals of better health, better care, and lower cost for all state residents.

These three strategies rely on a balance of competitive and collaborative forces. Governmental regulation is used only where necessary to ensure an effective health care marketplace, remove outdated barriers, and enable flexibility in public purchasing to support the health care delivery system.

Strategy 1

Drive value-based purchasing across the community, starting with the State as “first mover”

Washington will move away from a largely fee-for-service reimbursement system to an outcomes-based payment system that delivers better health and better care at lower costs. Specifically, within five years, Washington aims to move 80 percent of its State-financed health care to outcomes-based payment and work in tandem with other major purchasers to move at least 50 percent of the commercial market to outcomes-based payment.⁹

To achieve the “affordable care” five-year state health care innovation aim, Washington State as a purchaser will take a lead role as “first mover” to accelerate market transformation. Washington will lead by example by changing how it purchases care and services in State-purchased insurance programs, starting with the Public Employees Benefits (PEB) program, and Medicaid procurement. To influence the commercial market, Washington in tandem with its own State-purchasing efforts will engage multiple payers, providers, and purchasers in aligning common value-based purchasing and payment and basic system requirements across the community, much as other sophisticated industries and sectors do today to eliminate duplication and waste and encourage innovation.

Spotlight on ...

Outcome Measures

Under Engrossed Substitute House Bill 1519, the Washington State Legislature directed the Department of Social and Health Services and the Health Care Authority to base contract performance assessment for Medicaid-funded mental health, chemical dependency, physical health and long term care services on common outcomes. Performance measure categories include clinical measures as well as improvements in client health status, wellness, meaningful activities and housing stability; reductions in involvement with the criminal justice system, avoidable costs, crisis services, jails and prison; and reductions in population-level health disparities. Contracts must include these performance measures by July 1, 2015. While these additional, non-clinical measures will initially be reflected in State procurement, they may also be applied more broadly to inform and assess community partnerships.

Lead by example—Financing and purchasing across all State-purchased programs

As a major purchaser and payer for clinical and support services, Washington State has a considerable footprint in the marketplace. The State currently provides health insurance to more than 1.5 million people through PEB and Medicaid. As a state that has embraced the Medicaid expansion, this number will grow to over 1.8 million, or nearly a third of Washington’s insured population between 2014 and 2017. Additionally, Washington State’s Department of Labor & Industries (L&I) oversees and procures benefits to over 2 million workers, touching more than 120,000 injured workers in 2012.

Medicaid and PEB currently have separate procurement cycles, approval processes, and regulations. Washington will create a common framework to align timelines and approaches for the 2016 procurement cycle. Subject to approval by the PEB board and labor partner engagement, common strategies would require all contractors (including providers) providing State-financed health care benefits to do the following as a condition of receipt of State funds:

⁹ Washington recognizes that fee-for-service payment should not be eliminated, as it is appropriate for some forms for services (e.g., acute, low intensity).

- **Measure and report common performance (cost and quality) measures.** To measure the overall quality, value, and cost of State-financed health care, Washington will require active utilization of a common set of adult and pediatric measures, and the contribution of cost and quality data to the all-payer claims database, with public reporting on cost and quality performance.
- **Implement evidence-based purchasing and guidelines recommended by the Dr. Robert Bree Collaborative and the Washington Health Technology Assessment (HTA) Program.** Washington has an opportunity to build upon the momentum of two existing innovative programs in Washington: the Bree Collaborative and HTA. Both produce evidence-based standards of care and purchasing guidelines that, when implemented, move the state toward better health, better and more appropriate care, and lower costs.

As a major purchaser, Washington State will prioritize areas of high-variation, high-cost procedures and therapies and use its levers as a purchaser to drive innovation in current and future Bree areas of focus, including:

- Obstetric services
- Elective joint replacement
- End-of-life care and preferences
- Opioid use
- Spine/low back pain
- Cardiac care

- **Participate in the Foundation for Health Care Quality’s clinical quality improvement programs.** The Foundation for Health Care Quality (FHCQ) administers quality improvement programs in cardiac, obstetrics, spine, and surgery. Using clinical performance data as a tool, FHCQ works with providers and hospitals to adopt evidence-based practices and improve the quality of care delivered. The State will work with its payer partners to require participating providers to participate in FHCQ clinical quality programs including, but not limited to, Clinical Outcomes Assessment Program (COAP), Obstetrics COAP, and Spine SCOAP.
- **Enable use of a provided suite of high-quality decision aids and training.** Research shows that use of evidence-based recommendations are heightened through person and family engagement, including shared decision making. The State will enable the use of high-quality decision aids beginning with the deployment of a new maternity care decision aid suite, and over time implementing additional suites in the various Bree topic areas.
- **Implement a robust employee wellness program and other strategies for a healthier workforce.** Washington State’s employee wellness program will be significantly strengthened, including a new Diabetes Prevention Program and assistance for employees who want to quit using tobacco, along with additional recommendations regarding food procurement and breastfeeding policies. In his recent Executive Order, Governor Inslee directed a joint Health Care Authority and Department of Health “State Employee Health and Wellness” steering committee to develop a comprehensive wellness program for state employees for implementation January 2014.¹⁰ This executive order and implementation of subsequent policies could serve as a template for other non-State entities to implement similar policies.

¹⁰ Executive Order No. 13-06 focuses on three key areas to improve health: providing wellness assistance to all state agencies so they can create their own effective wellness programs, incorporating wellness in state employee health insurance plans, and requiring state agencies to develop and implement healthy food and beverage policies. (<http://governor.wa.gov/office/execorders/documents/13-06.pdf>)

In addition, the State will pursue implementation of the following proven, value-based benefit design strategies starting in 2016. These examples represent initial models being planned; the capacity and capability of State contractors to design and implement innovations that move both State-purchased care and the market at large away from traditional fee-for-service payment will be a central feature in future procurement cycles:

- **Apply reference pricing and tiered/narrowed networks.** Reference pricing establishes a standard price for a drug, procedure, or service and then generally asks consumers to pay the charges beyond that amount. By 2016, Washington will implement reference pricing for joint replacements and colonoscopies in its PEB contracts, once approved. Both Safeway and CalPERS have demonstrated that well-designed reference pricing practices yield better quality care and savings for members and employers.¹¹ Washington also will encourage its contractors to build tiered networks based on price and quality into its PEB program, subject to needed approval and ongoing dialogue with the State’s labor partners. Cost differentials will be created so consumers share in the benefits of choosing to use providers delivering high-quality care at lower cost. Washington will model its tiered network approach upon Intel’s tiered networks strategy.
- **Move toward Accountable Care Organizations (ACOs) and alternative payment models for Medicaid and State employees.** An accountable care organization (ACO) is characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. Under ACOs, provider groups willing to be accountable for the overall costs, utilization, and quality of care for their patients are eligible for a share of the savings achieved by improving care. Washington is pursuing ACO models as an additional option for public employees and Medicaid.¹² During the development phase, Washington will look to innovative best practices and model programs such as L&I’s center of excellence/ACO model called Centers for Occupational Health & Education (COHEs), created to help severely injured employees return to paid employment in an efficient, person-centered way. The State may consider adopting its care management strategies for its ACO models.

As Washington builds new payment methodologies, it will incorporate the efforts already moving forward with Washington’s Federally Qualified Health Centers and Rural Health Clinics to build an alternative payment methodology that rewards innovation and outcomes over volume of services delivered, while enabling the enhancement of the critical services provided by these integral community based providers.

Serve as Multi-Stakeholder and Multi-Payer Market Organizer

In tandem with reforming its own procurement and implementing value-based design strategies in state-purchased programs, Washington State also will actively partner with other purchasers, payers, and providers to develop and adopt complementary strategies that enable rapid delivery system change.

“The Plan’s core strategy for the State to take a lead role as “first mover” is vitally important to creating a strong primary care system, which is needed as the foundation for accountable care.”

*- Cindy Robertson
North Shore-Medical & Rural Health Clinic
Association of Washington (RHCAW)*

¹¹ Cliff EQ, Spangler K, Delbanco S, Perelman N, Fendrick MA. A Potent Recipe for Higher-Value Health Care: Aligning Quality, Price Transparency, Clinical Appropriateness and Consumer Incentives (White Paper from CPR and The University of Michigan Center for Value-Based Insurance Design), (Sept. 2013) (<http://www.catalyzepaymentreform.org/news-and-publications/cpr-in-the-news/94-news-and-publications/publications>).

¹² HCA in consultation with Washington State’s Office of the Insurance Commissioner, Office of the Attorney General, and Department of Health will review and determine the legal definition and licensure/regulatory status of ACOs to ensure that ACOs not engaged in insurance are not subject to insurance regulations.

Washington State will lead multi-stakeholder efforts to align and bring to scale current transformative payment and delivery strategies. Together, the strategies offer a cohesive pathway to facilitate action and achieve the various goals of the Innovation Plan.

Spotlight on ...

Rural Health

Vast portions of rural Washington State are challenged by provider scarcity; individuals who are more difficult to serve; physical and cultural distance; separation between primary care, specialists, and tertiary services; and long-term supports and services. Challenges are heightened even further by seasonal travel constraints and limited public transportation.

These factors also pose challenges to effective prevention and early intervention services known to reduce more severe health issues later on. While linkages to limited local resources are increasingly made through an efficient use of local workforce, the constraints of serving rural areas make it harder to support individuals holistically.

However, these barriers have also made rural communities adapt in innovative and collaborative ways. Rural systems are leaders in deploying community paramedicine and peer counselors, and using telemedicine and electronic support tools to engage individuals in achieving their own health goals.

The Innovation Plan aims to adopt and bring to scale these promising and best practices both to benefit rural communities and their urban counterparts. It also provides the necessary infrastructure and system supports to assist rural communities in ensuring their unique challenges are better recognized and supported.

Currently, individual purchasers, providers, and payers are engaged in a number of separate innovative payment and delivery reform efforts, by themselves or with other stakeholder groups. While Washington State and the market encourages innovation, the patchwork of alternative payment and delivery system reform models with differing and potentially contradicting measures and metrics can be burdensome to providers, and limiting in terms of effecting a sizeable share of the market. Recent stakeholder efforts also indicate any one health reform strategy or implementation by any one stakeholder group in isolation is likely to be far less effective than aligned efforts implemented at the same time across multiple payers, purchasers, and provider groups.

Better alignment, however, must not devolve into one cookie cutter approach. Competition among payers and providers will continue to drive innovation even as collaboration moves forward on choice of metrics, measurement methodologies for processes of care, health outcomes, and performance reporting processes and structures.

Implement the “Public/Private Transformation Action Strategy”

As a part of deliberations leading to development of the Innovation Plan, plan leaders asked the Washington Health Alliance (the Alliance)—formerly the Puget Sound Health Alliance—to convene approximately 50 purchasers, health plan, provider, and other thought leaders from across the state to develop overarching goals and objectives for transforming the health care delivery system in Washington state. Emphasis was placed on strategies that can be aligned and implemented across multiple payers, providers, and purchasers to significantly accelerate health care transformation within the state. The scope of this work primarily focuses on hospital and ambulatory care settings. Within the Innovation Plan’s strategy regarding healthy people and communities, the State has proposed the development of a companion tool, which will strive to recognize and address the community determinants that often impact clinical success.

The “Public/Private Transformation Action Strategy”—a consensus product of a stakeholder process—sets an ambitious agenda for change that requires payers, providers, purchasers, and consumers to each change what they do in order to make it possible for all sectors to achieve better value and improved health. See Appendix C for the Public/Private Transformation Action Strategy.

Washington State will partner with the Alliance to organize “next phase” deliberations with and among multiple stakeholder groups to operationalize the plan. The next phase begins with securing more concrete commitments to the alignment process, defining what each stakeholder is prepared to contribute to implementation of the Public/Private Transformation Action Strategy, and what it needs from other stakeholders in order to do so in the following domains:

- Redesign health care delivery to reduce cost, improve quality, and improve patient experience;
- Restructure health care payment systems to support and reward providers who deliver high-value care;
- Restructure health care benefit design to enable and encourage patients to improve their health and use high-value health care services; and
- Educate and encourage state residents to improve their health and use high-value health care services.

As a first step, a critical mass of stakeholders will formally commit to the needed reciprocal actions to support the Transformation Action Strategy. Specifically:

- **Purchasers** commit to ensure they have programs and tools in place to educate, encourage, and facilitate the ability of employees/members to maintain and improve their health; to develop and use RFPs for evaluating and selecting health insurance or third-party insurance using specific value-based strategies; and to offer value-based benefit designs that clearly incentivize employees to maintain and improve their health, choose a primary care team to help maintain their health and coordinate their care, and use high-value providers and services for all aspects of their care.
- **Providers** commit to care coordination and redesigning delivery of health care to ensure high-quality, evidence-based health care is delivered, errors are minimized, and unnecessary care eliminated; to take responsibility for coordinating the services the patient receives during a full episode of care and further coordinate care for the patient; to work with purchasers/payers to design and use payment systems that appropriately tie payment to cost, quality, and patient experience outcomes; and to collect and publish information about the quality and cost of care offered by their institution and/or medical practice.
- **Payers** commit to work with providers to develop alternative payment methods and with purchasers on value-based benefit designs; to work with purchasers to develop and implement value-based benefit designs; and to routinely provide medical claims data to a statewide data collection mechanism.

See Appendix D for a sample commitment statement for purchasers, payers, and provider organizations.

Once goals and expectations of each group are firmly established, key stakeholders, collectively, will identify actionable opportunities for achieving a defined goal for reduction in health care spending. Criteria for prioritizing action steps and opportunities will be established. Operationalizing the Transformation Action Strategy will be an iterative process; once

opportunities are identified, tactics will be implemented. Over time, progress will be systematically measured and the process will be evaluated and adjusted as new opportunities are identified. Washington State has historically provided anti-trust safe harbors/State action protections to promote multi-stakeholder innovations in health care and a similar approach could be utilized if necessary.

The State will monitor individual organizations' commitment to the Transformation Action Strategy by asking stakeholders to reaffirm their commitments in writing at various points. If commitment and interest in moving the market wanes, the State will consider using various levers such as legislation to implement strategies on a system wide level.

The ultimate goal of the Transformation Action Strategy is for all stakeholder groups to act consistently in mutually reinforcing ways across selected activities. The incentive for each stakeholder group to actively participate and stay engaged in the process will be the end result of a less fragmented, more efficient system.

Align public and private purchasers on purchasing expectations and benefit design efforts

Washington will work with the Alliance's Purchaser Affinity Group to implement a suite of common, value-based purchasing and benefit design strategies to significantly drive the market as part of the Public/Private Transformation Action Strategy. Its membership includes a number of large purchasers such as Boeing, King County, the Alaska Air Group, and the Carpenters Trust of Western Washington, as well as a number of small and mid-size employers that, collectively, purchase health insurance for over 1.6 million covered lives, and are actively interested in implementing value-based benefit strategies. The Purchaser Affinity Group therefore can serve as a strong pacesetter to drive transformation through more aligned sourcing.

Common purchasing and benefit design strategies of interest include: a common RFP such as eValue8¹³ coupled with value-based payment requirements such as those outlined in the Catalyst for Payment Reform request for information¹⁴, mandatory collection and reporting of a common statewide adult and pediatric measure set, voluntary participation of self-insured purchasers in the state's evolving all-payer claims database, and other transparency and purchasing strategies implemented as part of the State as a "first mover" strategies. Common strategies will activate and complement the Transformation Action Strategy work and will also include augmented focus on workplace safety and wellness programs. Washington's goal is to have agreement among purchasing entities that have at least 60 percent total market share by 2019.

¹³ eValue8™ was created by business coalitions and employers like Marriott and General Motors to measure and evaluate health plan performance. eValue8™ asks health plans probing questions about how they manage critical processes that control costs, reduce and eliminate waste, ensure patient safety, close gaps in care and improve health and health care. It is most appropriately used in the commercial marketplace, not Medicaid.

¹⁴ *Aligned Sourcing*. Catalyst for Payment Reform. Web. <<http://www.catalyzepaymentreform.org/2013-03-03-05-08-38/2013-03-03-05-10-43/aligned-sourcing>>

Stakeholder Readiness for Reform

The Public/Private Transformation Action Strategy is an ambitious change agenda requiring all sectors to change their practices. However, preliminary readiness signs are promising. On the whole, each stakeholder group—purchasers, providers, health plans, State government, and other health care organizations—is in agreement with the objectives, strategies and guiding principles of the Transformation Action Strategy, as evidenced by a survey conducted with over 60 thought leaders representing a critical mass of purchasers, payers and providers in Washington. In addition, each stakeholder group rated its readiness to implement the Transformation Action Strategy in the next five years as high (see figure below).

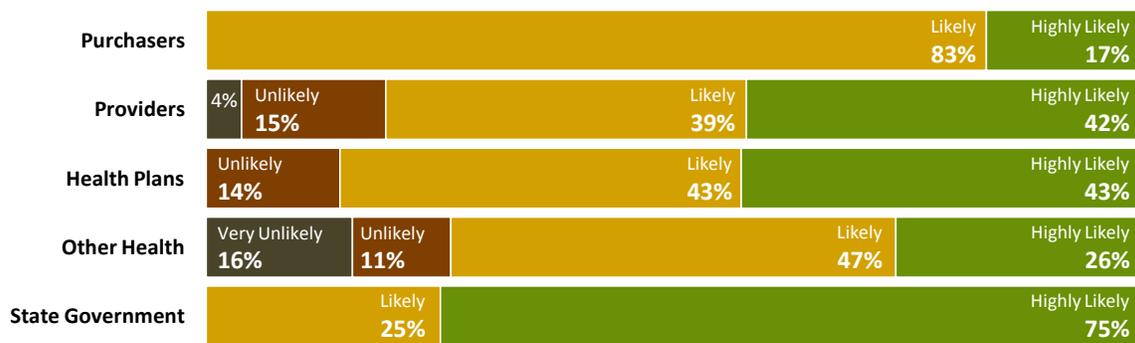
“We look forward to partnering with the State on strategies that will move the needle on creating better value and a more accountable delivery system. We also look forward to collaborating with providers, payers, and purchasers on additional strategies that will improve quality and reduce costs for the entire community.”

— Joseph Gifford, MD, Chief Executive, ACO of Washington, Providence Health & Systems

This level of readiness positions Washington well to achieve its five-year state health care innovation aims for clinical sector transformation.

Most Indicate “Readiness to Implement” in the Next Five Years

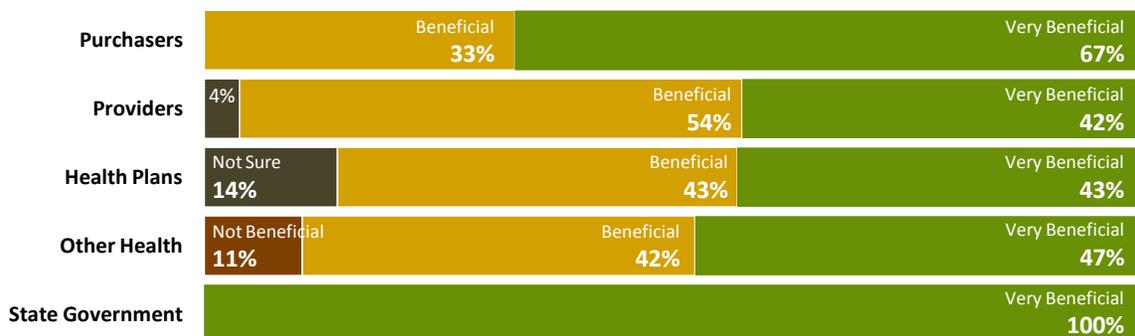
Q. *How likely do you think it is that, within 5 years, your organization’s policies and programs will be mostly consistent with the objectives and guiding principles?*



Stakeholders, speaking on their own behalf, are also optimistic about transformation, and that transformation will be beneficial to individual consumers.

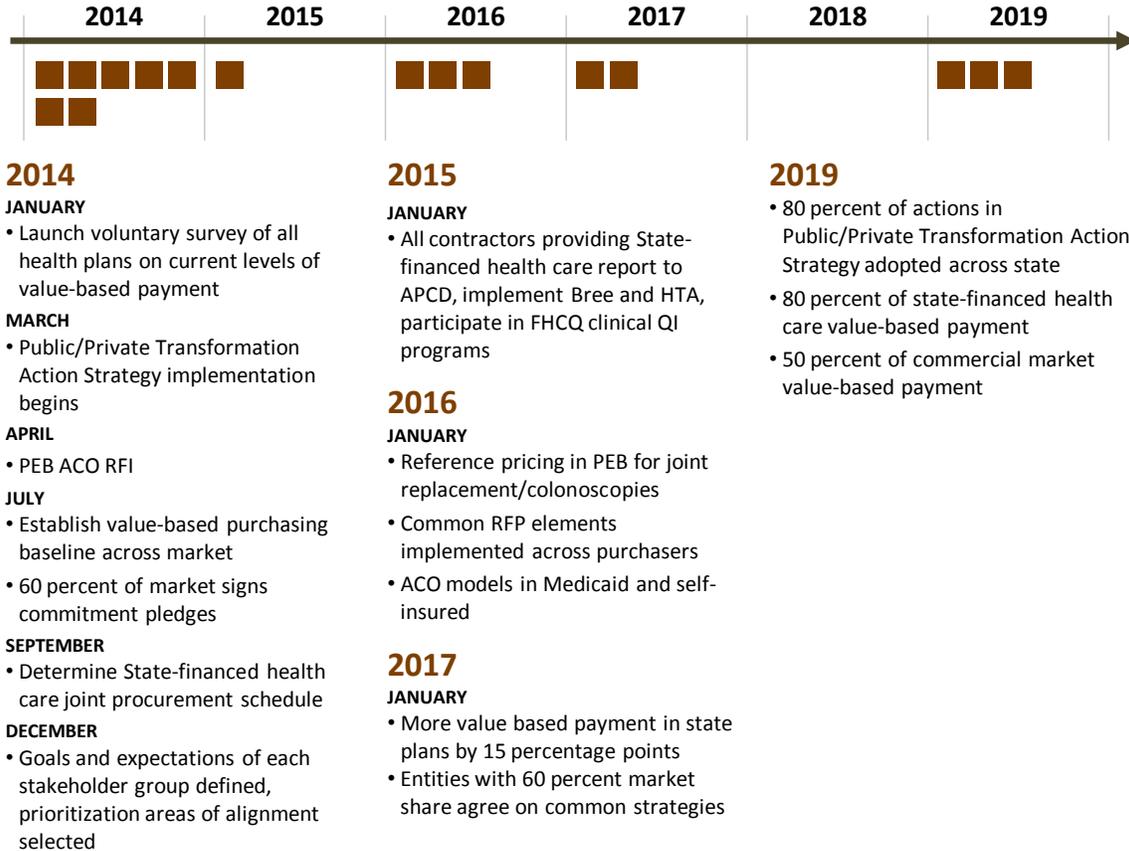
Most Agree that Transformation will be Beneficial

Q. *Speaking as an individual consumer of health care, rather than as part of an organization, do you believe that implementing the strategies and guiding principles would be beneficial to you?*



ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Value-Based Purchasing Milestones



Strategy 2: Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course

The Health Care Innovation Plan recognizes the impact that factors outside the health care system have on health. Eighty percent¹⁵ of health is determined by physical environment, health behaviors and socio-economic factors.

The plan also recognizes that good health in turn enhances quality of life; improves workforce productivity; increases the capacity for learning; strengthens families and communities; supports sustainable habitats and environments; and contributes to security, poverty reduction, and social inclusion.



Source (chart right): Authors' analysis and adaption from the University of Wisconsin Population Health Institute's County Health Rankings model 2010. <http://www.countyhealthrankings.org/about-project/background>¹⁶

¹⁵ Magnan, Sanne, Eliot Fisher, David Kindig, George Isham, Doug Wood, Mark Eustis, Carol Backstrom, and Scott Leitz. *Achieving Accountability for Health and Health Care: A White Paper Developed from the State Quality Improvement Institute, 2008-2010.* Minnesota.

¹⁶ Ibid

Ensuring better health, better care, and lower costs therefore requires Washington to better align at the state and community levels to close the gap between prevention, primary care, physical and behavioral health care, public health, social and human services, early learning/education and community development systems. Washington has drawn from the Expanded Chronic Care Model framework¹⁷ and the MacColl Center for Health Care Innovation's Regional Framework for Creating a Regional Healthcare System¹⁸ to merge population health promotion with clinical health care services. By working on both the prevention and treatment ends of the continuum from a broader perspective, communities, supported by State resources and policy responsive to local conditions, have enormous potential to support lasting improvement in health outcomes. It is this combined approach of effective population health promotion and improved treatment of disease that is Washington's weapon against the mounting burden of chronic disease.

The State must also shape and align its policies and actions to better foster and support resilient and connected communities to promote:

- Healthy eating, active living, mental well-being, reduction in tobacco use.
- Preconception health for women and healthy starts for all children.
- Prevention and mitigation of adverse childhood experiences (ACES) and toxic stress¹⁹ in families.
- Improved clinical-community linkages.
- Services and supports that build pathways to better health and improved quality of life that address social determinants of health.

Beginning with a "Health in All Policies" Approach

State agencies will work together to incorporate a "Health in All Policies"²⁰ approach to ensure communities are supported in regional improvement. This and other elements of planning and oversight will be led by the existing Washington State Health Care Innovation Plan inter-agency governance structure, the Executive Management Advisory Council (EMAC²¹), supported by the Governor's recently appointed Health Leadership Team.²²

¹⁷ Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S., The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. *Hospital Quarterly* 2003; 7(1) 73-82.

¹⁸ Wagner, E., Austin, B., Coleman, C, It Takes A Region: Creating a Framework to Improve Chronic Disease Care, prepared for: California HealthCare Foundation, November 2006.

¹⁹ *Adverse Childhood Experiences (ACE) Study*. Centers for Disease Control and Prevention. Web <<http://www.cdc.gov/ace/>>.

²⁰ World Health Organization Health in All Policies Definition: "Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity."

²¹ Executive Management Advisory Council is made up of Washington's Department of Commerce, Department of Early Learning, Department of Health, Department of Social & Health Services, Governor's Health Policy Office, Health Care Authority, Labor & Industries, Office of Financial Management, Office of the Insurance Commissioner, Office of the Superintendent and Public Instruction, State Board of Community and Technical Colleges, and Washington Health Benefit Exchange

²² "Executive Order 13-05" State of Washington Office of the Governor. Web. <<http://www.governor.wa.gov/office/execorders/documents/13-05.pdf>>.



GOAL: HEALTHY AND SAFE COMMUNITIES

Fostering the health of Washingtonians from a healthy start to safe and supported future

GOAL TOPIC	HEALTHY PEOPLE <i>Provide access to good medical care to improve people's lives</i>	SAFE PEOPLE <i>Help keep people safe in their homes, on their jobs and in their communities</i>	SUPPORTED PEOPLE <i>Help the most vulnerable people become independent and self-sufficient</i>
SUB TOPIC & OUTCOME MEASURE	Healthy Babies OUTCOME. Decrease percentage of preterm births from 9.6% in 2001 to 9.1% by 2016*	Protection and Prevention OUTCOME. Decrease rate of children with founded allegations of child abuse and/or neglect from 4.17 to 4.05 by September 30, 2014	Stability and Self Sufficiency OUTCOME. Keep the percentage of residents above the poverty level 1.7% higher than the national rate through 2030
	Healthy Youth and Adults OUTCOME. Decrease percentage of adults reporting fair or poor health from 15% in 2011 to 14% by 2017	Food Systems OUTCOME. Decrease incidents of forborne illnesses by 5% from the 2012 baseline by 2020	Quality of Life OUTCOME. Increase the percentage of supported seniors and individuals with a disability served in home and community-based settings from 86.6% to 87.2% by June 30, 2015
	Access/Pay for Quality OUTCOME. Decrease rate of uninsured in state from 15% to 6% by 2017*	Public OUTCOME. Decrease rate of return to institutions for offenders from 27.8% to 25.0 by 2020	
	<p><i>*Data will be available by ethnicity groups such as Native American, Asian, pacific Islander, Black, Hispanic, White, etc. or age groups.</i></p>	Traffic OUTCOME. Decrease number of traffic related fatalities on all roads from 454 in 2011 to zero (0) in 2030	
		Worker Safety OUTCOME. Decrease workplace injury rates that result in missing three or more days from work from 1,514 per 100,000 fulltime workers to 1,425 per 100,000 fulltime workers by 2016	

SOURCE: Washington State Office of the Governor, Results Washington, Governor Inslee's Strategic Framework, Healthy and Safe Communities. November 19, 2013

LEADING INDICATORS ARE AVAILABLE ON THE RESULTS WASHINGTON WEBSITE:
<http://www.results.wa.gov/whatWeDo/measureResults/documents/communitiesGoalMap.pdf>

Washington State agencies are working collaboratively to incorporate health considerations into decision making in all sectors and policy areas. This approach recognizes that agencies not traditionally associated with the health sector play a major role in shaping the social and physical environments that determine health.

Spotlight on ...

Tribal Health

While Washington's 29 federally recognized Tribes have achieved improvements in health status, American Indians and Alaska Natives continue to experience disproportionate health disparities in comparison to the state's general population.

Similar concerns across Tribes foster common objectives for improving health outcomes with targeted and sustained attention to understanding and supporting unique tribal community needs. Tribal thought leaders have suggested consideration of a statewide tribal "virtual" Accountable Community of Health or advisory body to strategically link Tribal health care needs with efforts of the regional ACHs. This may maximize the cross-cultural spread of promising and best practices and health system improvements across Washington State, and will be further explored with tribal leaders.

Washington's "Health in All Policies" approach includes organizing more consistently around the designated regional service areas. Increasing the number of State agencies making regionally aligned policy, administrative, and funding decisions will both streamline agency activity and enable more effective collaboration at the community level between sectors such as education, housing, public health, and health.

Gaps in meeting basic needs for an individual or a family, such as housing, create barriers to health and can increase health expenditures. For example, it is difficult to treat a homeless diabetic with regular insulin regimen if they have no place to refrigerate their insulin, or a family to address a care regimen for their high-needs child when they are moving from couch to couch.

Washington therefore is committed to working with communities to maximize health improvement strategies embodied in the "Health in All Policies" approach. Areas of active interest include better linking non-traditional health delivery settings such as schools, child care settings, low income housing and workplaces into the fabric of routine care provision in the state. Washington will investigate avenues to build these capacities, including potential for support through federal flexibility in Medicaid financing.

Foster accountability and coordination for population improvement through Accountable Communities of Health

Linking Communities with Health Care to Achieve Health. Accountable Communities of Health will strengthen and formalize supportive structures to link and align partners across the care and community continuum within a region. The ACH will be the connective tissue that will leverage the strengths of participating regional partners and facilitate adaptive solutions to achieve shared goals. Through this process, the ACHs will ultimately support partners in building more supportive communities and better coordinated, effective service systems, and improve the connectivity between communities and services.

Creating a healthy population and healthy communities is an adaptive challenge that no single entity has the resource or authority to tackle in isolation. ACHs will coordinate and target prevention and broad health improvement efforts through a strategic and intentional collaborative process that is built on the tenets of the collective impact model.²³

²³ "Collective Impact" Stanford Social Innovation Review. Web. <http://www.ssireview.org/articles/entry/collective_impact>.

Building a Common Agenda and Regional Health Improvement Planning. ACHs will build a common agenda as a foundational element and testament of regional partnership. The common agenda will be a voluntary transparent compact holding entities across the system accountable for achieving objectives through mutually reinforcing agendas.

This common agenda (or compact) becomes a cornerstone of the State’s relationship with the ACHs. The compact will enable the State to assess the level of functionality of the ACH, illustrating the degree to which community partners have committed to shared goals and are moving forward with separate but mutually reinforcing actions.

A critical component of the common agenda is the Regional Health Improvement Plan. The Regional Health Improvement Plan specifies the shared goals for the participating entities, aligned with both state and local priorities. The Regional Health Improvement Plan process, led by local public health jurisdictions, will build on the work of existing entities already engaged in community health needs and asset assessment processes.

ACHs are intended to drive broader engagement in setting regional priorities and action steps. Incorporation of current and past strategies to address health improvement at a local level, while maintaining focus on the broader strategies laid out by the State, will result in a healthier population and healthier communities.

Spotlight on ...

County/State Partnership for Improving Services for Dual Eligibles

Washington was one of 15 states to receive a federal grant to plan innovative ways to improve care for some of the state’s most vulnerable people: those who receive services from both Medicare and Medicaid. An extensive stakeholder process informed the demonstration proposal, called “HealthPathWashington: A Medicare and Medicaid Integration Project.”

HealthPathWashington pilots two strategies to coordinate physical health, behavioral health, and long-term supports and services:

- **Strategy 1:** In most counties, dual eligibles can enroll in a “health home” to receive care coordination across current systems of care; and
- **Strategy 2:** In King and Snohomish Counties, a transformative approach to systems change integrates Medicare and Medicaid funding and services into a single benefit package administered by health plans and delivered by the health plan’s network.

Since much of the Medicaid funding that would flow to health plans under Strategy 2 would otherwise flow through county delivery systems, Washington’s legislature required approval of implementation terms by the county legislative body in each area of operation. This was a condition for the necessary transfer of funds. This process precipitated a new, collaborative relationship between counties and the State that has allowed planning for an unprecedented level of financial and service integration to proceed.

Affected counties with this increased influence, and therefore commitment to Strategy 2 health plan pilots, cleared the way for the CMS-State Memorandum of Understanding that underlies implementation of the capitated model in 2014.

Development of this model overcame past resistance to change by focusing on common ground—the joint interest in improving health outcomes and wise stewardship of resources—and by including county representation in setting Medicaid contract standards, reviewing health plan bids, and planning readiness review and monitoring of health plan performance. The State also agreed to mitigate a portion of the financial impacts experienced by the counties related to decreased caseload and service provision.

Setting a Comprehensive Framework. Regional common agendas and health improvement plan formation will be informed and supported through the State’s “Health in All Policies” approach. As a first step, state and regional partners across sectors will together build a comprehensive prevention framework. It will act as a companion tool and link to the Public/Private Transformation Action Strategy developed in the context of hospital and ambulatory care setting settings. The framework will set out recommended reciprocal actions needed to shape and create healthy communities and healthy populations including priorities in:

“The formation of (ACHs) as a key strategy for fostering cooperative action for improvements in health, care and costs is of key interest to us. We welcome the opportunity to come to the table with other community health partners to plan, act, evaluate and learn together.”

*- Randall H. Russell, Managing Director
Washington Care Coordination Services Group &
Executive Director, Lifelong AIDS Alliance*

- Healthy eating, active living, mental well-being, reduction in tobacco use.
- Preconception health for women and healthy starts for all children.
- Prevention and mitigation of adverse childhood experiences (ACES)/toxic stress²⁴ in families.
- Improved clinical-community linkages.
- Services and supports that build pathways to better health and improved quality of life that address social determinants of health.

This will be a fluid process that will change as new strategies arise and new policies are set, and will be informed by best practices and existing frameworks in communities, the state, and nation, including:

- Washington State Plan for Healthy Communities,²⁵ a single, statewide strategy for prevention and Community Transformation Grant funded activities.
- Washington’s Public Health Network’s Agenda for Change Action Plan.²⁶
- Washington State Early Learning Plan,²⁷ a 10-year plan is the roadmap to build an early learning system in Washington.
- Washington’s Prevention Redesign Initiative (PRI).²⁸
- Washington’s Multiple Efforts geared toward preventing and mitigating Adverse Childhood Experiences.
 - Harvard University Center on the Developing Child Frontiers of Innovation Partnership with Washington State.²⁹
 - ACEs Public Private Initiative (APPI).³⁰

Apply a Regional Context for Medicaid Purchasing. Medicaid purchasing will align with the regional construct established for ACHs to better leverage *local* engagement and expertise in driving health improvement. Building on the experience of the state’s dual eligibles pilots, future

²⁵ “Washington State’s Plan for Healthy Communities” Department of Health. April 2013. Web.

<<http://www.doh.wa.gov/Portals/1/Documents/Pubs/140-030-WashingtonStatePlanforHealthyCommunities.pdf>>.

²⁶ “Agenda for Change Action Plan” Public Health Improvement Partnership. 2012. Web.

<<http://www.doh.wa.gov/Portals/1/Documents/1200/A4C-APsummary.pdf>>.

²⁷ “Washington State Early Learning Plan – Executive Summary” Sept. 2010. Web.

<http://www.del.wa.gov/publications/elac-qris/docs/ELP_Exec.pdf>.

²⁸ “Prevention Redesign Initiative” Washington State Department of Social and Health Services. Web.

<<http://www.dshs.wa.gov/pdf/Publications/22-1464.pdf>>.

²⁹ “Innovation in Washington State” Center on the Developing Child, Harvard University. Web.

<http://developingchild.harvard.edu/index.php/resources/multimedia/videos/frontiers_of_innovation_videos/innovation_in_washington_state/>.

³⁰ “The Washington State ACES Public-Private Initiative” APPI. Web. <<http://www.appi-wa.org/>>.

Medicaid procurement activities will use a similar process of collaboration with ACHs to ensure that a local presence is meaningfully included in procurement design, assessment, and subsequent oversight of delivery system performance.

Use Data to Drive Community Decisions. Washington recognizes that place matters when it comes to achieving better health. ACHs need data to prioritize initiatives and investments to move the needle on improving local health outcomes. The State will leverage its planned Health Mapping Partnership with the Institute for Health Metrics and Evaluation to better align rich data resources across agencies and as well as infuse much needed local and county based data. New geographic information systems (GIS)-mapping and hot-spotting resources and capabilities will support the State agencies and ACHs in partnership with their local members in better enabling communities use data informed decision making.

Explore new capabilities for cross-sector innovation investment. While the partners in an ACH can achieve many goals through the collective impact of their shared strategies and investments, some strategies will require new resources to accelerate change and spark innovation. During 2014, Washington State and its partners will work together to design a “Transformation Investment Toolkit” to support innovative projects in regions, aimed at addressing the needs of rural and/or urban populations. The toolkit will include a number of financial tools that can be used by funding partners to provide “venture capital” to finance evidence-based strategies to meet the aims of improving care and population health while reducing future costs in the social and health sectors. The toolkit could include “social impact bonds,” mission related investments, and revolving loans and/or loan guarantees.

The toolkit will be designed to produce investment vehicles and priorities that reflect four basic principles:

- There must be reliable evidence that a proposed intervention will produce promised savings.
- A contractual agreement must be in place among those who will reap the savings to repay the loan, bond, or revolving fund.
- To the greatest extent possible, the savings realized will be shared among those who did the work and replenish the funding source, so that additional projects can be created.
- The goal will be to fund a “balanced portfolio” of projects that address a full spectrum of needs.

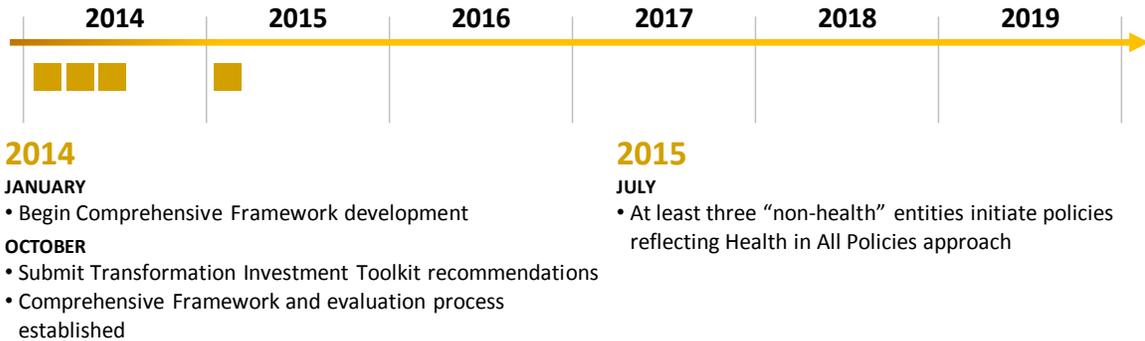
New investment strategies are part of an emerging movement in prevention. As such, the ACH would be directly involved in identifying the projects, stewarding their development and possibly managing the investment fund locally. Funded projects would tie directly to the Regional Health Improvement Plan activities, and have strict evaluation requirements. Examples of potential investment initiatives could include projects that reduce the impact of asthma, provide health services in housing for chronically homeless individuals, expand evidence-based home visiting programs, or prevent or mitigate ACES.

It will be critical to assess challenges and make recommendations to build a path forward for the development of the Transformation Investment Toolkit. In 2014, experts from the Governor’s office; State agencies; the community development, health, and finance sectors; philanthropy; and each region will be jointly tasked with identifying and evaluating financing mechanisms that have the potential to align public- and private-sector funding more directly with improved social outcomes; increase the pool of capital available to fund prevention and early intervention; encourage a broad diversity of service providers to collaborate; and encourage a more rigorous approach to performance management. They also will explore the proposed funding

mechanisms, investigate current application of these concepts in other sectors and regions, define the set of social/health issues viable for investment, and recommend the mechanisms with the best potential to achieve positive health outcomes and return on investment. This work will provide opportunities for stakeholders to be engaged in the development of the toolkit, with the goal of submitting broadly supported recommendations to the Governor’s office by fall 2014.

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Healthy Community Milestones



Strategy 3 **Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities**

Needlessly complex health care and benefit systems are major obstacles to prevention and effective management of chronic disease. The Public/Private Transformation Action Strategy articulates Washington’s plan for both clinical prevention and screening and effective management of chronic conditions. Interlocking and mutually supportive benefit design, education and reimbursement changes work in tandem with changes in delivery system organization to drive better outcomes at lower costs across all market segments. The Transformation Action Strategy, as supported by the Innovation Plan’s foundational building blocks, sets forth concrete steps to accelerate adoption of the Chronic Care Model across Washington, and its central vision of productive interactions between prepared, proactive practice teams and informed, activated patients.³¹

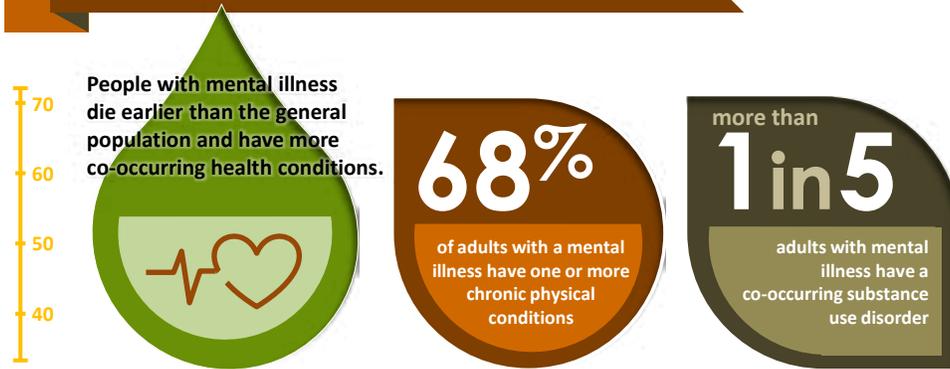
Better serving individuals with both physical and behavioral health issues will yield enormous returns, both in monetary savings and by preventing needless suffering and premature death. Collaborative care for mental health, substance use, and primary care services produces better outcomes and proves the most effective approach to caring for people with multiple health care needs.³² To this end, in addition to the general strategies for improving chronic illness care outlined in the Transformation Action Strategy, the Innovation Plan focuses on two key integration strategies:

- Spread and sustain effective models of integrated physical and behavioral health care.
- Restructure Medicaid procurement through a phased approach to support integrated physical and behavioral health care with links to community resources.

³¹ Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood)*. 2001;20:64-78.

³² “What is Integrated Care?” SAMHSA-HRSA Center for Integrated Health Solutions. Web. <<http://www.integration.samhsa.gov/about-us/what-is-integrated-care>>.

The PROBLEM



Source: Adapted from SAMHSA-HRSA Center for Health Integration Health Solutions infographic

Spread and sustain effective models of integrated physical and behavioral health care

Effective and innovative models of integrated physical and behavioral health care are operating in Washington State today.³³ Washington’s Innovation Plan aims to further spread and support models of effective collaborative care in both physical and behavioral health-centered settings. Cross-cutting infrastructure elements built or enhanced through the Innovation Plan will support the spread of these models where clinical practices and health centers are looking to operate bi-directionally in a community system of care.

This approach can reduce mental health symptoms, is particularly effective for depressed patients who also suffer from a medical condition, and delivers major savings³⁴. Furthermore, these models are important in assuring that substance abuse services are also available to individuals with varying complexity of physical and mental health co-morbidity. To varying degrees, transformative models co-locate clinicians, coordinate care across providers and systems, incorporate collaboration and joint decision making on treatment, engage in joint planning and financing of services, and employ a holistic wellness orientation to the array of services offered. They have all made advances along a path to full integration, with bi-directional relationships between physical and behavioral health providers. For example, leading community mental health centers have successfully demonstrated their ability to broaden their scope to better identify and coordinate services required by individuals with complex physical and behavioral health needs.

“Mental health and chemical dependency services need to become better integrated with each other; any further separation would be a step backwards. These service systems should be integrated in a single payment and management structure. More effective service coordination is also needed with physical healthcare, through bi-directional integration approaches and care coordination.”

— Ann Christian, Chief Executive Officer
Washington Community Mental Health Council

³³ Models include Collaborative Care primary care sites evaluated in the IMPACT study, as well as behavioral health models such as those exemplified by Kitsap Mental Health Services—a CMMI Innovation Award Grantee—Asian Counseling and Referral Services, DESC and Navos, all SAMHSA-HRSA Center for Integrated Health Solutions Primary and Behavioral Healthcare Integration Program awardees. Peninsula Community Health Services is a recipient of the Social Innovation Fund Grant through the John Hartford Foundation. Many of these innovation leaders are following practices developed and elaborated by the University of Washington AIMS Center, following the principles of measurement-based care, treatment to target, stepped care, and other aspects of the chronic illness care model developed by Edward Wagner and colleagues at the Group Health Research Institute MacColl Center for Healthcare Innovation, also located in Seattle, Washington

³⁴ “Collaborative Primary Care: Preliminary Findings for Depression and Anxiety” Washington State Institute for Public Policy. Oct 2013.

They are a natural setting for bi-directional integration in which the co-location of clinicians has strengthened the capacity of multiple local providers to meet a wide array of behavioral health needs, as well as increased access to physical health care for community mental health center clients. An additional innovative model of co-located integrated services is seen with MultiCare Good Samaritan Behavioral Health’s provision of Mobile Integrated Health Care for adult public mental health clients in Pierce County. In this model, health care is delivered from a mobile unit that visits four community mental health centers each week.

Bi-Directional Integrated Care Examples	
<p style="text-align: center;">KITSAP MENTAL HEALTH CENTER</p> <ul style="list-style-type: none"> ■ Behavioral health (BH) center - psychiatric consultation for primary care providers (PCPs) supports rapid diagnostic, medical management, and training. ■ Behavioral health provider serves community PCP offices for low/ moderate BH needs and to coordinate access as needed to specialty BH services. ■ Primary care provider co-located in behavioral health center supports patients who prefer PCP services at the behavioral health center. ■ Team-based approach to clientele identified as having chronic health conditions in addition to BH needs. Team includes medical assistants and focus on improving health status. 	<p style="text-align: center;">VALLEY VIEW HEALTH CENTER</p> <ul style="list-style-type: none"> ■ Primary care clinic (Federally Qualified Health Center) – Regularly scheduled, technology-supported, psychiatric consultation for primary care providers supports rapid mental health diagnosis and treatment (including psychiatric medications), and training. ■ On site, behavioral health provider serves patients at the community PCP offices for low/ moderate BH needs and to coordinate access as needed to specialty BH services. ■ Services provided are patient-centered, promote evidence-based practices, and have a primary focus on improving clinical outcomes. Regular, proactive screening and monitoring assures that patients are treated to achieve clinical goals and do not “fall between the cracks.”

Additionally, through the Mental Health Integration Program (MHIP)³⁵, physical and behavioral health care needs are served primarily in a physical health care setting. Behavioral health services are co-located in the physical health care setting and include access to psychiatric consultation and services to rural primary care offices for low/ moderate behavioral health needs. Programs such as these (i.e., based on the Collaborative Care model³⁶) are backed by considerable evidence of effectiveness in safety net populations and patients from diverse ethnic groups. They can and do reduce health disparities observed in these populations. As has been the case with similar initiatives across the country, MHIP demonstrated that the most powerful results combined the Collaborative Care Model with practice facilitation and supportive payment methods.

Effective spread and adoption of more highly integrated and collaborative care requires focus and resources. A survey of community mental health centers, conducted by the Washington Community Mental Health Council, identified key barriers to spreading integrated service delivery.

³⁵ “Overview: Integrated Mental Health Care” AIMS Center, University of Washington, Psychiatry Behavioral Sciences. Web. <<http://uwaims.org/overview-integrated.html>>.

³⁶ Unutzer, Jurgen MD, MPH et al. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. May 2013.

Spotlight on ...

Housing and Employment Supports

Any vision for an integrated approach to providing physical and behavioral health care must include housing and employment supports. Homelessness interferes with one's ability to receive physical and behavioral health services, jeopardizes chances for successful recovery, and puts individuals at risk for mental health and substance use disorders. Additionally, unemployment increases the risk for mental health and substance use disorders³⁸. Innovative models utilized in Washington state support the building evidence that housing and employment supports are cost-effective and assist recovery.

In the first outcomes paper from Seattle's Downtown Emergency Service Center's 1811 Eastlake Housing First program for chronically homeless people with severe alcohol problems, University of Washington researchers show that providing housing and on-site services, without requirements of abstinence or treatment, is significantly more cost-effective than allowing people to remain homeless.³⁹ North Sound Mental Health Administration's study of their Supported Employment program found that Supported Employment services result in the highest reduction in cost of service of any adult outpatient program over two years. Looking at the post two-year period, people in a Supported Employment program reduced outpatient service cost by 73 percent compared to only a 61 percent reduction for regular outpatient services.

These barriers, in response priority order include inflexible reimbursement structures, information sharing obstacles, regulation (e.g., licensing, accreditation, reporting), infrastructure capacity (e.g., remodeling, equipment), workforce (e.g., availability of trained staff, cultural competence), and legal barriers such as site restrictions. From the models of effective bi-directional integration of physical and behavioral health currently operating in Washington, learnings include:

- **Access to expanded clinical and claims data is essential.**

Providers and care teams must have access to stable data systems for sharing patient health information and for monitoring quality and performance measures that support the goals of whole-person care and accountability for health outcomes.

Some behavioral health providers lag behind in terms of health information technology and do not fit easily into the CMS requirements for electronic health record meaningful use support³⁷. The Innovation Plan proposes to support behavioral and primary care health providers' access to clinical tools offered through the State HIE, enabling real-time shared care planning. Washington is currently developing an expanded tool set to complete the secure exchange infrastructure the HIE currently operates.

New capabilities would include a clinical data repository, care management tools, less resource-intensive EHRs, and a patient portal. With maturing standards of data exchange through the country, including the Continuity of Care Document (CCD), and a significant enhancement of the HIE toolset, community and provider capacity for care coordination and patient activation will be strengthened considerably.

³⁷ CMS programs provide incentive payments to eligible professionals, hospitals and critical access hospitals as they adopt, implement, upgrade, or demonstrate certified EHR technology.

³⁸ Adult Behavioral Health System- Making the Case for Change, November 29, 2012

³⁹ Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems - The Journal of the American Medical Association (Vol. 301 | No. 13, April 1, 2009)

Behavioral health providers also must ensure that protected health information is both private and secure. Washington State will therefore provide technical assistance support and tools at the outset that will permit behavioral health providers to more readily obtain and document client consent for information sharing.

The State will also provide intentional intermediary support for providers moving toward integrated care delivery for high-risk Medicaid enrollees through expanded statewide analytic capacity to connect with PRISM, a data tool that identifies individuals with physical and behavioral health co-morbidities and consequent need for targeted care management.

Spotlight on ...

Tribal Health

Hallmarks of Washington's tribal programs are various forms of integrated physical, behavioral, and dental health care. The work of a 35-member Tribal Centric Behavioral Health workgroup has identified further opportunities to improve cross-system connections and support the physical and behavioral health needs of American Indian / Alaska Natives and their families. Recommendations in the workgroup's report⁴¹ align with and leverage Innovation Plan elements that support practice transformation and strengthen linkages between health care delivery systems and critical community resources.

■ Clinical practice redesign requires support.

Development of effective models of integrated health care has previously been possible with targeted financial support, such as the CMMI Transformation grants. The newly formed Transformation Support Regional Extension Service will provide and/or facilitate practice support to accelerate transformation of care delivery.⁴⁰

Flexibility in payment methodologies also will be necessary to sustain practice redesign so that financing is less administratively burdensome, funding streams are integrated, and providers able to accept risk for an array of clients and services can do so without disruption in care.

For Medicaid enrollees, this may require waiver(s) of federal requirements; a dialog and analysis that is continuing as advancements in Medicaid purchasing are assessed in light of implications to the development of ACHs and critical linkages with social supports.

- **Increased workforce capacity and new skills are necessary.** Additional emphasis on “whole-person” care, the implications of a multi-disciplinary team approach, and the value of local community health workers and experienced peer supports who provide a strengths-based approach to partner with clients are changing the health care workforce and the skills needed to meet individual, family and community needs.

Washington plans to enhance secondary and post graduate training programs, building on existing best practices in curriculum development, such as the training program developed at Olympic Community College in consultation with Kitsap Mental Health Services. Specifics will be informed by ACH priorities established to respond to local needs. As outlined in the Innovation Plan's workforce building block, a workgroup will be convened to develop road map and timeline elements to build a community health worker (CHW) workforce in Washington State⁴². This will also address capacity building for effective use and training of

⁴⁰ The support will focus on training, tools, technical assistance, and implementation support to get started; build teams; and adopt measurement based care, clinical skills, tracking, patient/client engagement and a change management culture.

⁴¹ “Office of Indian Policy” Washington State Department of Social and Health Services. Web. <<http://www.dshs.wa.gov/oip/index.shtml>>.

⁴² The Department of Health now has a functioning training program to enhance skills of CHWs. In the short term, The Comprehensive Health Education Foundation has provided professional support and consultation with sites and

Certified Peer Counselors. The engagement of CHWs can decrease care cost, increase client participation and increase personal responsibility for well-being. A similar effect is notable from the work of Certified Peer Counselors who are trained individuals, in recovery from behavioral health conditions and uniquely skilled at engaging individuals through their own personal stories of recovery.

Spotlight on ...

Long Term Services and Supports

The Innovation Plan recognizes the critical value of long-term services and supports (LTSS) in maintaining the health of vulnerable Washingtonians with serious health and personal care needs and those with disabilities.

LTSS efforts and outcomes around care transitions, person and family activation, and community linkages dovetail with the state's aims of better health, better care, and lower costs. While the Innovation Plan is focused more narrowly on physical and behavioral health integration, it is anticipated that future efforts will build upon initial whole-person initiatives to more directly integrate LTSS.

Washington implemented community based health home networks in its managed care and fee for service delivery systems beginning in July 2013. These networks are building critical community infrastructure and relationships between delivery systems that are essential to ensure care is coordinated at the local level. Care coordination is delivered by individuals embedded in local community organization so they are available to make in-person visits and by telephone to help the individual and their families.

■ **Washington's ability to provide integrated services and whole-person care is constrained in part by inconsistent rules for substance use professionals.**

Certified chemical dependency (CDP) professionals are unable to provide chemical dependency services outside specified settings although their scope of practice would allow it. Efforts are underway to lift the restrictions and to support other highly trained practitioners in obtaining their CDP certification.

Restructure Medicaid procurement to support integrated physical and behavioral health care with links to community resources.

Effectively driving and supporting change at the clinical and community levels requires that the State revise its approach for purchasing Medicaid coverage and services. By 2016, the State will enter a new era of Medicaid purchasing with a greater level of accountability and community involvement to serve the whole person through integrated physical and behavioral health care delivery.

Under the proposed structure, Medicaid procurement will be reorganized into regional service areas that correspond with boundaries defined for Accountable Communities of Health. As such, service regions reflect opportunity for *local* innovation, collaboration and accountability for services and performance in the delivery system. Within each regional service area, multiple accountable risk-bearing entities, or "ARBs," will compete for physical and/or behavioral health system contracts. Competing organizations may include health maintenance organizations, managed care organizations, behavioral health organizations, accountable care organizations, risk bearing public/private entities, county governmental organizations, or other community-based organizations with a risk-bearing partner or direct capacity to assume full financial risk (for physical and/or behavioral health).

potentially could provide broader based support to additional sites in consultation with Accountable Communities of Health. The Department of Social and Health Services currently certifies peer counselors, with an ongoing waiting list. The impacts of these efforts can be evaluated against measurable outcomes.

This is a paradigm shift for Washington State. To leverage the catalyst role of ACHs in driving regional health improvement, Medicaid purchasing requires a partnership of State and local government, health care providers, health plans, and community-based organizations to ensure that the local context is reflected in procurement design, assessment, and subsequent meaningful oversight.

While this is essential, at the same time the State must retain ultimate decision-making responsibility for contractor selection and performance oversight. In addition, unified financing, delivery, and administrative systems that maximize health achievement at the regional level may require federal waiver(s) of Medicaid regulations. The dialog for re-shaping Medicaid procurement has begun and will be critical to the future sustainability of the program.

Medicaid competitive procurement targeting integrated purchasing of mental health, chemical dependency, and physical health care will occur in stages, toward the Governor’s vision of full integration by 2019⁴³. This approach will also enable Washington to address CMS’ concerns and the expectation that Medicaid mental health services be acquired through competitive procurement⁴⁴.

Based on a thorough consultation process with stakeholders, including local governments, key elements of a competitive procurement will be established with the greatest degree of integrated delivery anticipated where regional service areas develop an ACH with collaboration among ARBEs and community resources for housing, employment, criminal justice, and other services that complement effective integrated physical and behavioral health care delivery.

Key purchasing discussions will cover the inclusion of counties in specific procurement geographic regions. They will also consider ACH feedback on the desirable balance of competitive ARBEs serving a region while ensuring streamlined administration at the practice level and access to substance abuse services for individuals at varying degrees of risk and health status complexity.⁴⁵

“The Washington Association of Alcohol and Addiction Programs membership really aligns with the plan’s emphasis on the integration of chemical dependency with managed health plans for the many individuals that make up the non-disabled Medicaid expansion population. We believe this will go a long way in realizing the promise of the Affordable Care Act with regard to appropriate access and healthcare savings. Persons suffering from addiction can and do recover every day.”

— Cheryl Strange, Vice President, Pioneer Human Services & President, Washington Association of Alcoholism & Addictions Programs

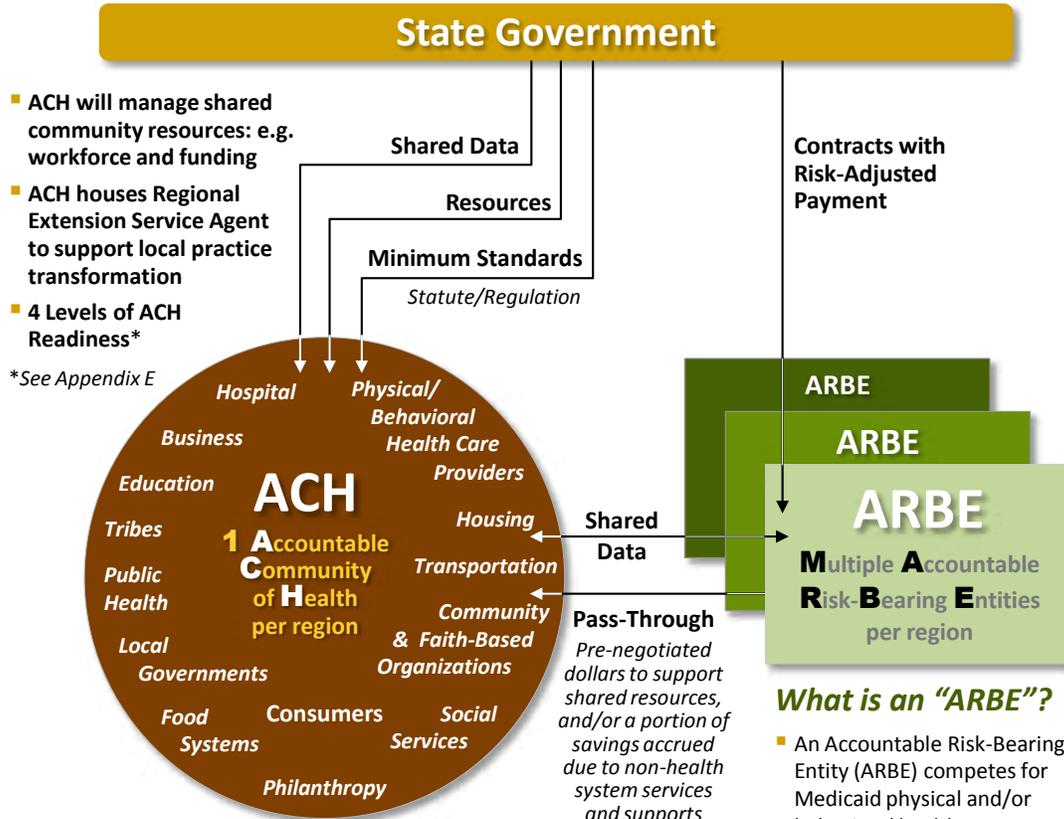
In consideration of the extensive feedback and input received throughout the Innovation Planning process, further key policy and operational questions will need to be addressed with state and community partners during procurement development for both purchasing pathways. Preliminary planning for these discussions is underway.

⁴³ “A New Approach to Behavioral Health Purchasing” Washington State Office of the Governor. Nov. 2013. Web. <<http://seattletimes.wpengine.netdna-cdn.com/opinionnw/files/2013/11/Mental-health-procurement-Inslee-plan.pdf>>.

⁴⁴ On July 5, 2013, CMS sent a letter identifying concern over the nature of the current mental health contracts with Regional Support Networks, offering two options, (a) open competitive procurement and (b) a cost-based reimbursement system based on payment for services rendered.

⁴⁵ Through the Affordable Care Act, the requirement to cover services for Screening, Brief Intervention and Referral to Treatment (SBIRT) has been set as a requirement for Medicaid benefits.

New Integrated Regional Approach: Medicaid Financing and Delivery Re-Engineering



See Appendix H for more on the accountable risk-bearing entities.

In the initial procurement phase, two pathways will be offered, both of which are intended to lead to the eventual full integration of physical and behavioral health care and requirements for social support service linkages for Medicaid consumers who need them. Essential behavioral health services, regardless of the ARBE construct, include:

- Inpatient treatment
- Residential and outpatient treatment
- Evaluation and treatment services
- Chemical dependency residential and outpatient treatment
- Opiate substitution treatment
- Chemical dependency outreach, intervention, and referral
- Intensive outpatient mental health services
- Offender reentry services
- Case management
- Utilization management
- Information services

Spotlight on ...

Oral Health

Washington's oral health system—while largely separated from other areas of health care financing and delivery—is making great strides in ensuring individuals are treated holistically.

Oral health integration into primary care in the state includes practice transformation, engagement with regional community-based efforts, public awareness campaigns around early preventive care, and inclusion of oral health requirements in patient-centered medical home certification.

There is much to be learned from initiatives such as The Everett Clinic's case management and health coaching to address oral disease in primary care, training around the connection between oral health and overall health through family practice residency programs, the Whatcom Alliance for Health Advancement's dental needs assessment and referral system, and Neighborcare Health's promotion of collaboration between dental and medical services.

Oral health improvement is a strong interest of many communities and will be part of Accountable Communities of Health and practice transformation support efforts.

Additionally, learnings from current efforts around physical and oral health integration and the Innovation Plan's physical and behavioral integration strategies can inform and support one another.

Further critical procurement discussions with stakeholders must consider the functional and risk alignment between ACH regions and ARBEs for providing a seamless continuum of crisis outreach, diversion, and involuntary commitment services. Initial contracts supporting the two procurement pathways are expected to be effective in 2016.

- **The first pathway is provided to “early innovator” regions** in which ARBEs show readiness to manage integrated physical and behavioral health services and link them to shared community resources⁴⁶ and the functionality of ACHs is advanced enough to influence effective linkages and necessary changes.

Future procurement opportunities would be staged as additional regions demonstrate interest and readiness. It is intended that multiple ARBEs would be actively competing in each “early innovator” region at any given time. However, this raises policy and operational questions that need to be addressed to ensure that financing and administrative requirements are not transferred downstream as an additional burden to providers operating desired bi-directional integrated care models. As discussions continue, policy questions likely will be refined and answered to clarify procurement details and bring the regional context into focus.

- **The second pathway is available in all remaining regional service areas**, with physical and behavioral health services delivered through separate but parallel managed care contracts. ARBEs in the form of behavioral health organizations (BHOs) will be responsible for the delivery of coordinated mental health and chemical dependency treatment services. ARBEs in the form of managed care organizations will be responsible for the delivery of coordinated physical health and limited mental health services provided in a physical health setting.

The boundary of responsibility between these two ARBE models is a key and ongoing discussion topic with clarification essential to ensure that Medicaid purchasing advances toward fully integrated ARBE models by 2019.

⁴⁶ Conceptually, this may include programs for involuntary commitment, housing, employment services, crisis and help lines and prevention/ health promotion. Details would be a key discussion in the next procurement design.

Appendix H identifies several policy discussion questions yet to be fully considered in the implementation phase. The two purchasing pathways reflect a move beyond the current status quo in Washington, in which the level of integration of financing and administrative systems is increasingly geared toward support for integrated service delivery. Acceleration of their success is predicated on the resolution of the impediments reflected through the Innovation Plan, such as the need for data sharing capacity and authority, streamlined administrative reporting and assessment tools, aligned and simplified regulatory requirements, and State contracts with incentives and penalties that result in the performance accountability and outcomes needed to achieve the goals of the Innovation Plan.

An overview of the options that underpin this strategy is included in the figure below with reference to options in other states that may guide the consideration of remaining policy issues and acceleration of Washington State’s integrated Medicaid procurement.

Beyond the Status Quo: New Options for Washington



*ASO would coordinate care & providers would bill on a FFS basis; BHO would be capitated, coordinates care while providers bill the BHO

ROADMAP FOR HEALTH SYSTEM TRANSFORMATION

Key Integrated Care Milestones



2014

JULY

- Medicaid “Innovation Waiver” concept paper submitted to CMS

2015

JANUARY

- Initiate Medicaid RFP: Early innovator and BHO/HO

JULY

- Medicaid “Innovation Waiver” approved

2016

JANUARY

- Medicaid early innovator and/or BHO/HO in place

2019

- Full purchasing integration of physical/behavioral health care



■ SECTION 4

Financial Analysis

Financial Analysis ■ Washington's Innovation Model

Washington's State Health Care Innovation Plan is estimated to generate cost savings of just over \$730 million in three to five years, with an estimated 13:1 return on investment. These estimates are based on conservative actuarial assumptions that avoid the compounding influence of trend, with savings and return greatest in Medicaid. They illustrate the importance of the plan's proposed strategies to integrate physical and behavioral health care delivery systems and supports. Under more mainstream actuarial assumptions that accelerate implementation of Innovation Plan interventions across all market sectors, the opportunity for savings could be in excess of \$1 billion.

Introduction

Mercer Health & Benefits ("Mercer") was engaged to assist in the preparation of a financial evaluation of the Innovation Plan. This summary of findings describes the analytic approach, including data assumptions, basis of the assumptions, and methodologies underpinning the findings. The entire Mercer report is included as Appendix K. Substantial portions of that report are excerpted below with additional State-specific information incorporated.

The populations addressed in the analysis include State Medicaid beneficiaries, members of the Public Employees Benefits program (PEB), commercially insured state residents, and Medicare beneficiaries. The intent is to recognize, to varying degrees, the impact of the Innovation Plan across Washington's marketplace, and its propensity to impact the health and health care of the state as a whole. For each population, the analysis addresses:

- The population's projected total medical and other service costs absent the Innovation Plan; and
- Anticipated cost savings resulting from specific outcomes anticipated as a result of the Innovation Plan interventions.

Estimates of the costs necessary to implement the Innovation Plan are considered in total (not specific to population segments) and compared to total estimated savings across all population segments. This allows estimation of potential return on investment over the first three years of the project period. Investment costs represent only the initial funds required to implement the Innovation Plan. They do not duplicate other State investments already contemplated as a normal course of business, such as to administer the Medicaid and PEB programs. However, the State anticipates that future growth in costs for these programs will be dampened over time as a result of the Innovation Plan. Any costs related to the administration and maintenance of the Innovation Plan beyond its five-year duration will be assessed in conjunction with future State budgeting cycles.

References to published studies, prior experience studies and other sources of information relied upon in developing the estimates presented in this financial analysis are included in Appendix J.

Analytic Approach

The Innovation Plan envisions far-reaching and cross-cutting changes to the ways in which the state organizes and purchases health care and support services, and how providers are reimbursed under State-purchased health benefits programs. By acting as a “first mover” and through execution of the Public/Private Transformation Action Strategy, it is further anticipated that many of the interventions first implemented by the State will subsequently be adopted by other purchasers and payers, or will indirectly affect care delivery for all participants in Washington’s health care system—and thus result in additional savings from commercial and Medicare programs. However, operational details of tactics that would support specific savings from individual components of the plan are limited. For example, although many major payers and providers in Washington, including clinical leaders in quality and innovation, have expressed commitment to participate in the Innovation Plan’s Public/Private Transformation Action Strategy, the common health care system redesign, payment reform, value-based benefit design, and consumer education strategies envisioned are yet to be fully operationally designed. As a result, the Innovation Plan is considered as a whole to be the required supporting infrastructure needed to achieve the specific objectives described in the proposed model.

A subset of the expected outcomes is amenable to actuarial methods and therefore addressed in the financial analysis, i.e., those that are quantifiable and have direct impact on medical expenditures. While this approach does not attempt to quantify all the potential financial outcomes resulting from implementation of the Innovation Plan, it does serve to provide a robust demonstration of the Innovation Plan’s ability to generate a positive return on investment.

Although the Innovation Plan horizon is five years, the analysis is performed entirely in 2015 dollars. This avoids the compounding influence of trend which may serve to distort impacts over time. In other words, savings estimates are made relative to a “zero-trend” environment. Because this environment is unrealistic absent significant intervention, the approach is likely to result in conservatively low estimates of savings from the Innovation Plan. In addition, the analysis is limited to annual estimates of savings for the first three years of implementation, with an assumption that impacts will be increasingly apparent over time.

Unlike many actuarial analyses, the resulting estimates combine analysis of other studies and implementations, reliance on actuarial experience and judgment, high-level estimation methods, and an understanding of Washington’s health insurance markets developed over many years. They do not reflect detailed models, simulations or micro-simulations, given that

many of the interventions described are relatively broad themes not suited to such analyses. The resulting financial analysis is an actuarial opinion that captures both the potential savings from the proposed Innovation Plan interventions and the challenges in capturing the savings. Estimates of the return on investment for the Innovation Plan are real-world, albeit somewhat conservative. There are several reasons that conservatism was employed. These include execution risk; competing initiatives at federal, state, local, and provider levels; perceived level of industry and political support; and difficulties associated with shepherding multiple, significant, and fundamental changes concurrently, with implications beyond the health care system in many cases.

Direct Impacts on Health Care Costs

As described above, the financial analysis focuses on certain specific objectives of the Innovation Plan that can reasonably be expected to have direct and meaningful impact on the cost of health care in Washington state. The range of outcomes included in the analysis is summarized in the following table:

Innovation Plan Impact Area	Ultimate Savings Estimates (3+ Years Out)							
	MEDICAID		PEB		COMMERCIAL		MEDICARE	
	Range	Point Estimate	Range	Point Estimate	Range	Point Estimate	Range	Point Estimate
Chronic Care								
Physical and behavioral health Integration	1%-5%	2.5%	0%-2%	0.5%	0%-2%	0.1%	0%-1%	0%
Other chronic disease management	0%-3%	1%	0%-4%	1%	0%-4%	0.2%	0%-4%	0.2%
Acute Care								
Transparency / Payment Reform	0%-4%	0.45%	0%-4%	0.9%	0%-4%	0.18%	0%-4%	0.09%
Preventive Care								
Obesity reduction/ Other Prevention	0%-2%	0.37%	0%-2%	0.25%	0%-2%	0.05%	0%-2%	0.03%
Maternity Care								
Reduction in Elective C-Sections (37-39 weeks)	0%-0.05%	0%	0%-0.1%	0.03%	0%-0.1%	0.01%	0%	0%

Ranges for Medicaid and PEB savings were developed from relevant studies of experience from similar interventions in other geographies. Commercial and Medicare ranges represent the potential for “spill-over” effects resulting from the State acting as a “first mover” in the marketplace. In general, about 10 percent to 20 percent of the expected impact on Medicaid and PEB could be achieved by commercial and Medicare programs once the market changes envisioned by the Innovation Plan are fully implemented and operational.

Different assumptions or scenarios within the range of possibilities may also be reasonable and results based on those assumptions would be different. As a result of the uncertainty inherent in a forward-looking projection over an extended period of time, no one projection is uniquely “correct” and many alternative projections of the future could also be regarded as reasonable. This financial analysis was based on generally accepted actuarial principles and procedures to provide a useful framework for considering the potential value of the Innovation Plan for transformation of health care in Washington.

Prerequisites for Savings Assumptions

Because of the nature of the fundamental structural changes proposed by the Innovation Plan, savings are not quantified for individual components; instead outcomes are anticipated and savings in direct health care costs estimated through successful implementation of the Innovation Plan in its entirety. For example, concepts such as value-based contracting, value-based benefits, Accountable Communities of Health, and bi-directional integration of physical and behavioral health care are viewed as required infrastructure for achieving real savings in acute and chronic illness, and in preventing costs related to obesity, excess maternity costs, uncoordinated/fragmented health care, etc.

While the Innovation Plan as a whole is considered a prerequisite to the estimates, there are particular components for which critical assumptions are made. These include:

- **Value-Based Contracting.** The amount of State-purchased health care funded through value-based reimbursement will meet or exceed the targets set forth in the Innovation Plan. Contracts will include aggressive cost and quality targets, which, if realized will provide reasonable assurance that the proposed objectives will in fact be met. In particular:
 - Shared-savings arrangements are robust enough to ensure realized gains by the payer and include some provision for provider down-side risk if case performance objectives are not met.
 - Any direct patient management expenditures are structured in a way that ensures value for money, and of a magnitude that can reasonably be expected to provide positive return on investment assuming appropriate performance of the services.
- **Value-Based Benefits.** Where applicable, the structure of benefit programs will include strong incentives for the use of lower cost and higher quality/value providers and services. These may include, but not be limited to:
 - Payroll and benefit structures encouraging the use of narrowed networks consisting of demonstratively higher value providers.
 - The use of reference-based pricing (calibrated for savings) for appropriate discrete services with high unit price variation.
 - High-quality decision support aids and programs for individuals with diagnoses related to preference sensitive procedures.
- **Accountable Risk Bearing Entities (ARBES).** In each regional service area, particularly relevant for Medicaid, the State will require successful identification and contract negotiation with ARBEs that are willing and able to accept the risk and accountability expected in the Innovation Plan. These organizations will be held accountable for successfully delivering the outcomes prescribed, in particular the integrated delivery of physical and behavioral health care with necessary linkages to shared community resources. They also will be held financially responsible for the implications of falling short of performance targets.
- **Accountable Communities of Health (ACHs).** Achieving estimated savings will require organized, well-functioning ACHs in each regional service area, which are an important enabler of care delivery at the local level. Estimates assume and encourage the development of evaluation and measurement metrics early in the process. These support the intended purpose of measuring results, help discover and prioritize the most promising interventions, and allow transparency that will tend to drive markets to more efficient positions.

- **Transparency.** One of the most important dimensions of transformation lies in the ability to understand and communicate it. High-quality data supporting clearly articulated measurements against meaningful benchmarks will enable calculation of actual return on investment in the Innovation Plan. Success in this area will create implicit incentives for efficiency, cost savings, and broad improvement in the health of Washington residents.

Potential Sources of Savings Not Addressed

This financial analysis does not attempt to address every potential source of savings that may eventuate from successful implementation of the Innovation Plan. In particular, it does not quantify savings from programs outside the realm of health care. However, the Innovation Plan does envision collateral impacts such as:

- **Administrative efficiencies.** Reduced State administrative expenses through the potential restructuring and reorganizing of the agencies tasked with administering the Medicaid and PEB programs.
- **Reduction in social service and/or public safety expenditures.** Reductions in health, social services, or public safety expenditures resulting from more effective integration of physical and behavioral health care, with strengthened linkage to juvenile and adult detention systems, housing aid, and other shared community resources.
- **Reduction in PEB costs.** Decreased leave and disability costs alongside increased productivity from public and private employees as a result of improved individual and family health status.

Baseline Population Assumptions

Given that implementation of Innovation Plan investments is anticipated to begin in 2015, return on investment is calculated from a state fiscal year (SFY) baseline of 2015. Historical data were selected and brought forward by State agency staff to reflect SFY 2015 “ballpark” estimates for insured individuals and their health care costs. Based on the data available, independent technical assumptions were made for each population—Medicaid, PEB, commercial and Medicare. These data establish a foundation for actuarial opinion of the value of potential system impacts; they do not represent a basis for budget-level analytic modeling.

■ Medicaid:

Population data were based on November 2013 Caseload Forecast Council estimates for SFY 2015 total Medicaid enrollment, with adjustments to account for newly eligible Medicaid expansion adults.

Estimated **annual average per member per month** and **annual cost of care** were based on the aggregation of SFY 2010 claims for Medicaid medical, mental health, chemical dependency, and long-term supports and services, generated by Washington’s PRISM system. These data were grouped into 16 population-risk groups¹ to provide opportunity for more targeted analysis of return on investment impacts from Innovation Plan activities such as the bi-directional integration of physical and behavioral health care. To ballpark SFY 2015 estimates steps included:

¹ Populations were assigned to four risk groups based on service use – high medical risk, high long-term supports and services need, complex mental health needs, and substance abuse /arrests for substance-related offenses. These four risk groups were cross-classified to define the 16 subgroup classifications.

- Calculation of the annual average per member per month (PMPM) cost for SFY 2010 Medicaid claims² - \$442.60.
- This SFY 2010 PMPM was first trended forward to SFY 2015 using the prevailing Medicaid medical zero-trend rate to set a conservative SFY 2015 PMPM unchanged from SFY 2010. Since Medicaid growth rates were artificially constrained during Washington’s fiscal crisis an “upper” boundary PMPM was calculated using the national health expenditures (NHE) average annual medical growth rate of 3.49 percent (2008-2015) to support sensitivity impact analysis assuming constraints were not in place - \$525.41. Consistent with the general conservative approach to the financial analysis, the zero-trend option prevailed.
- Annual costs of care were calculated by multiplying the SFY 2015 baseline population by the SFY 2015 PMPM.

■ PEB:

Population data were based on the 2012 annual report and brought forward to 2015 under an assumed consistent growth rate of 1.5 percent. While these data represented calendar year, it was assumed they would be adequate for a fiscal year estimate so all estimates could be on a state fiscal year basis.

Estimated **annual cost of care** was based on SFY 2015 projections for State and employee premium cost sharing for medical and dental coverage, adjusted to include employee point-of-service cost sharing estimated at about 11.7 percent of total employee expenditures, based on available 2011 estimates. PEB projected revenues for SFY 2015 were used as the basis for total premium cost sharing.

Estimated **annual average per member per month** was computed from SFY 2015 population and annual cost of care estimates.

■ Commercial:

Population data for Washington state’s commercial market were based on estimates of 2012 covered lives published by the Office of the Insurance Commissioner for group, individual, association and self-insured coverage. These data were also used in the Innovation Plan’s environment. In keeping with the conservative approach to obtaining orders-of-magnitude estimates of potential system impacts from Innovation Plan elements, these estimates of 2015 commercial coverage were maintained at 2012 levels. However, on the recommendation of the Washington State Health Benefit Exchange, the total was adjusted to reflect the estimated 2014 enrollment in the Health Benefit Exchange since that was anticipated to be predominantly a previously uninsured population.

Estimated **annual average per member per month** for the commercial market was first estimated from 2008 premiums available from the Office of the Insurance Commissioner; data for premiums across the full commercial marketplace were not readily available for later years. These were brought forward to 2015 using an annual average increase of 5 percent, which is consistent with increases reflected in the latest Washington State Private Employer Health Insurance Databook published by the Office of Financial Management (~\$547.00). Because of the time lag, 2015 premiums were also estimated using average Washington state private employer premiums for single adults, obtained from the 2012

² This average applies across the total Medicaid population and therefore is not a figure typically reported in reference to any individual Medicaid sub-population.

Medical Expenditure Panel Survey (MEPS)³. These too were trended forward to 2015 at a 5 percent annual growth rate (\$517.46). Consistent with the general conservative approach to the financial analysis, the MEPS-based premiums were used to establish the Innovation Plan baseline. They supported an order-of-magnitude estimate for the commercial marketplace, covering individual, group, association, and self-insured products, for which no premium data are readily available.

Estimated **annual cost of care** for 2015 was computed from population and annual average PMPM estimates. Data from the Office of the Insurance Commissioner were used to determine that the actuarial value of most plans on the individual market falls in the range of .20 to .48 while the actuarial value of plans in the small group market typically has been between .60 and .80. Key drivers in this regard are (a) a lack of maternity, prescription drug, and other limited coverage; and (b) high deductibles and out-of-pocket costs (many of which are additive). No adjustments were possible to translate this information into reliable out-of-pocket expenditures. As a result, total annual cost of care covered through the commercial market reflects premium costs only.

■ Medicare:

Population data for Washington state were based on the Kaiser Family Foundation (KFF) state data reporting of Medicare enrollees available at <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/#graph>. “These data include individuals who are eligible for Medicare and are living in US territories or protectorates outside of Puerto Rico or in another country at the time. CMS is not able to assign correct counties of residence to these individuals, though they are enrolled in the Medicare program. Starting in 2011, data are from KFF analysis of the State/County Penetration file, released in March of the given year.” An estimate for 2015 Medicare enrollment in Washington state was calculated using the latest 2011-2012 growth rate, 4.7 percent, carried forward to 2015.

Estimated **annual average per member per month** for Medicare was based on 2009 Medicare spending available from KFF state data reporting at <http://kff.org/medicare/state-indicator/medicare-spending-by-residence/>. These data were brought forward to 2015 using CMS national health care expenditure trends and projections reported in December 31, 2012 at: <http://cms.hhs.gov/research-statistics-data-and-systems/statistics-trends-and-reports-/medicareprogramratestats/downloads/medicaremedicaidsummaries2012.pdf>.

Estimated **annual cost of care** was computed from population and annual average per member per month estimates.

³ Generated using MEPSnet/IC. http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp from the Agency for Healthcare Research and Quality. Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State (Table II.C.1), years 1996-2012: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009), 2009 (July 2010), 2010 (July 2011), 2011 (July 2012), 2012 (July 2013). Medical Expenditure Panel Survey Insurance Component Tables.

Investment Assumptions

The Innovation Plan includes an investment of approximately \$51 million, which can be summarized in three general areas to be distributed over the first three years of implementation:

- Community infrastructure development to support the set-up and implementation and sustainability planning of Accountable Communities of Health in defined regional services areas (total \$9 million).
- Delivery system transformation support related to workforce development, provider assistance with bi-directional integration systems development and consultation, and payment reform (total ~\$15 million).
- Analytics and evaluation capacity for community, market place and public purchasing measurement, reporting and value based contracting/benefits improvements (total ~\$27 million).

Summary of Results

After reviewing the Innovation Plan, comparing and contrasting its features with other similar endeavors, assuming success but applying conservative assumptions as described above, and synthesizing this information at the level it currently exists, savings and return on investment estimates are presented in the table below.

Even with conservative assumptions, the return on investment from the Innovation Plan is significant. It is clear that a sizable gap exists between current care organization and delivery and today's definition of "best practice" such that recouping even a fraction of the potential savings system-wide more than offsets the investment costs envisioned in the Innovation Plan. The approach will continue to be refined, with structure and detail added to the interventions to support successful implementation.

	Medicaid	PEBB	Commercial	Medicare	Total
SFY 2015 Baseline Data					
Size of Population	1,445,944	357,070	2,803,245	1,182,150	5,788,409 ⁴
Annual Cost of Care (all funding sources)	\$7,680 M	\$2,089 M	\$17,407 M	\$13,410 M	\$40,585 M
PMPM	\$443	\$488	\$517	\$945	\$584
Estimated Savings Percentages					
2015	0.6%	0.4%	0.0%	0.0%	
2016	1.4%	0.9%	0.1%	0.1%	
2017+	4.3%	2.7%	0.5%	0.2%	
Annual Savings					
2015	\$50 M	\$8 M	\$5 M	\$1 M	\$64 M
2016	\$110 M	\$19 M	\$23 M	\$7 M	\$160 M
2017+	\$332 M	\$56 M	\$93 M	\$29 M	\$510 M
				Grand Total Savings	\$734 M
				Estimated Investment	\$51 M
				Return on Investment (\$)	\$683 M
				Gross Return on Investment	14.4 : 1
				Net Return on Investment	13.4 : 1

⁴ Note that the total does not represent the full state population. Even after the full implementation of the Affordable Care Act, some portion of the population will remain uninsured and therefore is not included in these estimates.

Plan for Sustainability

Sustainability is fundamental to Washington's Innovation Plan given that statewide system transformation demonstrations and larger-scale efforts predate it and will continue beyond its five-year duration. As noted, it is unlikely the "zero-trend" environment used to estimate savings will occur absent significant intervention. Infrastructure investments, revised purchasing incentives, payment reforms, expanded linkage to community resources, and other strategies bolstered by the Innovation Plan will result in a high-performing health system that sustains itself beyond the Innovation Planning investment period.

Washington has been working for many years toward the interrelated aims of healthier populations, improved care, and lower cost, supported by funding typically provided through governmental grants and programs, the State general fund and tax sources, private "collaborative" contributions, and philanthropic sources. During the fiscal crisis of the early 21st century, many transformation efforts were launched at the local level, with State financing of targeted demonstrations intended to guide broader developments when financial security was more assured.

Anticipated future CMMI testing grant funding, along with State, marketplace, and philanthropic contributions will enable important investments in infrastructure that leverage earlier successes and consolidate the ongoing business case for broad infrastructure improvement. One-time investments, not possible during recent years of government fiscal austerity, will significantly and rapidly accelerate efforts to generate savings and drive gains in health at both the population and patient care levels. Funding also will support continued evaluation of progress, checking and adjusting strategies as needed. Shared accountability for savings, cost avoidance, and progressive improvement, with relatively modest funding for ongoing operational costs will maintain transformation momentum going forward, especially where local, public and private sector gains can be generated from cross-cutting health system and social support efforts. In particular, efforts that result in prevention/delay in the deterioration of physical and behavioral health co-morbidities have already shown capacity for return on investment that make them self-sustaining.

For example, common measurement, enhanced by an all-payer claims database governed by a statewide public/private collaborative organization, will bring greater transparency to Washington's health care market, and create the conditions in which value-based opportunities can be readily identified and decisions made by purchasers, payers, providers, and communities for further improvements. Similarly, as ACHs succeed in driving regional health improvement, addressing health disparities, and reducing costly downstream problems, the case for targeted financing to leverage cross-cutting system improvements will be even more evident. The same is true of the practice transformation support to be provided through the Transformation Support Regional Extension Service, which is currently backed by solid evidence of return on investment.

Overall, it is expected that improved system performance and demonstrated return on investment to multiple stakeholders, including State and local government, purchasers, payers, providers, and philanthropy partners, will consolidate interest in ongoing governmental and cross-sector support for the Innovation Plan.



■ SECTION 5

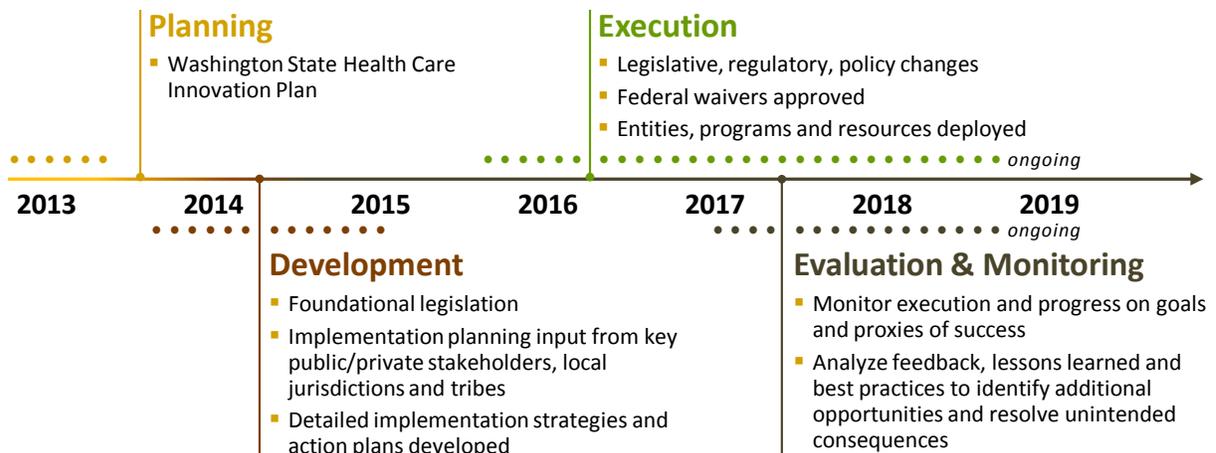
Transformation Roadmap

Roadmap for Health System Transformation

Washington’s Innovation Plan outlines an ambitious strategic vision for health and health care transformation in the state. While the plan outlines specific aims, strategies, and tactics, the path and methods to achieve them are not yet fully developed. The Innovation Plan’s roadmap for transformation outlines critical milestones and necessary policy and legislative actions that must occur in order to bridge from the high-level Innovation Plan to implementation.

The Innovation Plan is only a point on Washington’s innovation journey. The state’s path forward will rely heavily on input and engagement from local jurisdictions, Tribes, providers, quality improvement organizations, purchasers, organized labor, consumers, health plans, communities, policy makers, philanthropy partners, and others to ensure the mobilization of key players and sectors to catalyze highly focused, coordinated action and to spread innovative solutions to meet state aims.

The high-level roadmap for transformation is broken into three key phases: development, execution, and continuous monitoring and evaluation.



Elements of the Innovation Plan hinge on existing, complementary efforts within the state, such as expansion of health information exchange and the development of the all-payer claims database. While these efforts are essential to implementation of the Innovation Plan, they are not reflected in the roadmap, although they were taken into account when developing milestones and timelines.

Development

The development phase will focus on expanding upon the plan's outlined tactics to identify specific and detailed implementation action plans, relying heavily on stakeholder and tribal input and engagement. This stage aims to generate detailed tactics for each of the components of the Innovation Plan, as well as ensure policy and infrastructure supports are in place to support the next phase of implementation. The development phase will allow for the passage of foundational legislation around transparency, common performance measures, regional service areas, and Accountable Communities of Health development (see Appendix I for Governor-request legislation introduced in the State House of Representatives). Select key milestones within the development phase include:

January, February, March 2014:

- Initiate discussions with key thought leaders including communities, Tribes, providers and public health jurisdictions regarding the design of Accountable Communities of Health.
- Begin the development of initial Comprehensive Framework for Prevention.
- Launch a voluntary survey of all Washington health plans and third-party administrators to firmly benchmark current levels of value-based payment.
- Initiate the discussion and development, if necessary, of a Medicaid "Innovation Waiver" for flexible funding mechanisms.

April 2014:

- Convene the exploratory Workforce Roadmap and Community Health Worker task force.
- Pass supporting legislation regarding transparency, common performance measures, regional service areas, and Accountable Communities of Health.
- Develop the preliminary Data Mapping Partnership design.

June 2014:

- Establish the Accountable Communities of Health funding structure, request for information parameters, baseline requirements, and other key details, informed by a meaningful, collaborative process.

July 2014:

- Develop the statewide measure set and determine the strategy for reporting the set.
- Submit the "Innovation Waiver" concept paper to the Centers for Medicare and Medicaid Services.
- Sixty percent of Washington's market (payers, purchasers, providers) commit to align their strategies with the Public-Private Transformation Action Strategy.
- Establish the baseline for value-based payment in the state.

August, September, October 2014:

- Determine regional service areas.
- Determine the schedule for joint procurement of State-financed health care.
- Determine an alignment and partnership strategy for the Transformation Support Regional Extension Service and state providers of technical assistance.
- Build initial data visualization and geographic information systems-mapping capabilities in consultation with local health jurisdictions and community partners.
- Submit recommendations for the Transformation Investment Toolkit.
- Issue requests for information/qualifications to Accountable Communities of Health.

January 2015:

- Issue Medicaid requests for proposals for “early innovator” regions and behavioral health organizations/Healthy Options plans, reflecting dual, phased approach to integrated purchasing of mental health, chemical dependency, and physical health care.

Execution

Successfully bridging to execution relies on effective, strategic, and inclusive processes within the development phase. This is imperative because in order to achieve the aims of the Innovation Plan it is critical that aligned efforts be implemented across multiple State agencies, purchasers, payers, local jurisdictions, providers, and communities. The implementation of any one strategy by any one stakeholder group in isolation will not be effective in achieving transformative change. Execution builds upon strategy and infrastructure developed in the previous phase to deploy determined policies, programs, and resources. Select key milestones within the execution phase include:

January 2015:

- Certify at least three Accountable Communities of Health.
- Establish the Transformation Support Regional Extension Service’s organizational structure and advisory board at the state level.
- Requirements are in place for contractors providing State-financed health care to deliver relevant data to the all-payer claims database, implement Bree Collaborative and Health Technology Assessment program recommendations, and participate in Foundation for Health Care Quality clinical quality improvement programs.
- The maternity improvement shared decision aid suite is available and used by State-financed contractors.
- Begin the phased development of data visualization and GIS mapping tools and technical assistance, based on need.
- Begin Workforce Roadmap implementation.

July 2015:

- Begin regular reporting of the statewide measure set.
- At least three Accountable Communities of Health are operational.

- The Transformation Support Regional Extension Service is fully functional at the state and regional levels.
- At least three “non-health” State agencies initiate policies reflecting a “Health in All Policies” approach.
- The “Innovation Waiver” is approved by the Centers for Medicare and Medicaid Services.
- Telehealth and telemonitoring training and equipment are available, and reimbursement barrier solutions are in process.

January 2016:

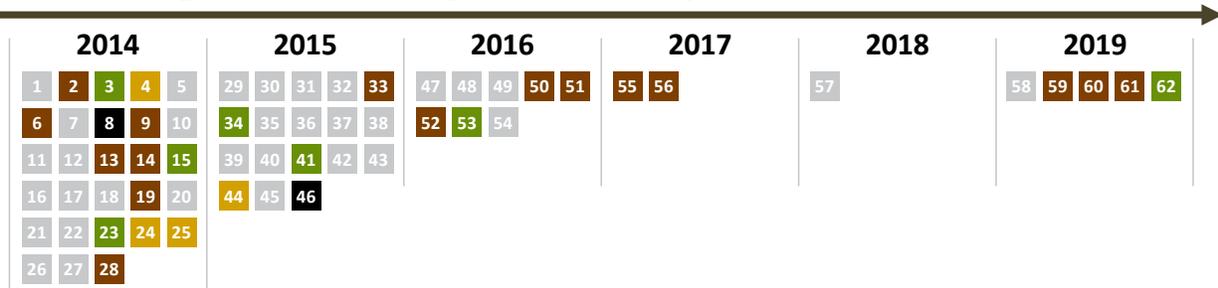
- Medicaid contracts are in place for early innovators integrating mental health, chemical dependency, and physical health care, as well as behavioral health organization and Healthy Options contracts.
- Accountable Communities of Health are operational in all regions.
- At least five State agencies recognize and begin to align distribution of services, administration, and funding in designated regional service areas.
- Implement common RFP elements across state purchasers.

Evaluation and Monitoring

The evaluation phase will begin early and continuously monitor progression toward the state’s aims and intermediate proxies of success. Specific elements for program evaluation related to the Accountable Communities of Health, strategies to integrate physical and behavioral health integration at the delivery level, and State purchasing requirements such as reference pricing, use of decision aids, and implementation of Bree Collaborative recommendations will be developed, in addition to evaluation of overall systems impacts. The evaluation and monitoring phase will begin early and regularly inform next steps and adjustments in execution. A continuous feedback mechanism within the evaluation structure will analyze feedback and learnings to identify opportunities for spread and resolution of unintended consequences. Additionally, the state will continue as a learning health system with Innovation Plan strategies continually informed by evidence generated by state entities such as the Washington State Institute for Public Policy and the University of Washington, as well as national entities. The evaluation phase will monitor progress toward ultimate impacts on health, health care, and costs, as well as intermediate goals, including:

- The regular progression of Accountable Communities of Health along the outlined continuum.
- Fully integrated purchasing of physical and behavioral health care by 2019.
- The regular increase of value-based payment in state health plans.
- The uptake of the Public/Private Transformation Action Strategy throughout the state.

Washington's Roadmap for Health System Transformation



Cross-cutting building blocks

- Transparency (TPY)
- Person/family engagement (P/FE)
- Regionalize transformation (RT)
- Accountable Communities of Health (ACH)
- Data Partnership (DP)
- Transformation Support Regional Extension Service (RES)
- Workforce (WF)

Strategy 1. Drive value-based purchasing across community (V-BP)

- Strategy 2. Prevention and early mitigation of disease (P&EM)
- Strategy 3. Integrated care/supports for physical/behavioral health (IC)
- Legislative action or request

2014

JANUARY

1. ACH: Initiate tribal ACH discussion
2. V-BP: Launch voluntary survey of all health plans on current levels of V-BP
3. IC: Initiate Medicaid "Innovation Waiver" discussion and development
4. P&EM: Begin Comprehensive Framework development.
5. RT: Begin regional service area discussion and designation process.

MARCH

6. V-BP: Public/Private Transformation Action Strategy implementation begins
7. WF: Convene workgroup and CHW Taskforce

APRIL

8. Foundational Innovation Plan legislation passed

9. V-BP: PEB ACO RFI

10. DP: Preliminary design developed

JUNE

11. ACH: Establish funding structure, RFI parameters, baseline requirements and other details through collaborative process

JULY

12. TPY: Statewide measure set and full deployment strategy determined
13. V-BP: Establish state baseline for value-based payment
14. V-BP: 60% of market signs commitment pledges to Transformation Action Strategy
15. IC: "Innovation Waiver" concept paper submitted
16. WF: Initiate additional CHW functional sites
17. DP: State and local data inventory complete, building on existing

SEPTEMBER

18. RES: Finalize alignment/partnership strategy for RES and state TA providers
19. V-BP: Determine State-financed health care joint procurement schedule
20. WF: Finalize roadmap
21. RT: Regional service areas defined

OCTOBER

22. ACH: RFI to ACHs (and then rolling)
23. DP: Initial development of GIS-mapping and visualization
24. P&EM: Comprehensive Framework and evaluation process established
25. P&EM: Transformation Investment Toolkit recommendations submitted

NOVEMBER

26. RT: Key State agencies ensure alignment with regions

DECEMBER

27. SHCIP legislation request
28. V-BP: Goals and expectations of each stakeholder group defined, prioritization areas of alignment selected

2015

JANUARY

29. TPY: State measure set baseline data collected
30. P/FE: State-financed contractors use maternity decision aid
31. ACH: At least 3 ACHs certified (then rolling)
32. RES: Hub organization and advisory board established
33. V-BP: All contractors providing state-financed health care report to APCD, implement BREE & HTA, participate in FHCQ clinical QI programs
34. IC: Medicaid RFP for early innovator and BHO/HO
35. WF: Begin roadmap implementation.
36. DP: Begin phased deployment of visualization and GIS-mapping tools and TA

JUNE

37. RES: TA contractors in place

JULY

38. TPY: Regular reporting of statewide measure set begins
39. ACH: At least 3 ACHs operational
40. RES: Fully functional at state and community levels
41. IC: "Innovation Waiver" approved
42. WF: CHW additional functional sites initiated
43. WF: Telehealth and telemonitoring training and equipment available
44. P&EM: At least three "non-health" agencies initiate policies reflecting Health in All Policies approach

AUGUST-SEPTEMBER

45. RES: Identify and deploy early physical/behavioral health practice transformation model in at least 1 region

DECEMBER

46. SHCIP legislation request

2016

JANUARY

47. P/FE: Partner with IMDF on next wave of decision aids around joint replacement, end of life or other Bree area
48. ACH: ACHs in all regions (Level 2 or higher)
49. RES: Deploy physical/behavioral health practice transformation support in more regions
50. V-BP: Reference pricing in PEB for joint replacement/colonoscopies
51. V-BP: Common RFP elements implemented
52. V-BP: ACO models in Medicaid and self-insured
53. IC: Medicaid early innovator and/or BHO/HO contracts in place
54. RT: At least 5 State agencies align with regional service areas

2017

JANUARY

55. V-BP: Entities with 60% market agree on common purchasing strategies
56. V-BP: More V-BP in state plans by 15 percentage points

2018

57. ACH: ACHs in all regions (Level 3 or higher)

2019

58. ACH: ACHs in all regions at Level 4
59. V-BP: 80% of actions in Public/Private Transformation Action Plan adopted across state
60. V-BP: 80% of state-financed health care V-BP
61. V-BP: 50% of commercial market V-BP
62. IC: Full integration of purchasing of physical/behavioral health care



■ SECTION 6

Evaluation

State-Based Evaluation Plan

The five-year State Health Care Innovation Plan aims are three-fold:

1. By 2019, 90 percent of Washington residents and their communities will be healthier.
2. By 2019, individuals with physical and behavioral co-morbidities will receive high-quality care.
3. By 2019, Washington's annual health care cost growth will be 2 percent less than national health expenditure trend.

The General Plan for State-Based Evaluation of the State Innovation Model

The state-based evaluation of Washington's State Innovation Model (SIM) will comprise two components:

1. A qualitative process evaluation (sometimes referred to as a "formative" evaluation), examining the implementation of the SIM; and
2. A quantitative evaluation that assesses the extent to which, and the speed with which, the SIM achieved its specific quantitative objectives (healthier Washington residents and communities; high-quality care for individuals with physical and behavioral co-morbidities; annual health care cost growth in Washington state 2 percent less than the national health expenditure trend). Where feasible given available resources, in addition to tracking progress over time (before and after implementation of the SIM) on the performance measures for each of the three specific aims, the quantitative evaluation will seek to estimate the impact of particular elements of the SIM (e.g., value-based payment innovations, benefit design changes) and the SIM overall on those performance measures.

In addition to measuring the ultimate impact of the SIM on the specific aims outlined above, during 2014-2019 the evaluation will periodically track the short-term, proximal effects of particular payment, delivery, and organizational interventions within the SIM on the same three aims. This approach to evaluation will promote continuous, real-time learning and facilitate timely response to unintended consequences and changing

environmental and market conditions. In that sense, the evaluation will contribute to performance measurement and improvement as part of a “plan-do-check-act” (PDCA) cycle of innovation.

The fundamental approach to this evaluation of SIM therefore will employ mixed methods—using qualitative methods to better understand and interpret whatever quantitative impacts we might observe. The evaluation will attempt to ascertain causal effects of SIM, where possible; but given the limitations of observational data, the best possible inferences may amount to “plausible attribution” of impacts to the SIM and certain specific components.

Qualitative Process Evaluation

The driver diagram for specific Innovation Plan aims is equivalent to a general “logic model,” or “theory of action,” for achieving the objectives of the Innovation Plan. For evaluation purposes, the driver diagram directly suggests the following illustrative (not exhaustive) questions for the qualitative process evaluation of SIM implementation:

1. To what extent have the action strategies actually been implemented (e.g., deployment of regional procurement strategies)? (“Fidelity” of implementation)
2. What have been the barriers and facilitators to implementing these strategies? Include a discussion of environmental context, stakeholder engagement, resources (physical, human, financial), and other salient factors.
3. Have you modified the strategy since it was originally proposed? In what way?
4. Please describe the logic model behind the strategy you are implementing to attain the objectives for the Innovation Plan Aims (1), (2), and (3). (How are the chosen “levers” expected to achieve the intermediate and final outcomes that they are connected to in the driver diagram for each aim?)

This process evaluation will utilize a combination of intensive, semi-structured key informant interviews, document review, and surveys of SIM stakeholders to answer these questions, which will be tailored as appropriate to the distinct expertise and perspective of different stakeholders. The stakeholder interviewees will include executives and leading staff of State agencies involved directly in SIM implementation (in their respective roles of information provision, purchasing, service delivery, quality assurance, regulation, and research). Executives and staff of private health insurers, employers, healthcare providers, and consumer organizations will be interviewed, as will representatives of local and regional organizations such as the Accountable Communities of Health (ACHs), accountable risk-bearing entities (ARBs), and community-based health and human services organizations. The qualitative evaluation will answer the four questions above, relative to the mediating processes identified in the driver diagram for each of the three specific aims. Provider surveys will be administered to augment key informant interviews and document review as a means of assessing the depth and breadth (spread) of the care delivery-oriented processes in shared care planning, collaborative care, and preventive screening.

For each of the three specific aims: (1) Healthy People and Communities; (2) Better Care for Individuals with Physical and Behavioral Health Co-Morbidities; and (3) Affordable Care, the qualitative evaluation will track progress over time in implementing the major strategies related to each of those aims (Prevention and Early Mitigation of Disease; Integrated Care and Supports for Physical and Behavioral Health; and Driving Value-Based Purchasing across Communities, respectively) relative to the milestones in the Washington Roadmap for Health System

Transformation. Examples (not exhaustive) of those milestones from the Roadmap for each of the three major strategies (and their corresponding aim and projected time of implementation) are listed below to illustrate the specific progress to be tracked qualitatively in the evaluation.

Prevention and Early Mitigation of Disease (Aim 1: Healthy People and Communities):

- Comprehensive Framework for Prevention established (October 2014)
- Transformation Investment Toolkit recommendations submitted (October 2014)
- At least three “non-health” State agencies initiate policies reflecting a “Health in All Policies” approach (July 2015)

Integrated Care and Supports for Physical and Behavioral Health (Aim 2: Better Care):

- Medicaid “Innovation Waiver” concept paper submitted to CMMI (July 2014)
- Issue Medicaid requests for proposals for “early innovator” regions and behavioral health organizations/Healthy Options plans, reflecting a dual, phased approach to integrated purchasing of mental health, chemical dependency, and physical health care (January 2015)
- Medicaid contracts in place for early innovator integrating mental health, chemical dependency, and physical health care, as well as behavioral health organization and Healthy Options contracts (January 2016)
- Fully integrated purchasing of physical and behavioral health care (2019)

Driving Value-Based Purchasing (V-BP) across Communities (Aim 3: Affordable Care):

- Sixty percent of Washington’s market (payers, purchasers, providers) commits to align their strategies with the Public/Private Transformation Action Strategy (July 2014)
- All contractors providing State-financed health care deliver relevant data to the all-payer claims database, implement Bree Collaborative and Health Technology Assessment program recommendations, and participate in Foundation for Health Care Quality clinical quality improvement programs (January 2015)
- Entities with 60 percent market agree on common purchasing strategies (January 2017)
- More value-based payment in State plans by 15 percentage points (January 2017)
- Eighty percent of actions in Public/Private Transformation Action Strategy adopted across state (2019)
- Eighty percent of State-financed health care value-based payment (2019)
- Fifty percent of commercial market value-based payment (2019)

This tracking of progress on milestones will be conducted primarily by the SIM implementation team, but the executive “dashboard” used by SIM leadership to document attainment of milestones will be an important parallel input for the qualitative evaluation.

Aim (1): Healthy People and Communities. The qualitative analysis will utilize key informant interviews, surveys, and document review—emphasizing health care providers, public health, human services, and social services stakeholders directly involved in evaluation, assurance, and service delivery functions. Questions will highlight stakeholders’ assessment of progress toward the principal intermediate outcome of enhancing community capacity to prevent or mitigate disease throughout the lifespan. Qualitative data collection will focus on implementation of several State levers for driving health improvement innovation:

1. **Financial.** Build and implement a common agenda within each Accountable Communities of Health, which considers community priorities and aligns with State priorities.
2. **Structural.** State agencies adopt a “Health in All Policies” approach to incorporate aligned health considerations into decision making in all sectors and policy areas. Use geographic information systems (GIS) mapping and hot-spotting capabilities to support the State and ACH in decision making. Provide practice transformation support at the state and local levels.
3. **Cooperative.** ACH strengthen and formalize supportive structures to link and align partners across the care and community continuum within a region.

Aim (2): Better Care for Individuals with Physical and Behavioral Health Comorbidities. The four general key informant and provider survey questions above will focus on the mediating processes (which also can be envisioned as “intermediate outcomes” along the way to achieving the ultimate aims of improved chronic illness care, with particular focus on better integration of care and supports for individuals with physical and behavioral health co-morbidities. The principal State lever for this aim is structural and involves the Medicaid procurement process. Specifically, the Medicaid procurement process will be restructured into regional service areas, which are linked to communities with better integration of physical, mental health, and substance abuse services.

The qualitative evaluation of this aim also will target the extent to which the following three key actions occur:

1. Effective models of physical and behavioral health integration are spread and sustained.
2. Methods of coordination and team-based care between physical and behavioral health providers are enabled.
3. Reimbursement methods that incentivize better integration of physical and behavioral health care at the delivery system level.

These key actions are closely related to improvements in clinical delivery, which will complement the impacts of restructured Medicaid procurement. In particular, qualitative analysis for the clinical delivery aspects of the Better Care Aim will examine: practice transformation supports and resources; increased workforce capacity and flexibility and attention to access-to-care standards; shared clinical information, outcomes-based provider payment, transparency and performance measurement; activation and engagement of individuals and their families (population-based, household surveys will be required to assess the latter). Interview questions also will explore barriers to, and facilitators of, integration of physical and behavioral health care.

Aim (3): Affordable Care. The same four general interview and survey questions will be posed to stakeholders, but the questions will focus on two overarching mediating processes designed to move away from a largely fee-for-service system to an outcomes-based payment system that delivers improved health, improved care, and lower costs: (i) Washington State leading by example as a purchaser (i.e., the State as “first mover”), and (ii) engaging multi-payers and purchasers in value-based payment and benefit design.

Qualitative data collection will focus on implementation of several State levers for driving affordable care innovation through value-based purchasing (VBP), starting with the State as the “first mover”:

1. **Financial.** Implement reference pricing for joint replacements and colonoscopies in PEB contracts.
2. **Structural.** Require all contractors of State-financed health care benefits to:
 - Use a statewide measure set and contribute cost and quality data to an all-payer claims database.
 - Implement evidence-based purchasing and guidelines recommended by the Dr. Robert Bree Collaborative and the Washington Health Technology Assessment Program.
 - Participate in the Foundation for Health Care Quality’s clinical quality improvement programs.
 - Use provided suites of high-quality decision aids and training.
3. **Cooperative.** Engage multiple payers, providers and purchasers to implement the “Public-Private Transformation Action Plan” to align payment and delivery system transformation.

The key informant interviews and surveys will target health care purchasers (state sponsors and payers and private employers) and private health insurers, with a focus on the drivers for this Affordable Care Aim. Drivers such as deploying regional procurement models and aligning public and private purchaser expectations and wellness efforts represent the mediating processes that will operationalize what it means for the State to “lead by example” and to effectuate a “multi-payer strategy.” These represent the levers that drive those processes (e.g., organizing Medicaid procurement in at least three regional service areas by 2016, building on the Washington Health Alliance (formerly the Puget Sound Health Alliance) purchaser affinity group, and developing a common request for proposals). Key informant interviews will assess the degree to which those levers are being applied and their impact on the intermediate outcomes.

Quantitative Impact Evaluation

The quantitative evaluation will focus on the dependent variables (ultimate objectives) targeted in each of the Innovation Plan’s specific aims. The planned Health Mapping Partnership and its associated data inventory will augment the data available for ongoing performance measurement and improvement efforts, while also expanding the quantitative data available for impact evaluation. The data inventory will include current data resources available through the Department of Health (DOH), Department of Social and Health Services (DSHS), the Health Care Authority (HCA), the Office of Financial Management (OFM), the Office of the Superintendent for Public Instruction (OSPI), Commerce, Labor and Industries (L&I), the Office of the Insurance Commissioner (OIC) and the Department of Early Learning (DEL). The Partnership and the evaluation will also tap PRISM (the State’s integrated social service client database), the Washington Educational Research and Data System; and Washington’s Homeless Management Information System (HMIS).

Aim (1): (Healthy People and Communities) By 2019, 90 percent of Washington residents and their communities will be healthier.

The measure concepts delineated in the driver diagram are a useful starter set of dependent measures for the impact analysis of Aim (1):

- Self-reported health
- Community resiliency scale
- Youth quality-of-life scale

- Children and adults at healthy weight
- Access to primary care
- Preventive care
- Children receiving vaccinations
- Community/clinical relationships
- Additional metrics specified in HB 1519 & SB 5732

In addition to these measure concepts outlined in the driver diagram, the evaluation will consider the following metrics for the quantitative impact evaluation of Aim (1):

Prevention and screening

- Proportion of adults with a healthy weight
- Proportion of adults with healthy blood pressure
- Proportion of children with a healthy weight
- Proportion of the state population:
 - That is tobacco-free
 - With no substance abuse
 - Current on evidence-based immunizations
 - Screened for serious infectious disease (HIV, Hepatitis C)
 - Screened for behavioral health issues
 - Assessed for oral health problems
 - Current on evidence-based cancer screening
 - With a designated primary care provider
- Infant mortality rate
- Incidence rates of newly diagnosed advanced stage cancer
- Death rates from cervical, breast, colon, and lung cancer
- Death rate from drug and alcohol abuse
- Death rate from suicide
- Projected life expectancy and quality of life
- Per capita spending on treatment of preventable conditions

Chronic conditions

- Proportion of individuals with one or more chronic conditions whose healthcare is being well managed
- Proportion of individuals with a chronic condition who have a medical/health care home
- Proportion of individuals with depression, mental illness, or chemical dependency participating in a treatment program
- Rates of avoidable emergency room usage for individuals with chronic conditions
- Rates of avoidable hospitalizations for individuals with chronic conditions
- Rates of avoidable hospital readmissions for individuals with chronic conditions
- Ratings by individuals of their experience with the care they have received
- Use of palliative care vs. treatment at end of life

- Ratings by individuals with chronic conditions of their health and ability to function
- Activation (patient engagement) level of individuals with chronic conditions
- Total cost of care for individuals with chronic conditions, risk adjusted

Acute conditions

- Rates of ER usage for non-urgent conditions
- Proportion of generic drugs prescribed (when generic alternatives exist)
- Proportion of initial births delivered vaginally
- Proportion of babies born full term and at normal birth weight
- Rates of high-tech diagnostic imaging, particularly for conditions such as low back pain
- Proportion of patients
 - Reporting good outcomes from procedures
 - Who die following major procedures
- Proportion of providers with published episode prices for common procedures
- Total spending (by purchaser and by patient) per episode on common procedures, risk adjusted
- Variation in total risk-adjusted spending by provider organization (cost of care) per episode on common procedures
- Per capita rates of procedures, risk adjusted, for procedures where evidence exists that there is overuse nationally
- Per capita spending on most common acute conditions, risk adjusted

The above health measures would be stratified by geographic region (regional service areas), by population socio-demographic characteristics (age, gender, census area geocoding for income and education), and by specific programmatic interventions within the SIM. By its very nature, the SIM creates a series of “natural experiments” in: (a) outcomes-based and value-based payment innovation, (b) care delivery redesign (e.g., collaborative care, shared clinical information, bi-directional behavioral/physical health integration), (c) performance measurement, (d) transparency, (e) clinical and community linkages, and (f) governance (the ACHs). Introducing those innovative interventions in a staged fashion over 2014-2019, offers the potential for a before-after, intervention-comparison design, which would facilitate analysis of the causal effect of certain SIM components on health outcomes.

Aim (2): Better Care. By 2019, individuals with physical and behavioral co-morbidities will receive high-quality care.

The following measure concepts of better care for persons with physical and behavioral health co-morbidities are drawn from the driver diagram:

- Reduction in mortality
- Tobacco and smoking cessation (all care settings)
- Behavioral health assessment (all settings)
- Oral health assessment (all settings)
- Diabetes care (all settings)
- Heart care (all settings)

- Appropriate treatment for chronic conditions
- Mental health consumers receiving services after discharge
- Quality of transitions across care settings
- Emergency department utilization
- Additional metrics specified in HB 1519 & SB 5732

The health outcome (mortality) analysis will be based on annual mortality data for the population of Medicaid clients from DOH.¹ The Medicaid expense (cost) analysis for persons with behavioral health comorbidities will draw source data from ProviderOne², the state's ProviderOne payment system, and three other data systems: TARGET, MH-CIS, and PBPS.³ The DSHS Integrated Client Database likely will be an important source of eligibility and service delivery data (FFS claims and managed care encounters) spanning behavioral health, mental health, and other health care services (hospital inpatient and outpatient, physician services, and prescription drugs).

The Predictive Risk Intelligence System (PRISM) database, developed by the DSHS Research and Data Analysis (RDA) Division with support from the Health Care Authority and DSHS Aging and Disability Services Division, is another valuable data resource for the quantitative evaluation of the Better Care Aim. This web-based, clinical-decision support application offers sophisticated predictive modeling tools and data integration, which facilitates care management for high-risk Medicaid clients. Key dimensions of PRISM include:

1. An electronic health record for Medicaid clients;
2. A comprehensive view of patient risk factors, service use, and health outcomes by integrating medical, behavioral health, social service, and health assessment data; and
3. State-of-the-art predictive modeling, refreshed weekly, to pinpoint patients at greatest risk for high future health care costs, to predict the patient's likely primary care provider, and to classify the extent to which emergency department visits are potentially avoidable.

In order to estimate the effect of the State Innovation Model on the outcomes and health care cost experience of Medicaid clients with physical and behavioral comorbidities, the evaluation team will examine a time series of outcomes and costs before and after SIM for Medicaid clients with those conditions. A matched comparison ("control") group of similar clients *not* participating in the SIM will be obtained, and a difference-in-differences (D-I-D), quasi-experimental design will be used to estimate the causal effect of the SIM on mortality and cost.

¹ Washington State Department of Health. Vital Statistics: Death Data. <http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathData.aspx> Accessed October 18, 2013.

² ProviderOne records all Medicaid claims for outpatient and residential substance abuse treatment services, all encounter data for Medicaid funded outpatient mental health managed care services, and residential claims for mental health treatment. Outpatient demographic and service encounter data is also recorded on the state's Treatment and Assessment Reports Generation Tool (TARGET), which retains client and service encounter data for Medicaid client and non-Medicaid funded services. The Mental Health Consumer Information System (MH-CIS) records demographic data for all mental health consumers and non-Medicaid mental health services. Finally, the Performance Based Prevention System (PBPS) reports substance abuse prevention services and also collects administrative and outcome data on all SAPT Block Grant funded prevention services. Washington State Unified Block Grant: Section E. Data and Information Technology. <http://www.dshs.wa.gov/pdf/dbhr/2012ubgsectione.pdf> Accessed October 17, 2013.

³ See, for example, DSHS' Integrated Client Database (ICDB): a longitudinal client database containing over a decade of detailed service risks, history, costs, and outcomes. ICDB is used to support cost-benefit and cost offset analyses, program evaluations, operational program decisions, geographical analyses and in-depth research. DSHS serves almost 2.4 million clients a year. The ICDB is the only place where all the client information comes together. From this central DSHS client database, we get a current and historical look into the life experiences of residents and families who encounter the state's social service system. <http://www.dshs.wa.gov/pdf/ms/rda/research/11/173.pdf>

The matching algorithm to define the comparison group will use client demographics (age, gender), diagnoses, and area of residence to develop a matched comparison sample of clients. Area of residence will be tied to measures of availability of behavioral and physical health providers, as well as census area, population-based measures of household income and educational status—all of which are important correlates of physical and behavioral health status and health services utilization. By distinguishing the two phases of integrated purchasing over time, the matched comparison, D-I-D design will estimate the differential effects of the SIM over the two phases.

In parallel, and as a cross-validation of the estimates from the D-I-D specification, the evaluators will deploy an interrupted time series (ITS) approach. The ITS design would estimate intervention effects by plotting time trends in mortality and cost against specific time points at which either the “dose” of the innovation changes (e.g., as the intensity or the breadth of SIM’s application changes), or the nature of the SIM is modified. If one observes a significant upward or downward spike in mortality or cost at those time points—after adjusting for client demographics and other observable factors that influence mortality or cost—than the effect is at least plausibly attributable to SIM.

The evaluation team, working in concert with the SIM leadership and implementation team, will balance the requirements of rigorous evaluation of the impact of SIM with the first priority of rapid innovation, system transformation, and performance improvement. By synchronizing the evaluation performance measures with the measure set for SIM itself, the objectives of both the SIM implementation and the impact evaluation would be fulfilled with minimal compromise to either.

Aim (3): Affordable Care. By 2019, Washington’s annual health care cost growth will be 2 percent less than the national health expenditure trend.

The dependent measures of performance relevant to this Affordable Care Aim will be the measure concepts defined in the driver diagram (by year: baseline 2011-2013; post-SIM 2014-2019).

- Health expenditure trend in the state
- The annual level of per capita total health care costs in the state (including measures adjusted for health risk score)
- A consumer affordability index for purchase of health care services and health insurance by level of income
- Measures of (potentially unwarranted) variation in diagnostic, medical, and surgical procedures (focusing on supply-sensitive procedures and delivery of safe and effective care)
- Potentially inappropriate or unwanted non-palliative services at end-of-life
- Use of generic prescription drugs
- Appropriate use of services

Key potential sources of data for these Aim (3) analyses will be the raw data submission files of Washington state insurance carriers and their self-insured data contributors already submitted to the Washington Health Alliance, as well as the to-be-developed all-payer claims data base (APCD) for Washington state as a result of the recently awarded Data Center Grant from the Centers for Medicare and Medicaid Services (CMS).

Quantitative analysis of this aim will concentrate on documenting the extent of outcomes-based payment in State purchasing programs and commercial insurance plans. Implementation of SIM will include a voluntary survey of all Washington state insurance carriers in January 2014 to develop measures of the type and distribution of value-based payment arrangements by carrier and across the state. The evaluation team will construct a count of State purchasing and private commercial agreements with provider groups (for payment) and insured groups (for value-based benefit design). The evaluators will generate descriptive, bivariate analyses that display the different patterns of payment models and plan benefit designs over time (2014 – 2019), by characteristics of the contracting provider organization (e.g., hospital or medical practice, practice size, specialty status – primary care, single-specialty, multi-specialty, rural/urban location, independent or affiliated with/owned by a health system, ownership structure) and the insured entity (e.g., individual or family plan, employer group by size, nature of funding arrangement: self-funded, partially self-funded, or fully insured).

- The appropriate denominator (unit of observation) for the quantitative analysis of this Affordable Care Aim is the purchasing “program,” the purchaser-provider contract (appropriately de-identified in any publication to protect the privacy and confidentiality of specific private contracts), or the health plan policy (and associated benefit design) agreement between the insurer and insured entity. Because the number of such units of observation is likely to be modest, any multivariate analysis of the determinants of penetration of outcomes-based payment and value-based benefit design will be limited to a small number of independent variables, such as the characteristics of contracting provider organizations and insured entities, respectively, as illustrated above.
- As part of the Affordable Care Aim, the following procurement strategy and evaluation design could be applied to estimate the effects of value-based payment on health outcomes, quality of care, and health care costs:
 - The procurement strategy in year one and the end of year three explicitly incorporate assignment of eligible contracted providers to the value-based payment group (intervention arm) and the current payment group (control arm) to enable rigorous evaluation of the impact of the value-based payment method on costs and health outcomes. In the initial implementation wave (year one), the eligible contracted providers assigned to the control group could become part of the value-based payment group at the end of year 3—thus giving providers in the initial wave some assurance of potential benefit from the value-based payment innovation.
 - This evaluation design represents a “waiting control group” approach to a trial. A second assignment would occur at the end of year 3, with a new set of eligible contract providers assigned to value-based payment (the intervention arm) and the remaining providers to the current (non-value-based) payment method. By switching the year 3 control group providers to value-based payment at the end of year 5, this evaluation strategy supports sustainability of the SIM by advancing value-based payment past its first five years, while also offering two sequential trials to produce rigorous impact evaluation. The second wave of value-based payment model(s) implemented at the end of year three likely would have evolved beyond that of the first wave (e.g., episode-based bundled payments and shared savings arrangements) to global payment arrangements (e.g., risk-based global, or professional services, capitation). Thus, the implementation of value-based payment would benefit from impact evaluation of the first wave (years 1-3), which would yield learning-by-doing in the design of global payment models for the second wave of value-based payment.

Meeting Terms of the Pre-Testing Assistance Award for the State-Based Evaluation Plan. The Washington State Health Care Innovation Plan (SHCIP) evaluation strategy includes three elements that match the requirements of the CMMI Pre-Testing Assistance Award to the state:

- 1. Plans to provide access to data and stakeholders to enable CMS to evaluate the extent to which the state’s delivery system reform plan was implemented, its effect on health care spending, and its impact on health care quality:**

The Washington state-based evaluation team will collaborate with key stakeholders, agencies, and organizations in the state to secure access to relevant data for the state-based evaluation and simultaneously to support the CMS national evaluation. As point 1 above implies, the focus of that effort will be access to data on health care spending (to identify the impact of SHCIP intervention(s) on cost of care) and on quality of care — broadly defined to incorporate clinical quality (processes of care), health outcomes, and patient experience.

Key stakeholders, agencies, and organizations include (but are not limited to):

- a. Office of Financial Management (OFM)**, which provides vital information, fiscal services and policy support for the Governor, Legislature, and State agencies. Examples are estimates of state and local population, monitoring changes in the state economy and labor force, and research on a variety of issues affecting the State budget and public policy, including developing executive policy research and development of legislation to support the Governor’s policy goals. OFM conducts research on health care issues related to the delivery system, insurance, quality of care, and planning⁴.
- b. Health Care Authority (HCA)**, which oversees eight health care programs, including:
 - Medicaid and Medical Assistance Programs (covering approximately 1.2 million low-income Washington residents, of whom about two-thirds are children covered by Apple Health for Kids).
 - Public Employee Benefits Board (PEBB) program (which provides medical, dental, life, and long-term disability coverage and offers optional insurance through private health insurance plans to eligible State and higher-education employees as a benefit of employment), and
 - Uniform Medical Plan (UMP), which is a self-insured, preferred provider health insurance plan available to PEBB enrollees⁵.

HCA also manages the development of the SHCIP and maintains a website that can be accessed to review relevant information on the planning process, collaboration, project history, and selected resources and documents⁶.

- c. Department of Health (DOH)** includes divisions for prevention and community health, environmental public health, disease control and health statistics, and health systems quality assurance, which collect relevant data for innovation evaluation⁷.

⁴ See, for example, the following weblink: <<http://www.ofm.wa.gov/forecasting/default.asp>>

⁵ More detail on HCA is available here: <<http://www.hca.wa.gov/pages/about.aspx>>

⁶ <<http://www.hca.wa.gov/shcip/Pages/default.aspx>>

⁷ Examples of relevant data and statistical reports are provided at the following weblink: <<http://www.doh.wa.gov/DataandStatisticalReports.aspx>>

- d. **Department of Social and Health Services (DSHS)** oversees several programs of immediate relevance to the state-based evaluation⁸, including mental health community programs and chemical dependence services (germane to physical and behavioral health integration). For example, the DSHS Executive Leadership Team includes the Assistant Secretary for Behavioral Health and Service Integration, who will be a key contact person for innovation design and evaluation pertaining to the SHCIP aim of physical and behavioral health integration.
- e. **Washington Health Benefits Exchange**, which will have continuing responsibility as the market organizer and facilitator in implementing the Affordable Care Act (ACA) in Washington state⁹. The Washington Health Benefit Exchange was created in State statute in 2011 as a “public-private partnership” separate and distinct from the State. The Exchange is responsible for the creation of Washington Healthplanfinder, an easily accessible, online marketplace for individuals, families, and small businesses to find, compare and enroll in qualified health insurance plans. Starting October 1, 2013, Washington Healthplanfinder offered Washington State residents:
- Apples-to-apples comparisons of Qualified Health Plans (QHP).
 - Tax credits or financial help to pay for copays and premiums.
 - Expert customer support online, by phone or in-person through a local organization, insurance broker or agent.
- f. **Region 10 Administration for the Centers for Medicare and Medicaid Services** would be another important contact point for innovation development and evaluation relevant to Medicare, Medicaid, or State Health Insurance Program (SCHIP) issues in Washington state¹⁰. Among other functions, the Region 10 Office of CMS in Seattle could help in liaison with other entities charged with organizing Medicare and Medicaid data, such as the CMS Research Data Assistance Center (ResDAC)¹¹.
- g. **Washington Health Alliance (the Alliance)** is a not-for-profit organization dedicated to convening the people who get, provide, and pay for health care in order to improve health care quality and affordability in a five-county region: King, Kitsap, Pierce, Snohomish, and Thurston Counties. The Alliance includes more than 150 state and county employers and union trusts, health insurers, hospitals and physician groups, government agencies, educational institutions, pharmaceutical companies, and individuals. Its five areas of focus are performance measurement, public reporting, performance improvement, consumer engagement, and payment reform. Accordingly, the Alliance is an important regional exemplar of the kind of voluntary coalition that supports SHCIP aims and development¹². Significantly, the Alliance conducts ongoing quality and a recently released Patient Experience Survey. The Alliance’s Health Economics Committee is also developing reports on regional cost of care, comparisons of resource use for common conditions across delivery systems, and provider price comparisons (the latter as part of a price transparency initiative).

⁸ Helpful weblinks include: <<http://www.dshs.wa.gov/aboutus/index.shtml>>, which offers general information and links to relevant programs :< <http://www.dshs.wa.gov/dshsataglance.shtml>>. The state’s data portal is another key resource for evaluation data: <<https://data.wa.gov/>>

⁹ <<http://www.wahbexchange.org/about-us/what-exchange/>>

¹⁰ <<http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/downloads/SeattleRegionalOffice.pdf>>

¹¹ See, for example, <<http://www.resdac.org/cms-data/search>>

¹² <<http://www.pugetsoundhealthalliance.org/about/>>

The organizations and agencies identified above are meant to be illustrative and not an exhaustive list. Ultimately, the evaluation plan will identify the role of specific entities and individuals, particular data sets, and data elements required to assess the results of implementing the Washington SIM. For example, there are additional data partners not traditionally linked to health care, but nonetheless integral to the State’s Health in All Policies and community linkages focus, e.g., the Office of the Superintendent of Public Instruction (OSPI), Commerce, and the Department of Early Learning (DEL).

2. Identification of potential sources of data, including provider surveys, Medicare administrative claims, state Medicaid and CHIP program information, beneficiary experience surveys, site visits with practices, and focus groups with beneficiaries and their families and caregivers, practice staff, direct support workers, and others (e.g., payers), for program evaluation:

The exact nature of provider surveys, administrative claims data for Medicare, Medicaid, SCHIP, beneficiary and patient experience surveys, private payer benefits and claims data, site visit contacts, and key informant interviewees will depend on the state’s implementation strategy for transformation, but all the aforementioned types of data sources will be required to conduct a comprehensive quantitative and qualitative evaluation of the SIM.

One integrating concept guiding the evaluation will be ongoing collection of data and perspectives from the “4 Ps”:

- Providers
- Payers
- Purchasers
- Patients

Given the centrality of the concepts of Accountable Communities of Health (ACH) and the Transformation Support Regional Extension Service to the design and implementation of the Washington State Innovation Model, to be built on the foundation of the SHCIP, a fifth perspective—“C” for Community—will drive the collection, analysis, and interpretation of data.

3. Plans to play an active role in continuous improvement and evaluation, particularly in regard to Medicaid and CHIP benefits. Each state is encouraged to identify a research group, preferably within the state, that could assist in the CMS evaluation and develop in-state evaluation expertise so that evaluation efforts continue after the model funding has ended:

In order to sustain a continuous performance improvement and evaluation effort, the Innovation Planning initiative will fashion an ongoing state-based research group, potentially engaging and collaborating with entities such as the University of Washington (UW) Department of Health Services, the Group Health Research Institute’s MacColl Center for Health Care Innovation, the UW Institute for Health Metrics and Evaluation (IHME), the Washington State University (e.g., the Social and Economic Sciences Research Center), HCA, OFM, DOH, DSHS, the Alliance, Washington State Institute for Public Policy, and other selected individuals and organizations regularly involved in the collection and analysis of data in the following domains:

- Health services utilization and cost
- Health care quality structure process and outcomes
- Population health measurement and reporting

- Public health prevention and health system activities and performance
- Public beneficiary and private plan enrollee health-related perceptions and patient experience
- Integration of physical and behavioral health services
- Provider pricing
- Health care workforce distribution and activity
- Consumer perceptions of health and health care
- Health insurance enrollment, premiums, and distribution by population group and nature of coverage (e.g., metallic tier, as defined in the ACA)

An ongoing strategy for obtaining private and public grant support, collaborative integration of SIM performance measurement and evaluation within state government, and private sector voluntary effort will be necessary to enhance and maintain continuous improvement and evaluation. Commitment from the executive and legislative branch, well-organized private sector and public sector partnerships (akin to the Bree Collaborative, the Alliance, and others), coupled with the development and maintenance of a “go-to” evaluation capability will determine the sustainability of SIM improvement and evaluation. Notably, the capacity to perform “rapid-cycle” innovation and evaluation will be instrumental in attracting sustained support for the SIM.



■ SECTION 7

Design Process

Design Process Deliberations

In 2012, Washington state moved to accelerate its efforts toward better health, better care, and lower costs by applying for a State Innovation Models (SIM) Testing Grant in Round One of the State Innovation Model program. At that time, more than 80 organizations joined state leaders in support of the initial vision, which led to a nearly \$1 million SIM Pre-Testing Award from the federal Center for Medicare and Medicaid Innovation (CMMI). The award funded a rapid planning process to build a five-year State Health Care Innovation Plan for Washington. The 2013 Innovation Planning process was an opportunity to substantially build out key strategies to improve health and health care delivery for Washington’s residents and communities.

Innovation Planning by the Numbers

1,100+

Number of participants in the planning process

400+

Pages of public comment received

280+

Number of thought leaders/organizations engaged

100+

Number of formal presentations given

12

Number of State agencies involved

10

Number of consultants and partners in the process

8

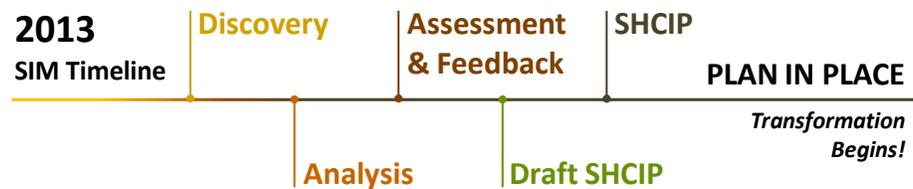
Number of months in the planning

5

Number of phases throughout the project

Phases of Innovation Planning

The Innovation Planning process was driven by five essential steps. The phasing, as outlined below, led to substantive findings and significantly amplified the innovations identified in the outlined Innovation Plan.



- **Discovery.** The discovery phase of Innovation Planning established a clear “as is” baseline. The first several months of the project were devoted to establishing broad perspective on the current baseline, including administrative structure, delivery models, payment policies, transformative strategies and levers, targets, performance metrics, overlaps, gaps, and barriers to the three-part aim of better health, better care, and lower costs.
- **Analysis.** The analysis phase built upon “as is” findings to establish clear “to be” options. Much of the late summer and fall of 2013 were devoted to establishing a broad perspective on options, including applicable levers, transformation options, readiness criteria, and necessary infrastructure and systems supports.
- **Assessment and Feedback.** The Innovation Planning process was continually informed by feedback from project governance, CMMI technical assistance providers, and state thought leaders including project consultants, the State Health Care Innovation Planning Feedback Network, local jurisdictions, communities, Tribes, state legislators, and those engaged in stakeholder convenings. This phase allowed for vetting of the findings and options, and was spent identifying gaps in thinking, assessing political and fiscal implications, clarifying misunderstandings, establishing the phasing of options to accelerate reform, and further identifying areas of consensus and obstacles. See below for more on governance and stakeholdering processes.
- **Draft State Health Care Innovation Plan.** A draft of the Innovation Plan was released for public comment October 31, 2013, and received formal feedback from nearly 100 stakeholders and local and Tribal governments. Additionally, CMMI technical assistance providers and the project officer reviewed the draft plan and provided substantive feedback on areas including emphasis on the deployment of State levers, stakeholder engagement and commitment, and layout and design.
- **Synthesis.** The final month of the Innovation Planning process was spent resolving issues identified by public and CMMI feedback, and finalizing a cohesive and transformative Innovation Plan.

Project Governance and Consultants

Cross-agency leadership were engaged to serve on two project governance committees, tasked to provide oversight of major elements and structure of the Innovation Plan, and provide critical feedback and insight on its content, cohesiveness, and scope. Additionally, the governance committees identified and helped ensure necessary agency in-kind support for plan development.

Executive Management Advisory Council (EMAC). Cabinet-level leadership team that met four times throughout the project to provide high-level guidance and sign-off. Offices represented on EMAC include:

- Department of Commerce
- Department of Early Learning
- Department of Health
- Department of Social and Health Services
- Governor’s Health Policy Office
- Health Care Authority
- Insurance Commissioner
- Labor and Industries
- Office of Financial Management
- Office of the Superintendent for Public Instruction
- State Board of Community and Technical Colleges
- Washington Health Benefit Exchange

Kitchen Cabinet. Agency leadership that met monthly. Members continuously served as State consultants into the project’s multiple streams of inquiry. Offices and programs represented on the Kitchen Cabinet include:

- Department of Health
- Department of Social and Health Services
- Governor’s Health Policy Office
- Health Care Authority
- Labor and Industries
- Medicaid
- Office of Financial Management
- Public Employees Benefit Board
- Washington Health Benefit Exchange

SHCIP Governance: State Team



To develop a collaborative plan, Washington formally contracted and partnered with multiple organizations to explore the “as is” environment for several streams of inquiry and to establish clear “to be” options to achieve better health, better care, and lower costs, as well as contribute to key elements of the Innovation Plan.

- **Cedar River Group.** Explored high-leverage areas of prevention and social determinants of health.
- **MacColl Center for Health Care Innovation.** In partnership with the University of Washington, drew upon clinical literature and promising practices to ensure Innovation Plan elements are supported by evidence.
- **Manatt Health Solutions.** Analyzed degree to which Washington’s current physical and behavioral health services are fragmented or integrated, and identified models and opportunities to integrate service delivery, improve the use of team-based care, and rationalize payment policies, particularly in light of Medicaid expansion.
- **Mercer Consulting.** Worked with the State and other project contractors on the development of the Innovation Plan financial analysis.
- **The Dr. Robert Bree Collaborative.** Identified areas of unwarranted variation with the greatest potential for transformative change and stakeholder levers to activate or implement Bree recommendations.
- **Strategies 360.** Determined the role and promise of Washington’s community-based initiatives and organizations to accelerate transformation of the health care delivery system in the state and increase consumer engagement in achieving better health outcomes.
- **University of Washington Department of Health Services, School of Public Health.** Investigated, identified, and recommended the framework for required Innovation Plan evaluation planning and provided guidance around ongoing continuous improvement of public program performance.
- **Washington Health Alliance (formerly the Puget Sound Health Alliance).** Convened public and private purchasers, payers and providers to identify key driving factors of increasing health care costs, opportunities for improving value, key principles for health care delivery system transformation in Washington state, high-priority performance measures, and high-priority levers to accelerate health care delivery system transformation.
- **Washington Park Consulting.** Provided comprehensive quality control for development of the plan, focusing on credibility and cohesion of the Innovation Plan to maximize implementation opportunities across multiple public and private stakeholders.

In addition to formal consulting and partnership agreements, countless thought leaders offered their in-kind guidance and expertise to ensure comprehensiveness of the Innovation Plan.

The Innovation Planning Process Streams of Inquiry

The discovery phase of the Innovation Planning process explored multiple streams of inquiry, to include:

- Multi-payer approaches to payment and delivery system reform;
- Regional health collaboratives and approaches;
- Overuse, underuse, and misuse;
- Physical-behavioral health integration; and
- Improving population health with a focus on prevention and social determinants.

While all streams of inquiry fed the final Innovation Plan, major areas that significantly informed the plan focused on multi-payer, provider and purchaser transformation, leveraging community collaboratives, and physical-behavioral health integration in Medicaid.

Multi-payer, provider and purchaser transformation

The Washington Health Alliance convened public and private stakeholders representing purchasers, payers, and providers to identify key driving factors of increasing health care costs, opportunities for addressing cost and quality to improve value, barriers and current use of levers to drive health care delivery system transformation. The primary focus of this stream of work was health care delivered in the hospital and ambulatory health care settings. Findings include:

- While a number of health care cost drivers were readily identified, most stakeholders agree there is a “short list” of drivers that have the most significant impact, to include:
 - Increasing prevalence of chronic disease and obesity;
 - Use of more expensive treatment options;
 - Use of more expensive locations and types of providers for care delivery; and
 - Rate of treatment versus non-treatment.
- A number of important opportunities have been identified to reduce cost and improve quality and, for the most part, they line up with the cost drivers noted above.
- Currently accompanying each of these opportunities are a number of significant barriers that are thought to be impeding the progress of health care delivery system transformation in the state. These barrier areas fall into the following areas:
 - Payment to delivery systems;
 - Organization of care delivery and comprehensive information on patients available to providers;
 - Transparent comparative information about provider/delivery system performance (cost, quality, utilization); and
 - Patient engagement.
- Although there is a fair amount of agreement on how significant cost drivers, opportunities and barriers are understood or perceived, a majority of stakeholders caution that special attention may be needed to address the specific challenges in different geographic areas of the state and/or for different population subgroups.
- There are many examples of innovative and worthwhile efforts under way across the state by provider organizations, health plans and purchasers. Good work is occurring in single organizations or across multiple organizations, but:
 - Much of what is being done is in the early stages of some form of “compliance” and not yet fully systematized.
 - Various efforts are currently fragmented—these efforts are not necessarily well coordinated with one another.
 - We lack a powerful, well-aligned coalition to guide more organized development—there is no overarching statewide framework (guiding principles or infrastructure with resources to support coordination), nor is there any consensus about how such a coalition should be implemented and resourced (by whom, how, etc.).

- Many efforts, although promising, do not have a clear path to sustainability and/or expansion.
- Many of the opportunities to transform the health care delivery system are reliant upon stakeholders having ready access to robust (market-wide), transparent information on value. This transparency is an important lever in itself, and also essential to support other levers. Currently, Washington lacks a statewide, all-payer strategy to ensure credible information, provided by a neutral third party, on variation in utilization, cost, and quality.

These findings resulted in multi-stakeholder recommendations for health care delivery system transformation, which was adapted for the Innovation Plan's Public/Private Transformation Action Strategy. *Comprehensive findings regarding multi-payer, provider, and purchaser transformation are available online:*

http://www.hca.wa.gov/shcip/Documents/Health_Care_in_the_Hospital_and_Ambulatory_Care_Settings.pdf.

Leveraging community collaboratives

Strategies 360 engaged community-based health organizations throughout eastern and western Washington to inventory their capacity and ability to leverage innovations outlined in the Innovation Plan. Findings included opportunities, challenges, and potential roles for community-based health improvement organizations moving forward, as follows.

Opportunities

- There is a high degree of interest and enthusiasm within the organizations, and a demonstrated willingness and capacity to collaborate.
- The 11 organizations cover 27 of the state's 39 counties, and most population centers.
- Common missions and values have allowed all to focus generally on the interrelated aims of better health, better care, and lower costs, and allow for sharing among organizations of information and best practices.
- There are thousands of participants statewide across key sectors.
- Some organizations have demonstrated success and sustainability, suggesting potential for similar successes by others.
- Diverse structures, characteristics, and priorities allow for innovation and the testing of a variety of approaches that reflect local values, interests, resources, and decision-making processes.
- Many are still in formative stages.

Challenges

- There is an absence of these organizations in some parts of the state.
- Some organizations have overlapping jurisdictions.
- Most organizations lack participants from some key sectors such as criminal justice, faith community, state government, business, education, and Tribes.
- There is generally limited participation by health carriers.
- Uneven public participation or opportunity for public input.
- Lack of staffing and sustainable funding is a major obstacle to comprehensive transformation initiatives.
- Diverse structures, characteristics, and priorities could be a barrier to alignment and collaboration.

- Many are still in formative stages, making it difficult to “hit the ground running” and measure organizational capacity and results.

Potential roles moving forward

- Develop and work in partnership with the state on health care transformation, eventually covering all counties.
- Initially engage with the State on the Innovation Plan largely as they currently exist, without significant prerequisites.
- Maintain a local identity while also serving state needs by staying true to their roots as community-based organizations, but are trusted, encouraged and relied upon by the state to develop innovative local programs to address issues of statewide concern.
- Operate in true partnership with the State, where there is agreement on what’s to be done and how authority, accountability and risk are shared; communication and accommodation goes both ways, each organization helps identify State laws and funding silos that unnecessarily interfere with its achievement of transformation goals, and works with the State to address them; and both local and State interests are identified and addressed.
- Strengths are acknowledged, valued and put to best use by the State. Strengths include close personal relationships built on trust, a common history and routine interactions around daily activities; knowledge and understanding of local people, circumstances, programs, interests and culture; the engagement of many, often with significant experience and expertise, who will not engage directly with the State; proximity to service delivery and those being served; and connection and commitment to their community as their home.
- Acknowledge, value and benefit from the strengths of the State, including greater resources and ability to absorb risk; relationship to the federal government and better ability to draw on national funding and expertise; access to and ability to analyze relevant data; a statewide communication network; standing to identify, direct and coordinate matters of statewide significance; understanding of and control over State law; and ability to amplify and legitimize the work of community-based organizations.
- Achieve short-term results while building long-term capacity.
- Accountability to uniform statewide standards, measuring both process and outcomes, achieved through local means.
- Routinely replicate what others, both within Washington and other states, demonstrate works, and apply lessons from what others demonstrate does not.

These findings informed the Innovation Plan’s key strategies regarding engagement and leverage of communities. *Comprehensive findings regarding community collaboratives are available online:* http://www.hca.wa.gov/shcip/Documents/Community-Based_Initiatives_and_Orgs.pdf.

Physical-behavioral health integration in Medicaid

Manatt Health Solutions engaged in a series of discussions with key informants, including counties, regional service networks (RSNs), providers, area agencies on aging, State program staff and other stakeholders to conduct a landscape review of Washington’s current delivery of physical and behavioral health services, and to identify current administrative structures, delivery models, and payment policies that support existing physical and behavioral health systems. It also was charged with analyzing the degree to which Washington’s current physical and behavioral health services are fragmented or integrated. Observations were as follows:

- There is no broad statewide integration and limited coordination across physical health, mental health, and chemical dependency systems. A lack of or gaps in accountability for the whole person creates unclear expectations and ambiguous responsibilities.
- Existing silos and funding mechanisms hinder movement toward integrated health care and better health outcomes.
- It is not just the delivery system, but administrative and financing barriers that impede increased coordination, co-location, and, ultimately, integration of care and services.
- Medicaid expansion will increase pressure on the mental health and chemical dependency systems.

Manatt built upon these findings to present options for advancing integrated care by looking to similar states, and outlined a pathway for integration in Washington. The pathway ranged from maintaining Washington’s existing structure while addressing major obstacles to centralizing responsibility for all mental health, chemical dependency and physical health. This pathway informed—and will continue to guide—the Innovation Plan’s core strategy to integrate physical and behavioral health. *Comprehensive findings regarding systems to support integrated physical and behavioral health care are available online:*

http://www.hca.wa.gov/shcip/Documents/Systems_Integrated_Physical_Behavioral_Health.pdf.

Workforce

In addition to specific topics driving the core strategies of the Innovation Plan, Washington received support from the National Governors Association to convene key thought leaders to identify approaches to meet health workforce needs in Washington. The Health Workforce Leader Summit’s 35 participants identified barriers to health workforce development, innovative workforce initiatives in Washington, and strategies and recommendations for health workforce development, including:

- Payment reform to transform primary care, specialty care, and community workforce deliver system.
- Increase physician residency training in Washington.
- Leadership to assess priorities and identify resources to support the Health Care Personnel Shortage Task Force.
- Reinstate and expand the State Loan Repayment Program.
- Implement and support regional-focused planning to identify and deploy resources to fill workforce gaps.
- Create a plan to better integrate behavioral health with health care.
- Retention strategies, including delaying retirement and payment strategies.
- Require State-funded schools to have plans to implement interprofessional education.
- Promote a system that will increase efficiencies and reduce workforce impact.
- Examine the oral health workforce to explore if it meets the population’s needs.
- Build on models for interprofessional education using simulation.
- Explore expanded use of community paramedicine.

A comprehensive summary of the Health Workforce Leader Summit is available online:

http://www.hca.wa.gov/shcip/Documents/sept_5_health_workforce_leader_summit_summary.pdf.

Stakeholdering and Communications

A foundational principle of the Innovation Planning process was that it be transparent and inclusive. To that end, the Innovation Planning project team, State leaders and consultants engaged in intensive stakeholdering and communication, with more than 1,000 total stakeholders reached throughout the state.

Consultant Stakeholdering

A key component of most Innovation Planning consultants' scopes of work was stakeholder engagement and information gathering.

- **Cedar River Group** engaged approximately 35 entities, including those representing the Children's Alliance, Dovetailing (early learning consulting), City of Seattle Office of Education, WithinReach, Partners for Our Children, Mockingbird Society, Seattle Children's, Public Health-Seattle and King County, Empire Health Foundation, Comprehensive Health Education Foundation, Downtown Emergency Service Center, Mercy Housing Northwest, Low-Income Housing Alliance, Center for Supportive Housing, Bill and Melinda Gates Foundation, Pacific Hospital PDA, Building Changes, Washington State Housing Commission, San Francisco Federal Reserve, University of Washington School of Built Environment, Portland Area Indian Health Board, and Neighborcare.
- **Manatt Health Solutions** engaged and interviewed an estimated 80 organizations and individuals including behavioral health organizations and providers, counties, State and local government entities, regional support networks, Medicaid health plans, community health centers, academic entities, and legislative staff.
- **The Dr. Robert Bree Collaborative** looked to its Governor-appointed members to provide input. Represented organizations include Premera Blue Cross, Washington Health Alliance, Washington State Department of Labor and Industries, Wenatchee Valley Medical Center, Inland Northwest Health Services, Providence Health and Services, Harborview Medical Center, MultiCare Health System, Boeing, Virginia Mason Medical Center, Pacific Crest Family Medicine, Regence, First Choice Health, Foundation for Health Care Quality, King County, Group Health Physicians, and Costco Wholesale.
- **Strategies 360** engaged in robust conversations throughout the Innovation Planning process with community-based health organizations, to include Benton-Franklin Community Health Alliance, Better Health Together, Central Western Washington Regional Health Improvement Collaborative, CHOICE Regional Health Network, Community Choice Health Network, King County Health, SignalHealth, Snohomish County Health Leadership Coalition, Southwest Washington Regional Health Alliance, and Whatcom Alliance for Health Advancement.

Washington Health Alliance convened nearly 50 purchasers, providers, health plans, and other partners over the course of three full-day meetings, and nearly two dozen additional interested stakeholders via two public webinars. Organizations engaged in the stakeholder group included Madigan Army Medical Center, Aetna-West Region, Wenatchee Valley Medical Center, Inland Northwest Health Services, Baker Boyer Bank, Qualis Health, Regence Blue Shield, OneHealthPort, Molina Healthcare of Washington, Washington State Hospital Association, King County, Carpenters Trust of Western Washington, CIGNA, Whatcom Alliance for Health Advancement, Virginia Mason Medical Center, Washington State Medical Association, and Community Health Plan of Washington.

State Health Care Innovation Planning Feedback Network

A broad base of stakeholders and governmental entities throughout the state were invited early in the Innovation Planning process to join the State Health Care Innovation Planning Feedback Network. The Feedback Network received regular email communications throughout the process sharing updates and requesting feedback. To date, the Feedback Network has more than 750 members representing health plans, purchasers, local and regional collaboratives, associations, State agencies, Tribes, and consumers. Much of the Innovation Planning process was driven by the feedback provided by this network, including nearly 300 general comments around topics such as behavioral health integration, oral health, social determinants of health, palliative care, and tribal health.

Tribal Engagement

As part of the State's government-to-government relationship with the Tribes of Washington state, Tribes were asked to engage early in the Innovation Planning process. Through the Feedback Network and tribal-specific engagement opportunities, nearly 35 individuals representing Tribes and tribal entities were engaged in Innovation Planning. Tribes and tribal entities represented in the process included:

- American Indian Health Commission – Washington
- Chehalis Confederated Tribes
- Jamestown S'Klallam Tribe
- Lummi Nation
- Muckleshoot Tribe
- NATIVE Project/Native Health
- Nooksack Tribe
- Northwest Portland Area Indian Health Board
- Port Gamble S'Klallam Tribe
- Quileute Nation
- Quinault Nation
- Seattle Indian Health Board
- Shoalwater Bay Tribe
- Skokomish Tribe
- South Puget Intertribal Planning Agency
- Spokane Tribe
- Suquamish Tribe
- Tulalip Tribes
- Urban Indian Health Institute

Tribal-specific communications and engagement opportunities included:

- A letter to tribal leaders from the Health Care Authority director asking for their feedback throughout Innovation Planning and input on how to best engage Tribes in the process.
- Outreach to the American Indian Health Commission and Northwest Portland Area Indian Health Board regarding suggested site visits.
- Tribal Affairs monthly meetings from May through October.
- A September American Indian Health Commission presentation.

- An October tribal thought leaders meeting.
- An October Northwest Portland Area Indian Health Board presentation and dialogue.
- An October presentation and discussion at the NATIVE Project.
- A November Tribal Consultation.

The Innovation Planning team received feedback from tribal representatives commenting on the need for additional and ongoing engagement.

Business Health Roundtable

In order to actively engage major private purchasers in Washington health and health care transformation, Governor Inslee worked with the Washington Business Roundtable to convene a series of small discussions between CEOs of progressive health institutions and CEOs of Washington Business Roundtable members. This effort engaged Washington employers, including Nordstrom, PEMCO, King County, and Weyerhaeuser, and health systems, including Providence, Group Health, University of Washington, and Virginia Mason.

Presentations

The Innovation Planning team, members of project governance and consultants were regularly engaged in presentations on the Innovation Planning process, findings and strategies. In all, more than 60 formal presentations were estimated to be delivered throughout the state during the eight-month process. Audiences ranged from government partners to hospital leaders and staff, and from community collaboratives to legislative committees.

While many presentations were made in person, several were delivered via conference call or webinar. Notably, the Innovation Planning process included a series of four webinars between June and October. Topics included introduction to the process, deep dives into strategies such as multi-payer transformation and physical-behavioral health integration, and an overview of the draft Innovation Plan. In total, more than 1,400 individuals registered for the webinars and more than 850 attended, with an average of more than 200 individuals in attendance at each webinar.

Feedback

The Innovation Planning process was continually informed by feedback received by the Feedback Network, during presentations, and through staff and consultants. While this enhanced the plan, the most significant feedback was received through a two-week public comment process on the draft Innovation Plan, during which the State received nearly 100 letters, emails, and responses to an online feedback tool. Comments were positive overall, with support and encouragement for the general approach outlined in the draft Innovation Plan and the State's inclusive and transparent Innovation Planning process.

Many comments focused on the need for more specificity and a desire to balance flexibility and alignment. All comments received during the public comment period were considered as the final Innovation Plan took shape. Themed comments that appeared consistently throughout stakeholder feedback on the draft Innovation Plan are presented as follows.

Feedback

General Comments

The draft Innovation Plan received several comments around the necessity to balance aspirations with realistic five-year goals, and to be mindful of unintended consequences as innovative concepts are tested. These comments pointed out that the state should continually learn from implemented Innovation Plan strategies and share early and continual demonstrations of success, barriers, and unintended consequences.

The draft Innovation Plan received several comments supportive of the plan's emphasis on building upon existing efforts.

Comments demonstrated general support for third parties—or private entities not directly involved in the delivery or payment of health services—to align efforts, accelerate progress, and reduce implementation costs. However, some commenters cautioned that there should be attention paid to ensure efforts are aligned and not duplicative.

The draft Innovation Plan received several comments that it should address crisis services.

Comments Related to Medicaid Procurement and Physical-Behavioral Health Integration

Commenters had varied views on the speed with which physical and behavioral health integration should be pursued, with a fairly even split between the perspective that Washington is ready for full integration—with necessary support in place around team-based care and data collection and sharing—and a phased approach that integrates mental health and chemical dependency, and later incorporating into primary health care. Those opposed to a phased approach cautioned it could increase provider administrative costs and weaken ultimate integration goals. Those commenting on chemical dependency integration generally agreed chemical dependency should be covered by health plans through the non-disabled Medicaid population. Some feedback encouraged the Innovation Plan to focus its emphasis on care design—particularly the collaborative care model—versus contracting mechanisms to achieve integration goals.

The Innovation Plan received several suggestions to ensure there will be only one Accountable Risk-Bearing Entity (ARBE) per region or limit the number of ARBEs in a region to avoid confusion and fragmentation. These were primarily related to the number of ARBEs serving highly complicated patients.

Comments related to Regional Approach and ARBE-Accountable Community of Health Relationship

The draft Innovation Plan received an overwhelming number of questions related to the relationship between the ARBE-Accountable Community of Health (ACH) relationship. Questions were related to who bears risk, how ACHs influence Medicaid, exchange of funding between the two entities, data exchange, administrative burden, and confusion around the ARBE-ACH phasing.

The creation of regional service areas was generally supported by commenters, but suggestions around the designation and formation of the regions were wide ranging. Comments included allowing regions to be locally determined, and support for seven, eight, or nine regions. While individual organizations often stated preferences for the region in which they fall, they included general recognition that no grouping will meet all concerns and needs.

While regionalization was supported, commenters encouraged that more emphasis be placed on statewide sharing of resources and how the Accountable Communities of Health will align. Alignment and sharing across regions was encouraged with regard to common performance measures, regional/statewide priorities, data analysis tools, and telehealth resources.

Feedback

Comments Related to Accountable Communities of Health

The draft Innovation Plan received mixed feedback with regard to perspectives on Accountable Community of Health (ACH) flexibility versus the need for strict ACH governance and robust oversight. Support for flexibility generally stated that the ACH concept as presented in the draft was overly prescriptive with regard to governance structure and priorities, and that the Innovation Plan should recognize the role of the community to determine its function and structure. Calls for oversight and more prescriptive governance highlighted the need for inclusion and equity within ACH member makeup and priorities.

Many stakeholders were concerned the ACH would usurp their role in communities. For example, local public health jurisdictions see their primary function similar to that of an ACH. Commenters representing health plans and providers emphasized the importance of keeping care coordinators (and the coordination of coordinators) within scope of their roles as opposed to coordinated through ACHs. There also was confusion around perceptions that the ACH is intended to be the steward of all community grants and funding. Additionally, the draft Innovation Plan received some comments that the roles of specific entities, such as counties and Tribes, should be emphasized.

Comments Related to State as “First Mover”

The draft Innovation Plan received overwhelming support from commenters for the concept of State as “first mover.”

Many comments expressed the opinion that it is critical that the State and Innovation Plan in general not be overly prescriptive. It was encouraged that the State and final plan define core standards around objectives, measurement, and basic operations while allowing for flexibility and innovation, particularly with regard to payment methods.

Commenters overwhelmingly supported the creation of a parsimonious statewide measure set informed by existing state measurement efforts and emphasizing the use of CAHPS and HEDIS measures.

Many cautioned what works for the commercial market may not work for Medicaid, and vice versa. For example, commenters noted that eValue8 is best suited for the commercial market and its use should not be required for Medicaid plans.

With regard to transparency and strategies around the all-payer claims database, commenters encouraged the Innovation Plan to address confidentiality and legal protections for payers.

The draft Innovation Plan received comments suggesting primary health be emphasized further by incorporating it throughout the document, but particularly address how the State will drive primary care through its role as “first mover.”

Comments Related to Prevention and Mitigation of Disease

The draft Innovation Plan’s emphasis on social determinants of health, and particularly supportive housing, was broadly supported by commenters.

Those who commented on the draft Innovation Plan’s exploration of “Transformation Investments” expressed interest in the idea, but support was split between those who saw it as overly ambitious and those who saw it as important to encourage the testing of promising practices.

Comments Related to Workforce

The draft Innovation Plan received overwhelming support for the creation of a Community Health

Feedback

Workers task force, and many commenters expressed interest in participating.

Many commenters expressed the need for a strengthened focus on workforce strategies. Commenters suggested highlighting the Innovation Planning Workforce Summit's primary recommendation around payment reform as a priority for workforce transformation, maximizing the roles of registered nurses and pharmacists, the importance of team-based care, the function of schools of medicine and nursing and professional organizations, and highlighting the role of organized labor in workforce development.

Comments Related to Rural Health

Several commenters called for greater attention to rural health and how proposed strategies will be adapted to address the unique needs of rural health.

Washington State Health Care Innovation Plan APPENDICES



Washington and Its Health Care Environment	A
Washington State Health Care Innovation Plan Glossary of Terms	B
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Appendix A

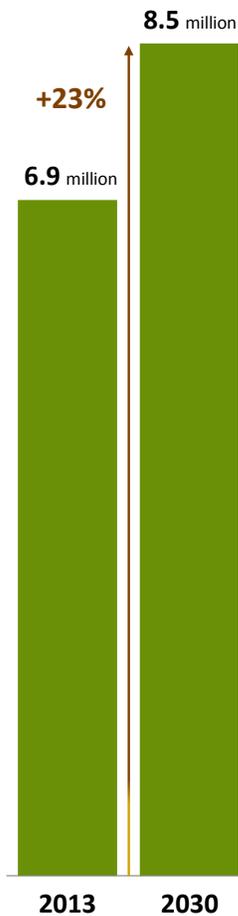
Washington and Its Health Care Environment

Washington State

Washington is the 13th most populous state with 6.9 million people¹. More than three-quarters of the population lives in counties west of the Cascade Mountains and along the Interstate 5 corridor, which transects the state from north to south. The three most populous counties are King, Pierce, and Snohomish, which all border Puget Sound.

MORE PEOPLE

Increasing numbers



Washington is growing and changing. The population is expected to increase 23 percent by 2030—from 6.9 million to 8.5 million residents.

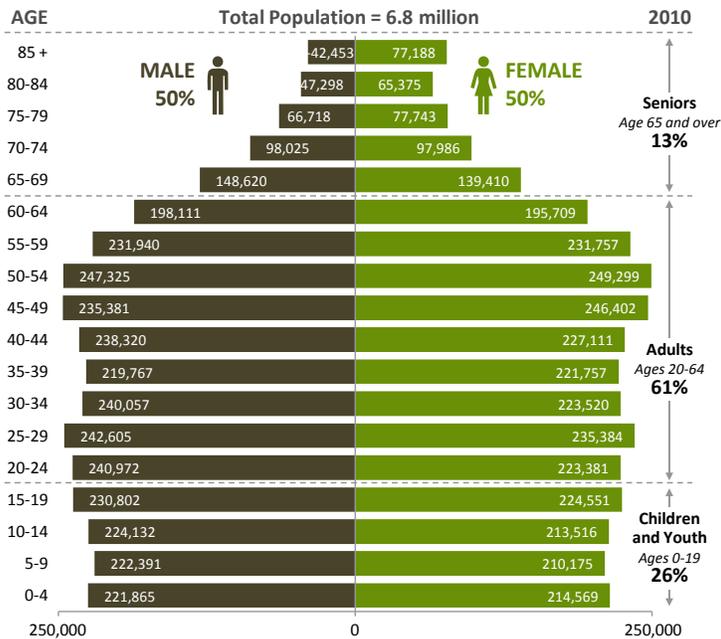
Our three most populated counties



Age, Gender, Racial and Ethnic Composition, Income, and Education Language Proficiency

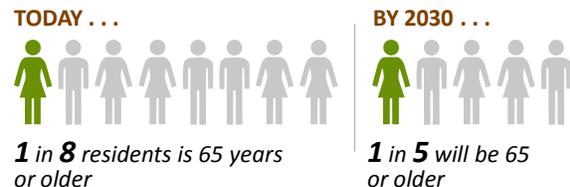
Washington differs demographically from much of the nation in several respects. On average, younger males slightly outnumber their female counterparts. In the upper age ranges, the national pattern holds, with women outnumbering men. At age 85 and older, women outnumber men by nearly 2:1. This shifting gender structure is consistent with national trends, and occurs because men are far more likely to die at younger ages than women.ⁱ

Age and Gender of the Washington State Population, 2010 U.S. Census

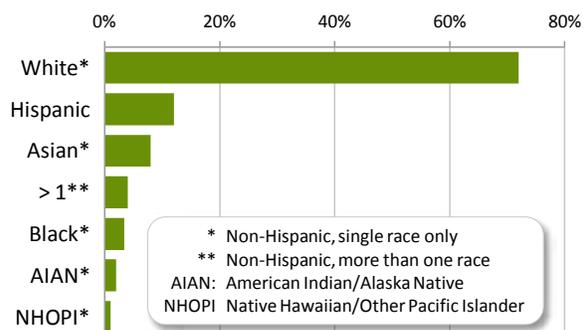


Washington is growing older. Today, one in eight residents is 65 years or older. One in five is expected to be 65 or older by 2030. Demand for long-term care and health care services will increase, driven largely by chronic health conditions.

MORE SENIORS An aging population



Washington has a somewhat different racial and ethnic composition from much of the country. Nationally almost 12 percent of the population is African American, compared to Washington's 3.4 percent. The state also has a smaller percentage of Hispanics, 11.6 percent versus 16.7 percent. Washington, however, has a larger population of Asian/Pacific Islanders, 7.9 percent vs. 4.9 percent. Washington's American Indian/Alaska Native (AI/AN) population is above average (2.9 percent versus 1.2 percent). Washington ranks ninth in the nation for limited English Proficiency population, though Washington ranks 13th in total population.ⁱⁱ



Washington’s population has become more diverse over the last decade, based largely on increased proportions of residents who reported being of Hispanic or Asian origin on the 2010 U.S. Census.ⁱⁱⁱ From 2000 to 2010, the percent of people who reported Hispanic origin grew from about 8 percent to 11 percent. By 2030, one in three is expected to be a racial or ethnic minority.

MINORITIES

A more diverse population

TODAY . . .



1 in 4 residents is a member of a minority racial or ethnic group

BY 2030 . . .



1 in 3 will be a racial or ethnic minority

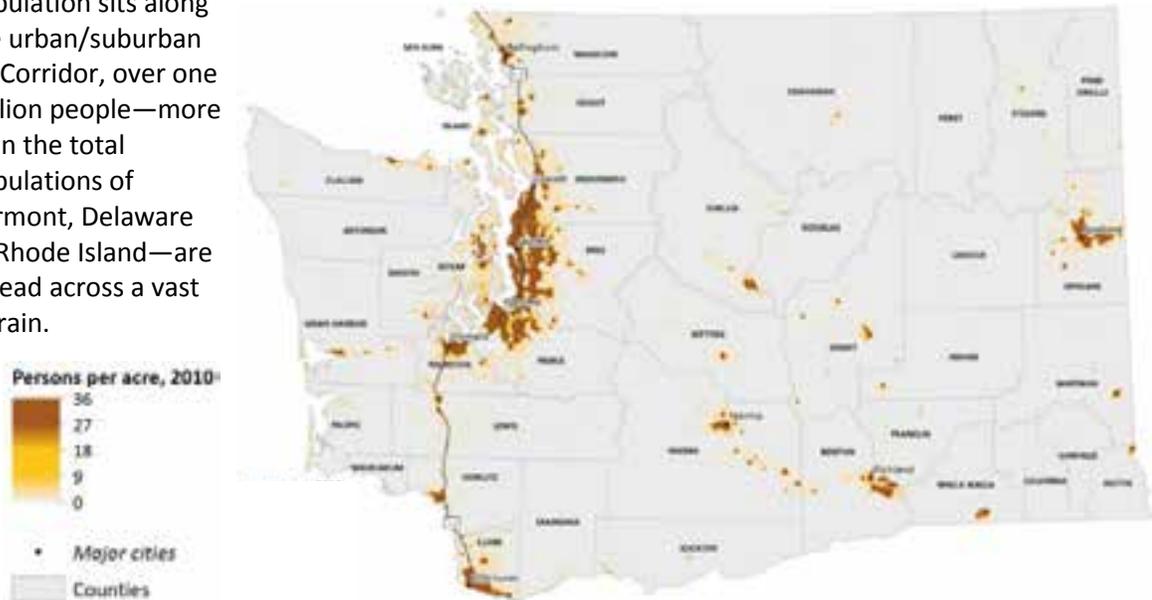
Washingtonians are somewhat better off financially. Thirty-nine percent of Washington’s population lives at or above 400 percent of the Federal Poverty Level (FPL) compared to 34.8 percent nationally. At the other end of the income spectrum, 20.8 percent of Washingtonians fall under 138 percent of the poverty level compared to 23.4 percent of the national population. Washington’s population between 138-400 percent of the poverty level is relatively similar to the national average.^{iv}

Washingtonians overall have somewhat more education. Approximately 31 percent of adults 25 years and older have at least a bachelor’s degree compared to 28.5 percent nationally. The state also has a smaller percentage of adults who have not received at least a high school diploma or GED. Approximately 10 percent of Washington adults have not graduated or received a GED compared to 14.1 percent for all US adults 25 and older.^v

Rural vs. Urban

While much of the population sits along the urban/suburban I-5 Corridor, over one million people—more than the total populations of Vermont, Delaware or Rhode Island—are spread across a vast terrain.

The State’s Population is Urbanized Along the I-5 Corridor



Washingtonians in rural communities are both older and younger than their urban neighbors. The median income in rural Washington is significantly lower, coupled with lower educational attainment, fewer opportunities for higher paying jobs, and a significantly higher poverty rate than the state average.^{vi}

Tribes

There are 29 federally recognized Tribes in Washington.^{vii} "Federally recognized" means these Tribes and groups have a special, legal relationship with the U.S. government. This relationship is referred to as a government-to-government relationship.

Federally Recognized Tribes



Population Health ■ Prevalence, Incidence, and Trends

In 2012, Washington was ranked 16th overall in “Healthy States” by United Health Foundation, presenting a picture of “above average” health. However Washington’s status in this survey has fallen from 2011, when Washington ranked ninth overall.^{viii}

General Health Status

A key indicator of actual future health is self-reported health status available through the Behavioral Risk Factor Survey. These data indicate both that Washington State residents are slightly above the national median, but approximately 16 percent of the population report fair or poor health.

	Washington	United States
Self-reported health status: Percent in Fair or Poor Health - Adults, 2011	16.1%	16.9%
Percent reporting diabetes, cardiovascular disease, and/or asthma – Adults, 2011	21.1%	22.5%

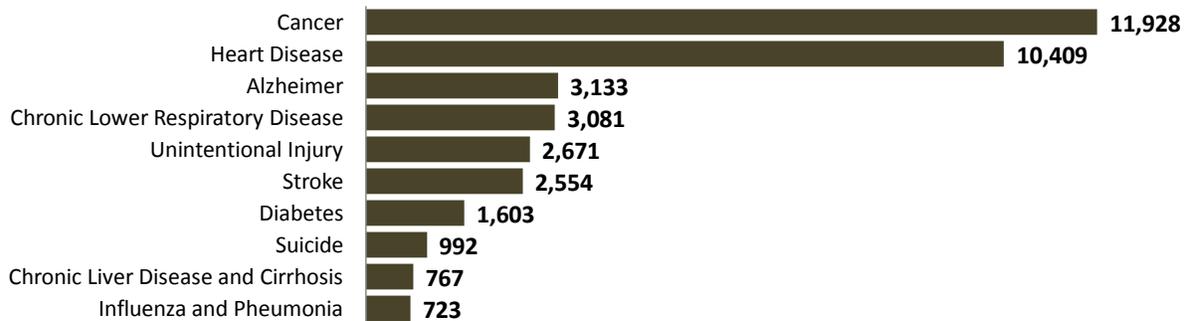
Source: Washington State Profile, SHADAC – SHADAC analysis of Behavioral Risk Factor Surveillance System Data

Life Expectancy and Mortality

On average, Washingtonians live 79.9 years, which is slightly better than the national average of 78.7.^{ix} Cancer is the leading underlying cause of death in the state, followed by heart disease. The following charts show the leading underlying causes of death for 2011 using standard National Center for Health Statistics (NCHS) coding. The underlying cause of death is the condition to which the death is attributed.

Leading Underlying Causes of Death 2011, Washington State, National Center for Health Statistics Groupings

Number of Deaths



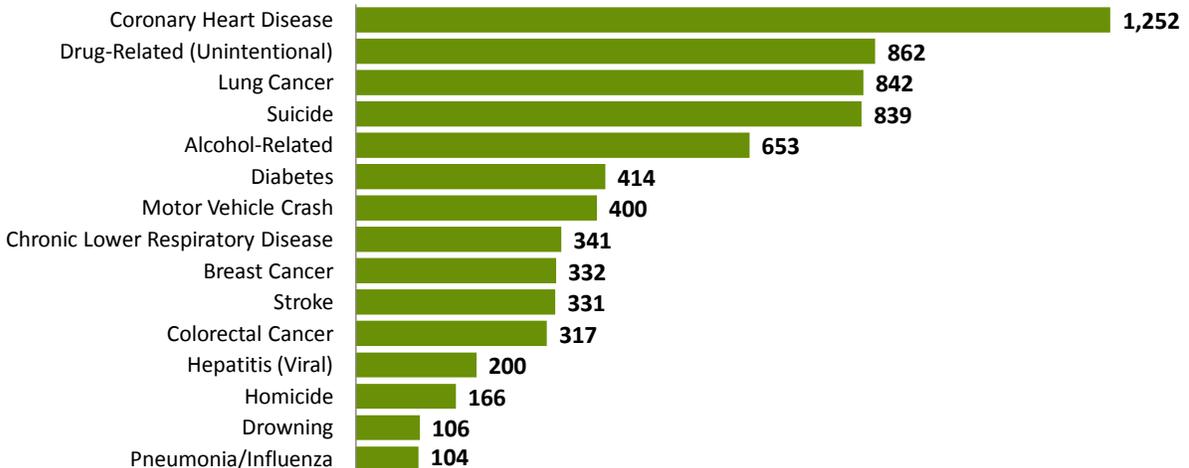
Source: Washington State Department of Health, CHARS Data

Major Risk and Protective Factors

Many Washingtonians younger than 65 years are dying premature deaths primarily from causes that are preventable and treatable (see bar graph below).

Leading Underlying Causes of Premature Death 2011, Washington State, Ages 0-64

Number of Deaths



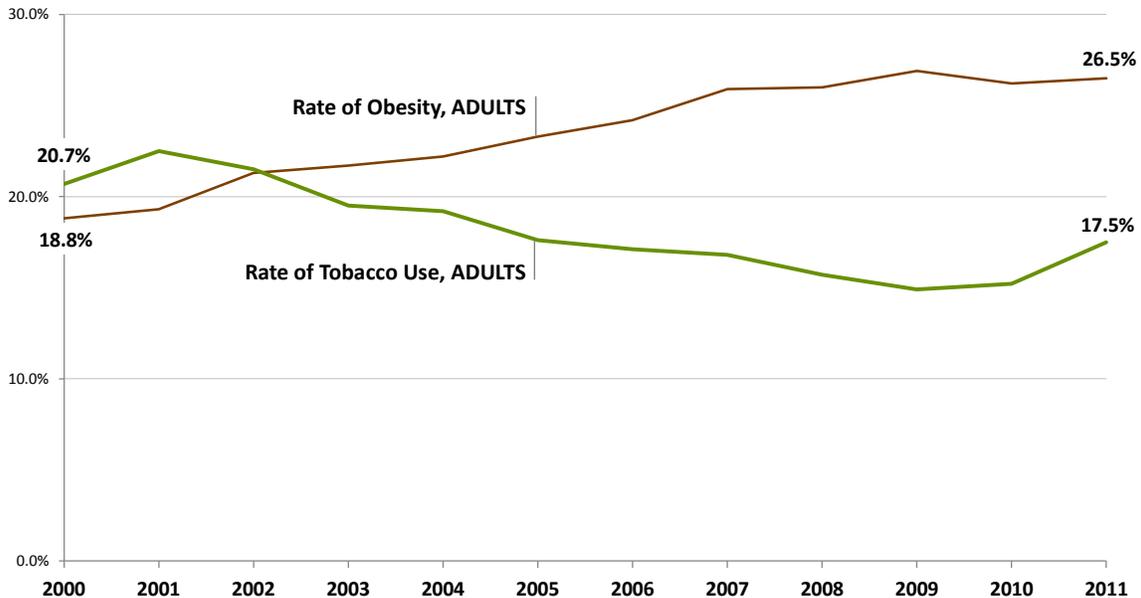
Source: Washington State Department of Health, CHARS Data

Many leading causes of death share common underlying risk factors, particularly behaviors such as smoking or lack of exercise and factors driven by socioeconomic position. For example, the 2009-2011 age adjusted death rates in census tracts with 20 percent or more residents in poverty was 40 percent higher than in those with fewer than 5 percent in poverty.

Large percentages of Washington’s adult population report these risk factors:

- In 2011, 17.5 percent of Washingtonians smoked. While this number has been decreasing over time, there has been a slight increase in smoking since 2009, when 15 percent of residents were smokers.^x
- In 2011, 26.5 percent of Washingtonians were considered obese. The obesity rate in Washington has increased by almost eight percent since 2000.

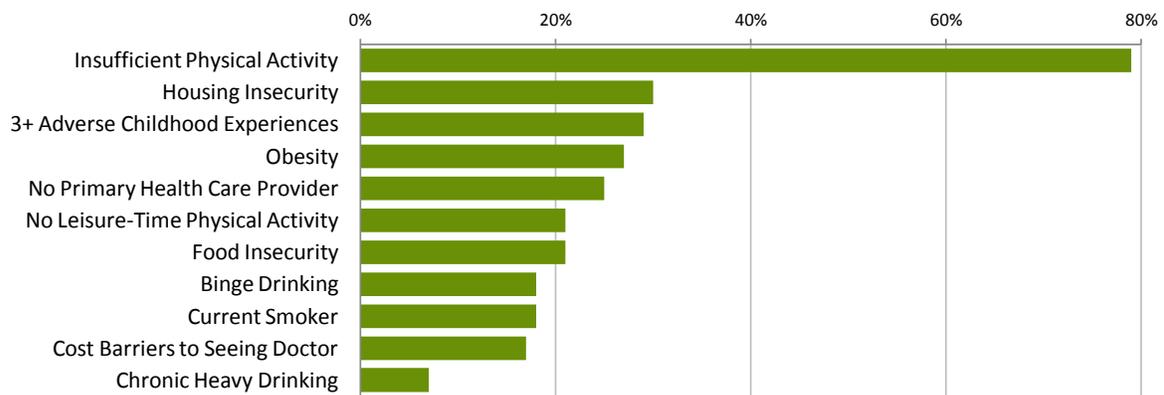
Rates of Tobacco Use and Obesity among Washington State Adults 2000-2011



Source: Washington Department of Health, Behavioral Risk Factor Surveillance System Data (BRFSS)

- Most adults do not meet recommendations for physical activity (insufficient physical activity); about 20 percent report no leisure-time physical activity.
- Between 20 to 30 percent of adults report housing insecurity and food insecurity, as well as three or more adverse childhood experiences, heights and weights indicating obesity, and lack of a primary healthcare provider.

Important Risk Factors for Poor Health, 2011



Source: Washington Department of Health, Behavioral Risk Factor Surveillance System Data (BRFSS)

Of these risk factors, all can be associated with socioeconomic position either directly (food and housing insecurity and cost barriers to care) or indirectly (smoking, chronic or binge drinking, and obesity). As noted above, socioeconomic position is strongly associated with age-adjusted death rates in Washington. Health disparities and socioeconomic position are discussed more fully below.

Causes of death grouped by common underlying preventable conditions or risk factors present more apparent targets of opportunity for improvement than when categorized conventionally. In Washington, nearly two out of three deaths annually result from smoking and obesity-related diseases, including heart disease, stroke, cancer, diabetes, and chronic lower respiratory disease.^{xi}

- **Heart Disease and Stroke.** Coronary heart disease emerges as the leading cause of death for Washington residents of all ages and for those who die before age 65. Given that most strokes are also caused by the same underlying factors that lead to coronary heart disease, the combination of these two conditions is by far the most important category of preventable death in Washington.
- **Diabetes.** Diabetes is the seventh leading cause of death. It continues to be among the top 10 leading causes of death for all ages and for those younger than 65 when grouping causes into meaningful categories in terms of prevention and treatment. Diabetes also contributes to coronary heart disease death, and many of the factors which increase the risk of contracting diabetes are the same as those for coronary heart disease.
- **Cancer and Lung Disease.** Lung cancer emerges as the most important cause of preventable cancer death for all ages and for those younger than 65. Much of chronic lower respiratory disease (medically called chronic obstructive pulmonary disease)—also a leading cause of death—is largely preventable. Both can be addressed through tobacco use prevention. Other important cancers include breast and colorectal, both of which also can be controlled through screening and early treatment.
- **Unintentional Injury and Substance Abuse.** Unintentional injury is the fifth leading cause of death overall and the leading cause for Washington residents ages 1 to 44. Unintentional injury includes unintentional deaths for which the underlying cause is drug-related or alcohol abuse, excluding drug- and alcohol-related deaths from motor vehicle crashes and drowning.

Deaths from opioid overdose have doubled in Washington State in the past 10 years due to an increase in prescription opioid overdoses, resulting from a rapid increase in prescriptions for these medications. In 2010, 62 percent and 61 percent of those who died of an opioid overdose or a prescription opioid overdose, respectively, were Medicaid clients.
- **Suicide.** Suicide is the eighth leading cause of death overall, but the fourth leading cause among those under 65 years when causes of death are grouped in a manner that is more meaningful for prevention and treatment. Suicide is clearly related to depression and tends to be higher in Washington than in the United States as a whole.

Not surprisingly the leading causes of inpatient hospitalization parallel the diagnoses leading to hospital admissions. Of the leading ten causes of death below age 65, six are included among the ten leading diagnoses for hospital admissions—diabetes, chronic lower respiratory conditions, drug abuse and dependence, coronary heart disease, alcohol abuse and dependence, and stroke.

Chronic Disease

In 2011, diabetes was the most frequently noted diagnosis for Washington residents of all ages. Additionally, chronic lower lung disease (chronic obstructive pulmonary disease), coronary heart disease, and asthma were among the top five listed diagnoses for Washingtonians of all ages. The rate of Washingtonians that report having diabetes, cardiovascular disease, and/or asthma has steadily increased overtime, from 15.6 percent in 2002 to 22.5 percent of the population.^{xii}

Maternal and Child Health and Early Developmental Outcomes

Over the last several years, Washington state has seen a downward trend in the birth rate as well as overall improvement in a number of critical measures that predict maternal and child health.

Washington also increasingly has recognized that the challenges faced by the state's sickest population begin with early life experiences that create "toxic stress." The Adverse Childhood Experiences (ACEs) study showed that development of serious illness, including mental health and substance abuse use disorders and a host of chronic illnesses are directly correlated with toxic stressors during childhood. Washington currently has 375,000 children ages 0-17 living in households with at least two ACEs.^{xiii}

Social and Economic Determinants of Health and Health Disparities

Social and economic conditions are major determinants of health. Income, wealth, education, employment, neighborhood conditions and social policies interact in complex ways to affect individuals' biology, health-related behaviors, environmental exposures, and availability and use of medical services. Health impacts associated with lower socio-economic position begin before birth and build throughout life. More simply stated, being poor is bad for one's health.^{xiv}

Washington residents who live in high-poverty areas tend to have poorer physical and behavioral health and higher levels of health related risk factors than residents living in other locations. Based on the 2009-2011 Washington Behavioral Health Factor Surveillance System (BRFSS), people who reported annual incomes of less than \$25,000 were more likely to report smoking, heights and weights indicating obesity, no leisure time physical activity, inability to see a doctor because of cost, not having a primary healthcare provider, experiencing three or more ACEs, and housing and food insecurity (assessed for 2011 only).

In 2011, the Centers for Disease Control and Prevention (CDC) issued the "Health Disparities and Inequalities Report"^{xv}. The report noted that the United States had made less than adequate progress in eliminating health disparities despite a national goal of reduction or elimination of health disparities. The report assessed disparities primarily by age, sex, race and ethnicity, and socioeconomic factors for 24 health indicators.

The Washington State Department of Health replicated this work for 19 of the 24 health indicators. Overall, Washington residents with fewer economic resources had worse health outcomes and higher levels of health-related risk factors.

ECONOMIC FACTORS

In Washington, those with fewer economic resources are at higher risk for . . .

- | | |
|---|--|
| <ul style="list-style-type: none"> • No health insurance (18-64) • No flu vaccination (65+) • Not current for colorectal cancer screening (50+) • Infant mortality • Motor vehicle crash death • Suicide • Drug-induced death • Teen birth rate | <ul style="list-style-type: none"> • Preterm birth • Coronary heart disease (CHD) death • Homicide • Obesity • Asthma • Diabetes • Hypertension (HT) • Binge drinking • Smoking |
|---|--|

Stroke death: Equal in Washington; not reported in MMWR; studies elsewhere show higher rates with fewer economic resources.

HIV: Economic disparities not reported in MMWR or Washington; other studies show increased risk of AIDS with lower income

Racial and ethnic disparities persist in Washington. African Americans and American Indians/Alaska Natives are significantly more likely to die from chronic disease than white residents. Racial, ethnic, and socioeconomic disparities exist for most chronic diseases including heart disease and diabetes. For example, recent CDC data found that Hispanic Washington residents were almost half as likely to report having excellent health as white residents. Also, African American residents and American Indian/Alaska Native residents both experienced infant mortality at a rate twice that of the overall population.^{xvi} After controlling for income, education, age, and gender, African Americans, American Indians, and Alaska Natives had significantly higher prevalence of diabetes than whites. Racial/ethnic disparities in behavioral health also persist in Washington State and the nation.^{xvii}

Risk Factors for Chronic Disease by Race, Income, Educational Attainment

Associated Risk Factors	Morbidity Risk Factors			Behavioral and Social Risk Factors				Health Care
	Hypertension Awareness	High Cholesterol Awareness	Obesity (BMI: 30%)	Insufficient Nutrition	Insufficient Physical Activity %	Smoking %	Adverse Childhood Experiences (ACE)%	
Washington State	29%	34%	27%	74%	38%	29%	29%	75%
Race/Ethnicity								
Non-Hispanic White	29%	33%	27%	75%	37%	19%	30%	77%
Non-Hispanic Black	43%	35%	39%	72%	44%	25%	29%	76%
Non-Hispanic Asian	24%	32%	8%	68%	48%	8%	9%	76%
Native Hawaiian/ Other Pacific Island	41%	32%	46%	72%	44%	22%	37%	69%
American Indian/ Alaskan Native	37%	34%	44%	76%	38%	31%	49%	73%
Hispanic	24%	34%	32%	79%	38%	14%	25%	58%
Income								
<\$35K	32%	37%	31%	79%	42%	28%	36%	66%
\$35K-\$74,999	29%	35%	28%	74%	35%	16%	29%	78%
≥\$75K	24%	30%	21%	70%	35%	9%	24%	84%
Educational Attainment								
≤High school	35%	40%	33%	81%	40%	27%	32%	71%
Some College	33%	38%	32%	76%	39%	19%	32%	80%
≥College graduate	27%	35%	20%	68%	38%	6%	20%	84%

Source: Washington Department of Health, Behavioral Risk Factor Surveillance System Data (BRFSS) (2007-2009)

counties in the state. When important health and social measures are displayed by census tracts however, marked differences appear. Life expectancy in King County varies by almost 10 years depending on one's zip code.^{xx} Twenty-three thousand households in the South Seattle zip code, 98118, speak 59 different languages. By that measure, 98118 is one of the most diverse zip codes in the United States.^{xxi} Clear disparities along racial, ethnic, and income lines also exist in rural areas.^{xxii}

Washington's Public Health and Health Care Delivery Systems

Washington has a robust health care delivery system consisting of public and privately owned networks of outpatient clinics; hospitals; community centers and clinics (federally qualified health centers, migrant health centers, and rural healthcare clinics); and tribal clinics.

Hospitals

As of February 2012, Washington had 97 community general hospitals and 13 other hospitals, which included three private specialized services, two State-owned psychiatric facilities, and four U.S. military and four U.S. Veterans Affairs hospitals.^{xxiii} As shown below, hospitals cluster in the Seattle, Spokane, and Tacoma areas. For example, Seattle is home to 12 hospitals.



Source: Washington State Hospital Association (www.wsha.org)

Local Health Departments/Districts

Washington has 31 county health departments (also referred to as Local Health Jurisdictions), three multi-county health districts, and two city-county health departments.^{xxiv} They are local government agencies, not satellite offices of the State Department of Health or the State Board of Health. Local health jurisdictions play a critical role in protecting and keeping communities healthy. They carry out a wide variety of programs to promote health, help prevent disease and build healthy communities. The Seattle/King County Public Health system includes 12 direct services sites that are Federally Qualified Health Centers (FQHCs).

Publicly Funded Health Care Infrastructure

Washington has comparatively robust publicly funded infrastructure.

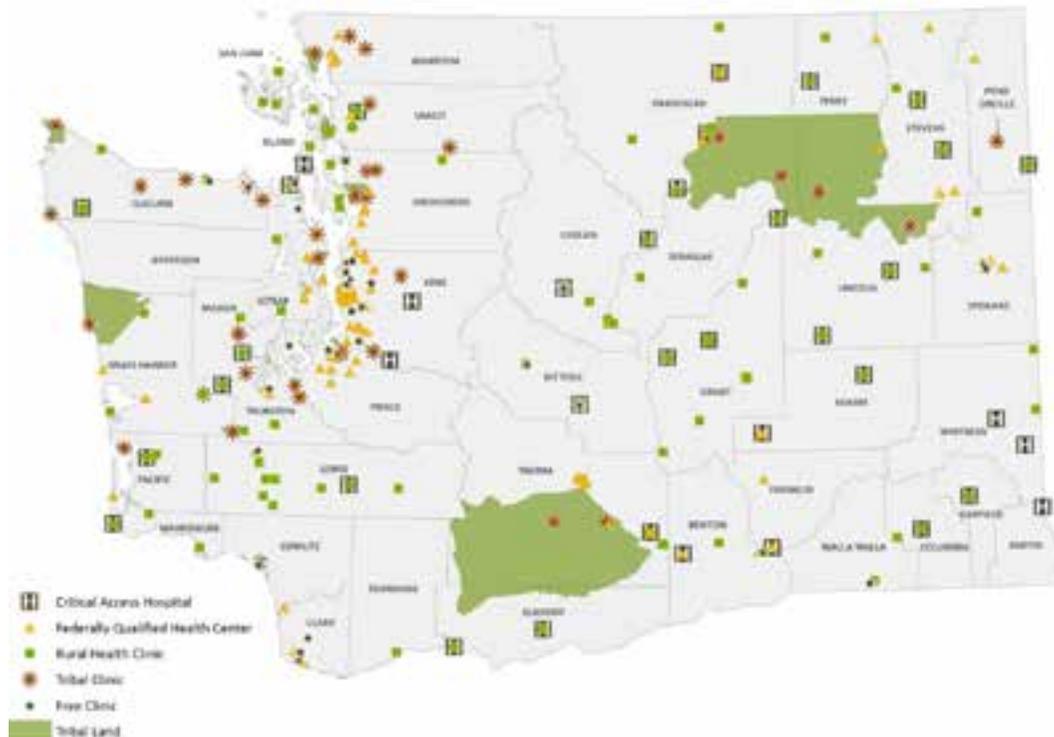
- **26 Federally Qualified Health Center (FQHC)** organizations, or Community Health Centers operating over 160 delivery sites (both rural and urban WA).
- **133 Rural Health Clinics.**
- **39 Free Clinics**, 11 of which are in rural communities.
- A number of **Tribal Clinics** functioning as FQHCs and all qualified as FQHC look-alikes.
- **38 Critical Access Hospitals** ranging in size from very small “frontier” hospitals to larger hospitals that can support specialty activity. Three are designated sole community hospitals.
- **56 Public Hospital Districts**, with 42 operating hospitals, while others operate emergency services, clinics, and other local health care services.

Access to primary care

The 2003 National Survey of Children’s Health indicated that about 86 percent of Washington children had a Health Care Provider (HCP), which is slightly greater than the national average. In 2006, the BRFSS found that 78 percent ($\pm < 1$ percent) of adult Washington residents ages 18 and older had a personal HCP. The percentage of adults with an HCP has been fairly stable since 2000. Trend data are not available for children.

Having insurance is an important predictor of regular access to primary health care. For example, 2004–2006 data from BRFSS show that 82 percent ($\pm < 1$ percent) of Washington residents with health insurance reported having an HCP compared with only 41% (± 2 percent) for uninsured adults.

Access to Clinics and Critical Access Hospitals



Source: Washington State Department of Health

Primary Care Workforce

Washington’s current health workforce must continue to build capacity and make the shift to more collaborative and team-based care across the gamut of rural and urban areas and in support of a population diverse in age, disability, race, and ethnicity. As is the case in many parts of the country, the primary care workforce is facing significant challenges, and must both expand in number, work to full scope, and find new ways of extending services. Data also demonstrate issues with mal-distribution of the primary care workforce in many rural areas of the state, particularly post-Medicaid expansion.

Health Care Providers per 100,000 Population

	Primary Care Physicians	Nurse Practitioners	Physician Assistants
STATE	82	26	13
Urban	87	25	11
Clark	60	18	12
King	113	27	10
Pierce	80	21	12
Snohomish	51	19	4
Spokane	84	38	17
Other Puget Sound Metro	77	26	15
Rural	68	28	18
East Balance – CE	65	29	25
East Balance – NE	70	24	31
East Balance – SE	79	30	18
North Sound	78	29	11
West Balance – NW	64	34	18
West Balance – SW	46	30	23
Yakima-Tri Cities	68	22	18

Source: Washington State Office of Financial Management, Health Care Provider Surveys (2011 Primary Care Providers, 2012 Nurse Practitioners, and 2012 Physician Assistants)

Insurance Market in Washington

Washington’s insured population and health insurance market have shifted over the last few years since the Affordable Care Act passed in 2010. The insurance landscape will continue to change drastically as more people become insured through Medicaid expansion and Washington’s Health Benefit Exchange, new plans enter and exit the public and commercial insurance market, or as employers/purchasers move out of state or change health plans/Third Party Administrators (TPAs).

Health Coverage in Washington

As of 2012, 45 percent of Washingtonians have insurance through individual or employer-based plans, followed by 40 percent with public insurance, and approximately 14 percent without insurance (see pie chart below).

Public Coverage. Washington’s Medicare beneficiaries make up 15 percent of the state’s total population.^{xxv} The majority of Medicare beneficiaries (78.1 percent) are in Fee-For-Service (FFS), with the remaining (21.9 percent) enrolled in Medicare Advantage plans.^{xxvi} Among the Medicare population, Washington spends \$8,497 per Medicare enrollee compared to the US average of \$10,365.^{xxvii}

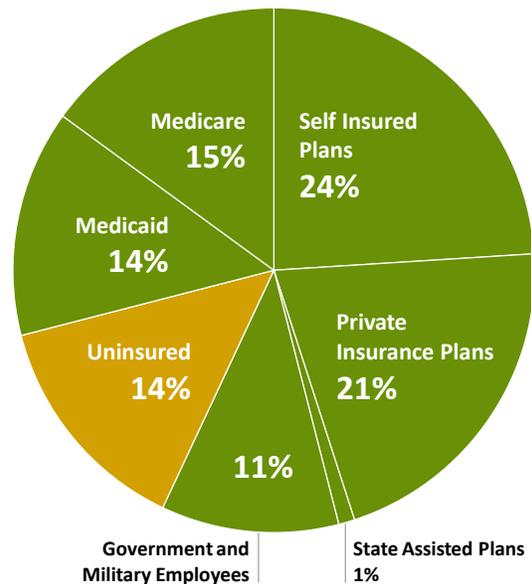
As of December 2012, just over a million individuals (adults and children) receive their full medical coverage from Washington Apple Health (Medicaid).^{xxviii} The majority (81 percent: 220,516 adults and 600,944 children) are enrolled in managed care, with the remaining in FFS Medicaid.

As of July 2012, and following a competitive procurement, five managed care plans serve the Washington Apple Health program. These include two previously established plans (Community Health Plan of WA and Molina) and three new plans (Coordinated Care, Amerigroup, and UnitedHealth). Three of the managed care plans participate in the state’s Exchange as Qualified Health Plans.

In 2014, Washington’s insurance demographics will shift dramatically. Over 75 percent of Washington’s uninsured adults—over 500,000 individuals previously uninsured—will have access to more affordable coverage under full implementation of the ACA, through either the Medicaid expansion or premium subsidy assistance (see pie chart right).

How Washington was Insured in 2012

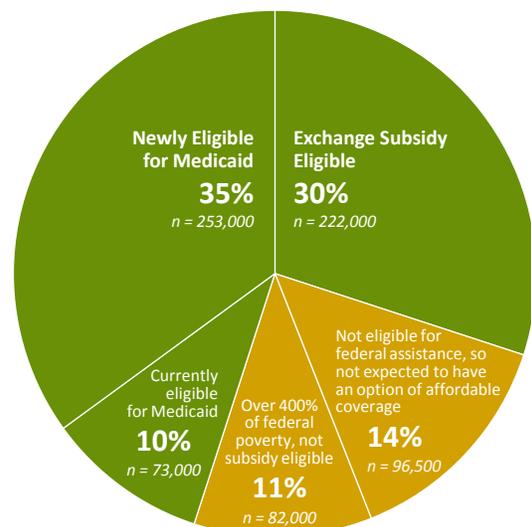
TOTAL POPULATION = 6,332,255



Source: Office of Insurance Commissioner

Washington’s Medicaid Program under the Medicaid Expansion, January 2014

APPROXIMATE TOTAL = 727,000



Source: Washington Health Care Authority

Washington's Private Health Insurance Market

Sixty-one insurance carriers are licensed/registered to sell health coverage in Washington. However, across public and private large, small, and individual commercial markets, Premera Blue Cross, Regence Blue Shield, and Group Health Cooperative and their subsidiaries and affiliates are the dominant carriers on the commercial side, with approximately 80 percent of the market collectively. In addition to the "big three" commercial carriers, Aetna, UnitedHealth Group, and Cigna are the major national plans. Molina Healthcare of WA was the largest Medicaid health plan in 2011.

Profile of Major Payers in Washington, in 2011

Plan	Enrolled Members				Utilization		Premiums
	Total	Commercial	Medicaid	Other	Ambulatory Encounters	Hospital Days	
Premera Blue Cross	660,917	402,855	-	258,062	4,206,230	100,759	\$1,912,321,823
Regence Blue Shield	548,970	366,671	-	182,299	10,239,603	96,339	\$1,621,840,694
Molina Healthcare of WA	411,206	27,819	377,347	6,040	2,371,047	77,296	\$ 753,893,764
Group Health Cooperative	335,826	218,799	-	117,027	1,344,313	83,723	\$1,590,759,500
Community Health Plan of WA	325,766	35,257	270,887	19,622	1,047,467	57,113	\$ 628,233,267
Group Health Options	208,023	204,262	-	3,761	681,559	30,183	\$ 757,184,129
LifeWise Health Plan of WA	112,459	112,459	-	-	811,843	13,058	\$ 244,727,670
UnitedHealthcare of WA	84,509	1,281	30,067	53,161	365,387	11,638	\$ 398,245,170
Asuris Northwest Health	63,301	48,312	-	14,989	956,423	9,783	\$ 186,777,286

Source: Annual statements from the Office of the Insurance Commissioner (09/12)

Types of Commercial Insurance Products

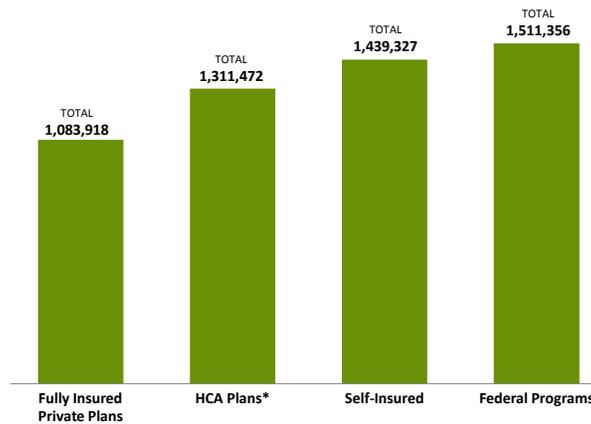
Regence and Premera are both Blue Shield or Blue Cross plans and compete with one another directly or through subsidiary/affiliated plans in all market segments. They primarily offer preferred provider organization (PPO) product offerings. Group Health Cooperative originated as a staff model health maintenance organization (HMO), but now also offers point of service and PPO products directly or through affiliated/subsidiary plans. The preponderance of Group Health members' care is provided by Group Health physicians, although it has large parts of its service area where it contracts either for specialty care or both primary and specialty. The plan typically contracts for hospital services with a more limited number of hospitals for its network. Group Health sells in all commercial market segments.

Overwhelmingly, PPO remains the dominant product in the Washington market, across all sizes of employers. Group Health's HMO product is still a significant market presence. The proportion of the Washington commercially insured population in high-deductible plans is relatively low, but is climbing. Reportedly, carriers are developing narrow/high performance network products, although these do not yet appear to have a significant market footprint.

Employer-Based Insurance and Role of Purchasers

Fifty-one percent of Washingtonians are covered by employer-sponsored coverage, and a large number of employers self-insure. Washington is home to many large, private national employers including Microsoft; Costco; Alaska Air Group, Inc.; Starbucks; Amazon.com; Expedia, Inc.; Nordstrom's; REI; and many others—all of which have self-insured plans. As of December 31, 2012, there were more covered lives in self-insured plans than in individual, small, and large group fully insured plans combined (see graph below). Market research shows that from 2011 to 2013, the number of self-funded lines of businesses continued to trend upwards, with an additional 79,000 covered lives, and this trend is expected to continue.^{xxix}

2012 Estimates of Health Coverage by Program Type
"COVERED LIVES"



*PEBB retirees (over 75,000) that currently have Medicare coverage are counted in the Medicare bar, not HCA Plans.

Source: Washington Office of the Insurance Commissioner

Key employers including King County, Boeing, and the State of Washington are regarded as purchaser leaders in working with their respective carriers and TPAs to improve value in health care. The major carriers and self-funded plans are beginning to feature episode based payments, and contract incentives to reduce higher than desirable use of certain types of procedures, tests, or non-generic drugs. Carriers are also rolling out new forms of payments to primary care and multispecialty groups that represent attempts to move away from what is largely a fee-for-service payment environment across the state.

Washington state as a whole, however, is not characterized by the type of dominant and consistent purchaser leadership in driving collective change as is the case in some parts of the country. Purchasers affiliated with the Washington Health Alliance (formerly the Puget Sound Health Alliance) have used eValue8, a common health plan evaluation tool for the commercial market to assess health plan performance, although participation by health plans has been voluntary.

The State of Washington as a Purchaser—PEB and Medicaid

Aside from the federal government, the State of Washington is one of the largest purchasers of health care in the state. Through its Public Employee Benefit (PEB) plan and Medicaid, Washington currently provides health insurance to over 1.5 million people, which will grow to more than 1.8 million over the next three years with the Medicaid expansion.

PEB provides health insurance to approximately 350,000 employees and their families and will spend nearly \$3.5 billion to provide state employee and retiree benefits in the 2011-2013 biennium.

Washington State has an older workforce compared to many private employers. In the PEB Uniform Medical Plan (the PEB health plan in which more than 75 percent of employees and their families are enrolled), the approximate average age of PEB employees is 48 and the average age of enrollees is 38. Musculoskeletal conditions are the top diagnosis in terms of per member per month expenditure, followed by factors influencing neoplasms, circulatory conditions, and symptoms and signs. ^{xxx}

Washington's Health Benefit Exchange – Washington Healthplanfinder

Washington made an early decision to operate a state-based exchange, and has focused on a successful launch. The exchange board, staff, and Washington's legislature are expected to turn increasing attention to enhancing consumers' ability to choose coverage and providers based on value.

The Health Benefit Exchange, recent Medicaid procurement activities, and the Medicaid expansion promise to change the competitive environment in Washington. Eight insurance carriers are approved to sell health plans through Washington Healthplanfinder, including Washington's major individual commercial carriers, and several carriers that have previously exclusively served Medicaid clients. One carrier offers stand-alone pediatric dental.

The opportunities afforded by the exchange have introduced new competitors into the individual market, and the combined Medicaid and exchange enrollment may give several of the new national insurers additional presence in the commercial space, particularly for individual coverage, but potentially for employer coverage as well. The importance of addressing "churn" and providing whole family coverage may result in more traditional commercial carriers considering the need for at least a modest Medicaid presence, or a Medicaid plan partner.

Health Information Technology and Health Information Exchange

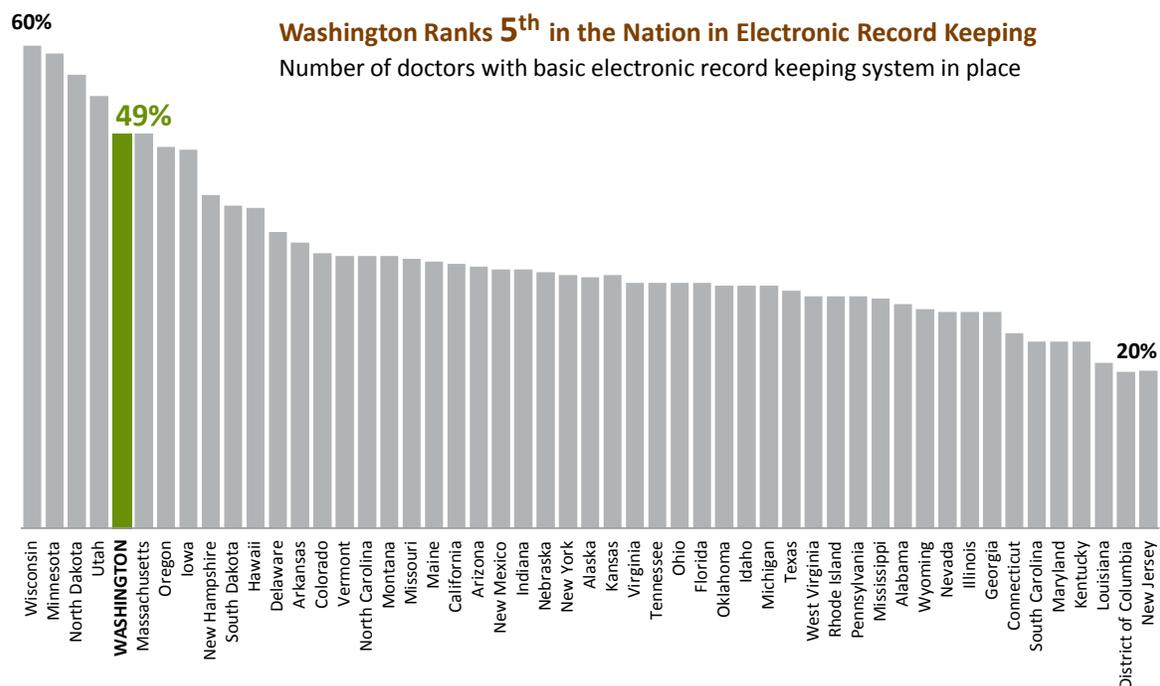
Washington is regarded as an early leader in health information technology (HIT) and Health Information Exchange (HIE) efforts, thanks to federal funding and state legislature leadership in HIT.

- In 2009 Washington received federal funding under the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) to assist Medicaid providers in the adoption of electronic health records (EHRs) and Meaningful Use requirements, and to fund planning and implementation for a statewide HIE.
- The Washington State Legislature in response to the federal funding, also in 2009, enacted laws in support of building a robust HIE and directed HCA to coordinate activities and designate a private sector organization to lead implementation of HIE.

- In 2011, the Washington State Health Care Authority (HCA) with assistance from Qualis Health wrote the State Medicaid HIT Plan (SMHP), which encompasses Washington Medicaid’s roadmap for HIT, HIE, and the EHR Incentive Program.

Electronic Health Record Adoption/The Medicaid Electronic Health Record Incentive Program

The prevalence of EHRs has greatly increased over the last five years, particularly in Washington, which has a higher rate of EHR adoption than most other states. Seventy-five percent of office-based practices in Washington have adopted EHRs versus 57 percent nationally. Much of this success can be attributed to the state-federal initiative, the Medicaid Electronic Health Record Incentive Program.



Source: Washington State Health Care Authority, November 2013

WIREC, the HIT Regional Extension Center for Washington managed by Qualis Health, provides vendor-neutral HIT consulting services related to the successful adoption, implementation, and utilization of EHRs for improving health care. These services include HIT outreach and education, EHR procurement guidance, workflow redesign, implementation support, and assistance on optimizing the use of EHRs, such as data and systems management support.

WIREC also guides eligible health care professionals to achieve meaningful use of EHRs and qualify for Centers for Medicare & Medicaid Services (CMS) incentive payments. Thanks to WIREC, Washington State has taken the lead in providing over \$80 million in federal Medicaid incentives for the acquisition of EHR to Medicaid providers who meet the minimum Medicaid patient panel requirements.

However, despite these successes, significant gaps remain in adoption of EHR systems. Rural health providers, some specialty and behavioral health settings, and smaller practices tend to have challenges in adopting the technology due to a variety of factors, including the size of their practices or inability to qualify for WIREC or meaningful use support (in the case of behavioral

health). Increasing EHR adoption of the entire community remains a priority, because EHRs are foundational to and a necessary prerequisite for a HIE.

Health Information Exchange

In January 2011, Washington State began implementing a secure, shared health information technology infrastructure to advance a statewide HIE. The primary focus of this initial step was to augment service delivery, not exchange clinical data, given that much of the information exchange that occurs in the market category is administrative in nature (claims, billing, etc.) A number of early adopters signed up, including Medicaid.

Washington's HIE is operated by OneHealthPort, a health information technology management company owned by leading local health care entities. The OneHealthPort HIE features tools that simplify secure data exchange and data transformation. The OneHealthPort HIE is overseen by the Washington State HCA, which works closely with OneHealthPort in setting priorities.

Currently, Washington State is developing plans to build out the existing HIE infrastructure in 2014 to enable exchange and storage of clinical data. The new HIE effort will enable:

- **Care coordination** – Deliver the information needed by care team members at the point of service to effectively treat individual patients who receive services from a number of different providers.
- **Care management** – Deliver information to individuals and organizations responsible for managing the ongoing process of care over time.
- **Public health monitoring and surveillance** – Deliver to public health officials the information needed to monitor public health trends and events
- **Consumer activation** – Deliver to consumers information about their care and the care of others they may be responsible for that allows them to be a more effective partner in the care received.

All Payer Claims Database

In September 2013, Washington State received a federal grant to create an All Payer Claims Database (APCD). Grant funds are expected to expand public/private quality reporting capabilities and enable the collection of cost data. Cost and quality data are expected to be reported publicly starting in fall 2015.

The APCD will be populated with insurance claims from public and private health insurance plans operating in Washington. The aim is an impartial, secure, and easy-to-use source of data to benchmark and track the state's health system performance as well as provide the price and quality data consumers and purchasers need to make informed choices.

The APCD will afford:

- Consumers access to health care pricing and quality data for decision making;
- Purchasers access to data to design high-quality benefit plans and provider networks;
- State agencies better health care analysis in the areas of cost drivers, geographic variation, access to care, payment reform, delivery system design for accountable care, and statewide health improvements like hot-spotting health concerns for intervention; and

- Providers with information for community-wide efforts to reform payment and delivery, creating a common source of metrics for “one source of truth” about provider performance and contribute to statewide metrics for all payers to reduce administrative costs.

The APCD will enhance Washington’s ability to report on care across a variety of settings, ranging from hospital inpatient through primary care in outpatient clinics and doctors’ offices. The database also will enable much greater price transparency. The inclusion of demographic information also means that data can be examined by patient characteristics such as age and sex. The APCD and the HIE will be community assets and powerful reporting tools and are necessary components of our state’s overall health system reform effort. Over time, Washington’s intent is to link the APCD and HIE as well as clinical data from other sources, to provide stronger and more real-time data needed to achieve Innovation Plan goals.



Source: 2009-2013, APCD Council, NAHDO, UNH.

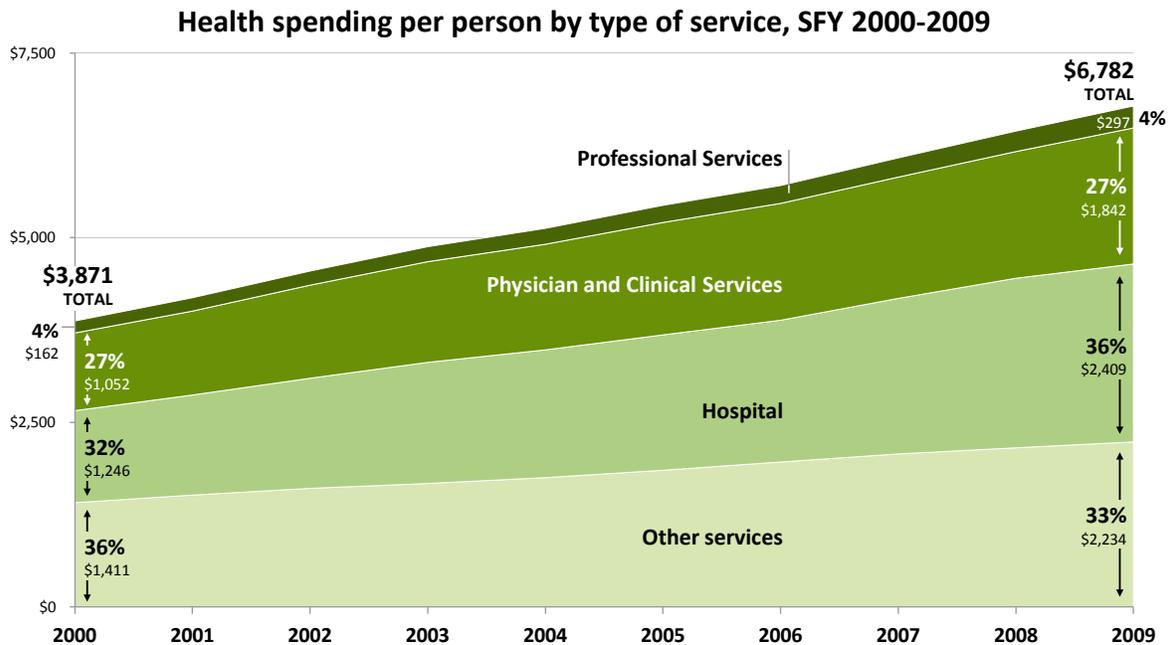
Current Health Care Cost Performance Trends and Factors Affecting Cost Trends

Personal health care expenditures in the State of Washington have grown from \$3.8 billion in 1980 (7.3 percent GDP) to \$45.4 billion in 2009 (13.6 percent GDP). Comparatively, national personal health care expenditures have grown from \$217.1 billion (8.0 percent GDP) to \$2.1 trillion in 2009 (15.1 percent GDP) and are approaching a projected 18 percent of the GDP.

The average annual percent of growth in health care expenditures in Washington is 7.3 percent which is actually higher than the national average at 6.5 percent.^{xxxii} In 2009, per capita health care spending for the average person in Washington was almost \$6,782.^{xxxii}

Average health care cost per person age 0-64 with private insurance is \$3,344. After adjusting for age, sex, and regional wage differences, the average varies by state hospital referral region, with Seattle’s average at \$3,183 and Spokane’s average \$3,904.^{xxxiii}

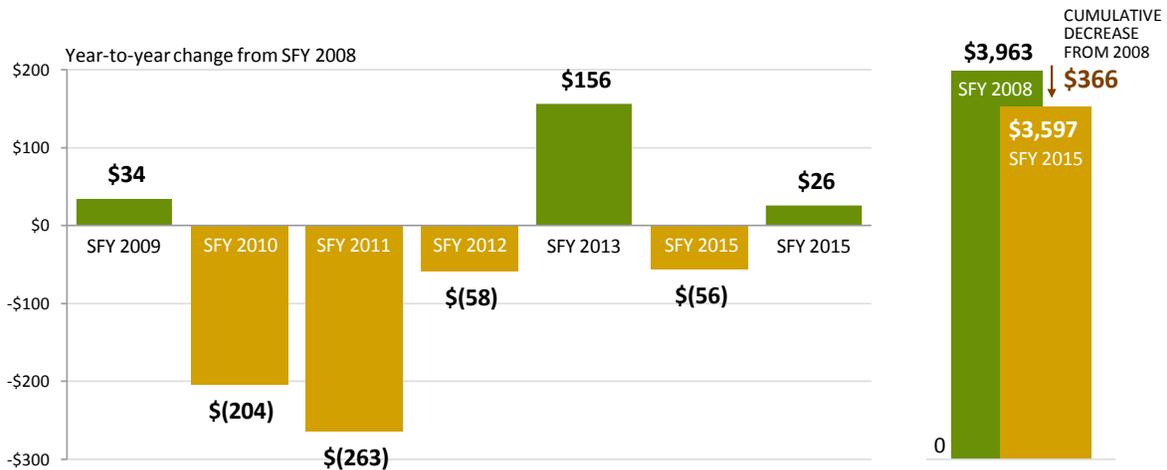
Distribution of Per Capita Spending by Service^{xxxiv}



Source and Notes: CMS Office of the Actuary, Health Expenditures by State of Residence. Other Services include the following: Dental Services; Home Health Care; Prescription Drugs; Durable Medical Products; Nursing Home Care; Other Health, Residential, and Personal Care. Other health professionals include non-physician providers such as nurse practitioners and physician assistants.

State-financed health care paints an atypical picture of cost trend, due in part to lower reimbursement rates in the Medicaid program. Average Medicaid spending per enrollee in Washington is \$5,343, below the U.S. average at \$5,535. Medicaid served 1,284,811 beneficiaries in 2010, with a total cost of \$5,580,497,447 (to the State and beneficiaries). Recent Medicaid cost trends have been at or below 2 percent annually, and between fiscal year (FY) 2008 and FY 2015, the overall per capita cost for the Medicaid population is forecasted to decline by 1.4 percent. With the impending expansion of Medicaid, Washington projects increased costs due primarily to increased health service usage by the 215,000 currently uninsured who are expected to enroll in Medicaid. For example, the total number of inpatient hospital days in Washington would increase by just over 100,000 and total health care spending would increase by \$840 million (2011 dollars).

Average annual per capita spending down 1.4% between SFY 2008 and SFY 2015



Source: Health Care Authority, Medical Assistance Per Capita Forecast

Washington's Public Employees Benefit per capita health costs are \$5,150 in FY 2013, with an average annual rate of growth at 4.3 percent over the last seven years, including two successive years of negative trends in FY 11 and FY 12.

Unwarranted Variation in Health Care Spending and Utilization in Washington

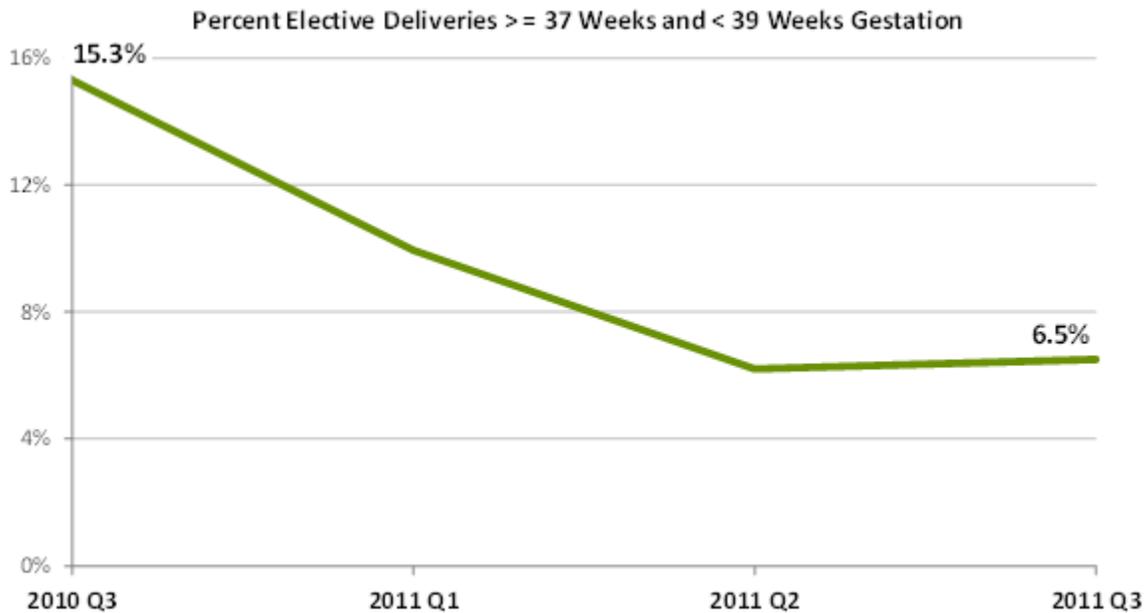
A significant amount of unwarranted variation in care and utilization exists nationally, and across Washington. Unwarranted variation (or geographic variation) in health care service delivery refers to differences that cannot be explained by illness, medical need, or the dictates of evidence-based medicine.^{xxxv} It can be caused by deficiencies in three areas:

- Effective care and patient safety (includes services of proven clinical effectiveness, such as providing preventive beta blockers after a heart attack).
- Preference-sensitive care (treatment for conditions that have significant trade-offs in terms of risks and benefits for the patient. But the choice of care is, or should be, driven by the patient's own preferences).
- Supply-sensitive care (care which is strongly correlated with health care system resource capacity and is generally provided in the absence of medical evidence and clinical theory).

Variations in care result in major costs in both lives and dollars. But transparent variation in health care delivery and utilization also indicate potential opportunities to reduce costs and improve the quality and value of health care delivery without compromising patient care.

Obstetrics (OB) care reflects substantial variation in labor and delivery practice patterns, with services existing across providers and facilities in Washington, despite local and national quality improvement efforts. Variation in OB elective deliveries, inductions, and primary C-sections is disconcerting because it may signal unfavorable outcomes for mothers and infants, as well as higher cost. Medicaid clients represent half of all births in Washington; therefore, decreasing the variation in OB care is of high interest to Washington State.^{xxxvi} For example, C-section rates vary greatly by hospital and region, from 10 percent to 39 percent. Washington has made significant improvement in elective induction before 39 weeks. However, more needs to be done to build upon and sustain progress. The rate of elective delivery without any medical indication among Washington hospitals still varies significantly, from zero to 18.5 percent, in 2011.^{xxxvii}

Trend in Elective Deliveries

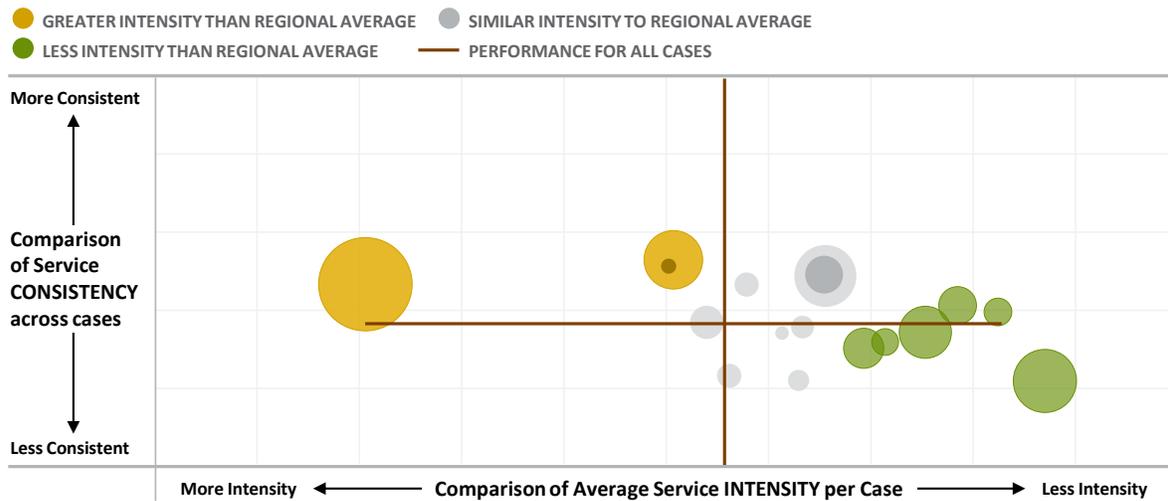


Source: Washington State Hospital Association, Washington hospital data voluntarily submitted to WSHA's Quality Benchmarking System (n = 39)

Elective joint replacement rates also vary considerably across Washington state and the nation. Classified as a preference-sensitive procedure by the Dartmouth Atlas, joint replacements are among the most common U.S. orthopedic procedures, with more than 650,000 knees and 250,000 hips replaced each year, at a combined cost of \$15.6 billion.^{xxxviii} Dartmouth Atlas data (Medicare) for Washington shows both high rates of joint replacement and high variation across Washington's hospital referral regions and hospital service areas.^{xxxix}

Overall end cost variation also is illustrated by regional joint replacement data. The Washington Health Alliance, using claims data, analyzed knee replacement procedures in the state. In the example below, the delivery system with the most cases in the Alliance database also has the highest service intensity per case. Two delivery systems have higher service intensity and six are lower. The difference in resource use between the most and least service intensive delivery systems is 13 percent. The Alliance estimates that on average the difference in cost per patient between the most and least service intensity delivery systems could range from \$1,700 to \$3,400.^{xi}

**Resource Use by Delivery System during:
Knee Joint Replacement, Minor Severity—APR DRG 302.1***



* Each bubble represents a single Delivery System (admitting hospital and professional care during the stay).
Bubble area represents case volume; commercially insured people, 2006-2009

Source: 2011 Report: Use of Resources in High-Volume Hospitalizations, Washington Health Alliance (www.wacomunitycheckup).

Decreasing variation requires a multi-pronged quality improvement strategy, including data to correctly identify and understand the magnitude of the problem. Variation in rates of joint replacement and in service intensity and price underscores the desirability of complementary strategies such as shared decision making, reference pricing, and Bree Collaborative recommended approaches.

Shared decision making is one proven strategy to decrease variation. Shared decision making is a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences. To help address the persistent problem of unwarranted variations in health care, in 2007 Washington became the first state to enact legislation encouraging use of SDM and decision aids to address variation and deficiencies in the informed-consent process.

Group Health Cooperative has been a leader in implementing shared decision-making tools and practices. When Group Health Cooperative introduced video-based “decision aids” for people with knee and hip arthritis, rates of knee and hip replacement surgeries dropped sharply (by 38 percent and 26 percent, respectively, over six months). The cost of caring for those patients also declined (by 12 percent to 21 percent, according to an article in the September 2012 Health Affairs^{xlii}).

Ambulatory Care Sensitive Conditions

Washington’s rate of Ambulatory Care Sensitive Condition (ACSC) hospitalizations is below the national average, but nevertheless accounts for one-tenth of all hospitalizations of the state’s adult population.^{xliii} Persistent regional differences also exist. Controlling ACSC hospitalizations can improve the population’s health, reduce health expenditures, and in the longer term also reduce the need for new hospitals and increased bed capacity. Reducing ACSC-related hospitalizations is addressed in the Innovation Plan’s Public-Private Transformation Action

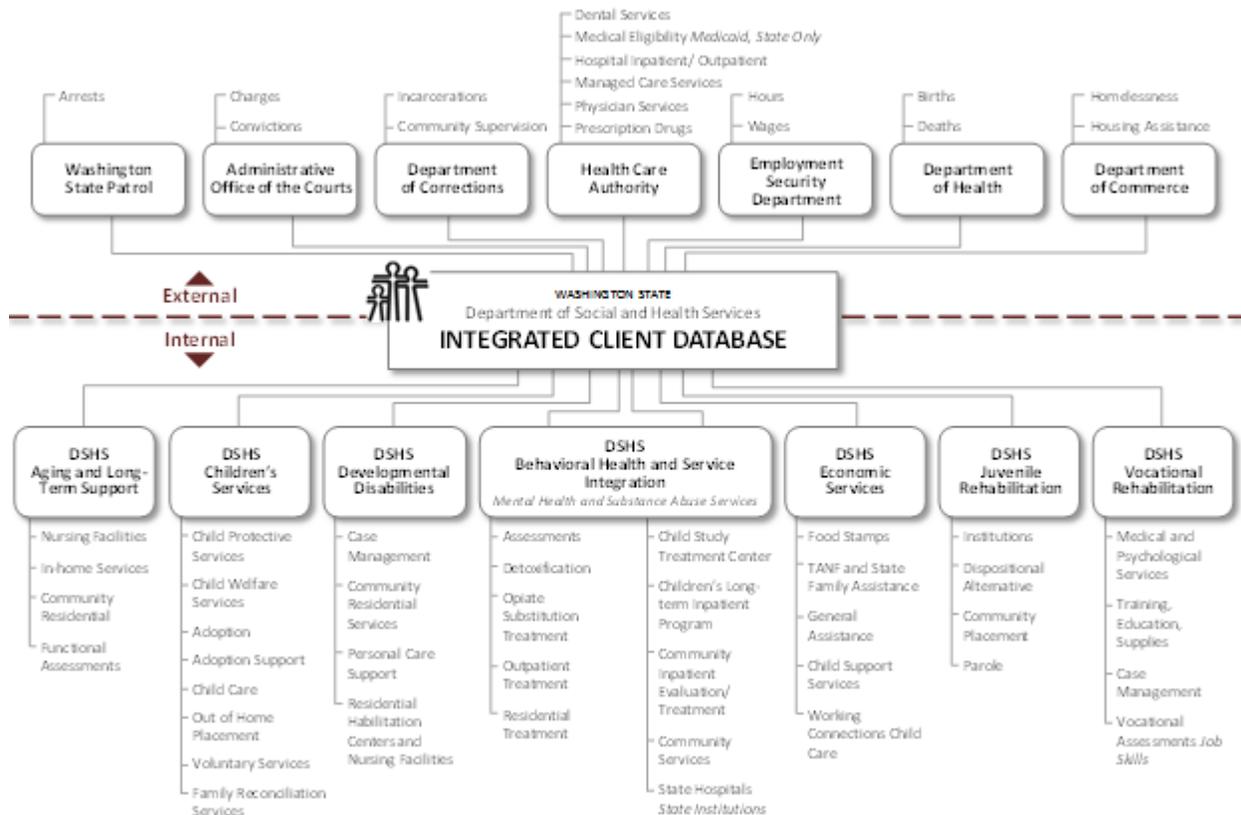
Strategy. Strengthening the state’s primary care system through the outlined strategies and tactics is a key theme.

Washington State Government and Health and Quality Activities

Health Data Sources

Washington currently lacks data sources and analytic capacity, a theme noted throughout this overview of the state’s health care environment. Building this capacity is also a strong component of the Innovation Plan. Accurate and detailed data describing the active professional workforce is not available. Information on health services facilities is limited. Utilization and price data is lacking. Washington does not currently have a statewide data source for ambulatory data, outside of Medicaid. Data on population health is available only for adults, and racial/ethnic data has limited the ability to adequately evaluate disparities in access, utilization, and cost of health care. Washington’s data sources also reflect inconsistent definitions, time lines, and descriptions of client groups.

Washington’s Integrated Client Database



Source: DSHS Research and Data Analysis Division, November 2013

Data is necessary to understanding unwarranted variation and developing strategies to improve the quality of care. Nationally, the Dartmouth Atlas publishes variation of care reports using Medicare data. Locally, the Washington Health Alliance publishes a quality report card called the Community Checkup. The Alliance’s Community Checkup is squarely aimed at measuring

unwarranted variation in the delivery of care in the Puget Sound region. The Alliance in 2011 produced its first report on utilization as a driver of health care costs in the Puget Sound region, using methodologies similar to the Dartmouth Atlas approach and looking at 21 conditions. It publicly reported on four conditions and showed significant variation on back surgery, hysterectomy, cardiac angioplasty, and percutaneous coronary interventions (PCI). The report also detailed variation in service intensity for a variety of procedures and began to delineate opportunities for reducing potentially unnecessary services, as well as consistencies in service delivery (a hallmark of process quality). No hospitals or physician groups were identified in this report, although the Alliance plans to unblind results in the future as a key component of transparency.

Current Health, Clinical, and Quality Improvement Activities and Measures

Despite its challenges with data, Washington has systems and entities that have provided great leadership in moving toward quality improvement and transparency, including the state's hospital, medical, and other professional associations, local health jurisdictions, and regional health improvement organizations.

- **Dr. Robert Bree Collaborative.** A statewide public/private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Bree members are appointed by the Governor and include representatives from public and private health care purchasers, employers, health plans, providers, and quality improvement organizations. The Bree identifies up to three areas annually where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the HCA to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB). To date, Bree has completed reports and quality improvement and payment reform recommendations in the following areas: obstetrics, cardiac care, appropriate use of PCIs, and spine/low back pain. The Bree is currently developing recommendations for a warranty for total knee and total hip replacements, and has chosen end-of-life care and addiction/opioid use as topics to study in 2014. (<http://www.hca.wa.gov/bree/Pages/index.aspx>)
- **Foundation for Health Care Quality.** FHCQ's physician-driven, clinically-derived quality measurement programs are nationally unique and have been successful for years in providing measured, benchmarked feedback to physicians and hospitals statewide. Many improvements have been, and continue to be, documented in the fields of interventional cardiology, general and pediatric surgery, vascular surgery, spine care and surgery, and obstetric care. This important work will continue and often forms the necessary clinical basis for quality/cost analyses. The Foundation also runs the Washington State Patient Safety Coalition. (www.qualityhealth.org)
- **MacColl Institute for Health Care Innovation at Group Health Research Institute.** MacColl provides comprehensive expertise at improving chronic illness care in ambulatory settings and partners with Qualis Health on the Safety Net Medical Home Initiative. (<http://www.grouphealthresearch.org/maccoll/maccoll.html>)
- **Qualis Health.** Qualis holds the Medicare Quality Improvement Organization (QIO) contract for Washington. Qualis' team of consultants and clinical leaders work with more than 1,000 health care providers and partners in Washington to improve patient safety in hospitals and

nursing homes; refine care transitions to reduce unnecessary re-hospitalization; redesign primary care to improve cardiac population health; protect Medicare beneficiaries by investigating individuals' concerns about their care; and preserve the Medicare Trust Fund. Qualis has served as a neutral convener for statewide and national health care quality improvement collaboratives and learning communities that have demonstrated significant improvements in quality and value. It is home to "WIREC," the Washington and Idaho Regional Extension Center. (www.qualishealth.org)

- **Rural Healthcare Quality Network.** RHQN was established more than a decade ago, and consists of rural health care providers engaged in meaningful improvement in the quality of care for patients in rural Washington. With more than a decade of support from the Department of Health's State Office of Rural Health, the RHQN was created by the state's critical access hospitals to monitor and improve the care provided by providers in critical access hospital settings (a federal requirement). (<http://www.rhqn.org>)
- **University of Washington AIMS Center.** The AIMS (Advancing Integrated Mental health Solutions) Center has developed and tested the evidence based Collaborative Care model to treat the large numbers of people suffering from mental illness, and is dedicated to improving the health of populations by advancing effective integrated behavioral and physical health care. (www.uwaims.org)
- **Washington Health Alliance** (formerly the Puget Sound Health Alliance). The Alliance is a coalition of purchasers, providers, unions, consumer representatives, and health carriers working together to improve the quality and affordability of health care in our region. It performs an important cross sector convening function and objectively measures, monitors, and publicly reports on the quality of health carriers and providers in a five county region (the Alliance has plans to expand statewide in 2014).

The Community Checkup is the Alliance's foundational public report. The Community Checkup highlights how often patients in the region receive key elements of proven, effective care at medical groups, clinics, and hospitals. The 31 ambulatory measures in the report fall into areas of prevention, chronic disease management, generic substitution, and appropriate use of services. The Community Checkup is based on claims data from purchasers and payers, with the data representing over 700,000 covered lives in Washington. Currently, only quality information is collected and analyzed. However, Washington State recently received a grant to expand the Alliance's database to collect and publically report cost data in addition to quality performance.

The Alliance's overall market impact on care delivery and plan performance has been constrained, both because it has yet to achieve a statewide presence and because it has not yet produced actionable data on price and relative resource use/efficiency among providers and plans. Additionally, its purchaser base does not include several of the area's major purchasers or significant numbers of mid-size employers. However, the Alliance has plans to do extensive outreach to business and organizations outside the Puget Sound region as part of their expansion effort, including staff visits and presentations.

(www.pugetsoundhealthalliance.org)

- **Washington Health Technology Assessment Program.** Created in 2006, the Health Technology Assessment (HTA) is an innovative program that determines if health services used by state government are safe and effective. The primary goals are to make: health care safer by relying on scientific evidence and a committee of practicing clinicians; coverage decisions of state agencies more consistent; state purchased health care more cost effective by paying for medical tools and procedures that are proven to work; and the coverage decision process more open and inclusive by sharing information, holding public meetings,

and publishing decision criteria and outcomes. Spinal injections, robotic assisted surgery, and cervical spinal fusion for degenerative disc disease are examples of topics HTA has reviewed and made coverage recommendations. (<http://www.hca.wa.gov/hta/Pages/index.aspx>)

- **The Washington State Department of Health** has been an important provider of health care learning collaborative support, often working in partnership with many of the entities listed above. A highlight is **Washington Health Information Network (WHIN)**, a public-facing information portal supported by the Department of Health. It provides State agency contact information and links to documents in health-related subject areas ranging from consumer protection to health professions licensure, environmental health issues, emergency preparedness/response, and data reports. WHIN also supports the WHIN Institute, a user-driven customized guide to its resources. (www.doh.wa.gov) (<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/WashingtonHealthcareImprovementNetwork/WHINInstitute.aspx>)
- **Washington's Department of Labor and Industries** has pioneered the highly effective Centers of Occupational Health and Education (COHE) program. Labor and Industries' analyst team works with the COHEs to pilot and spread new best practices, often developed in partnership with the **University of Washington**. COHEs work with medical providers, employers, and injured workers in community based programs. They improve injured worker outcomes and reduce disability by training providers and coordinating care. There are currently six COHE sites in Washington. (www.lni.wa.gov)
- **Local LHJs and county Regional Service Networks (RSNs)** are engaged in a number of quality improvement initiatives. LHJs constantly assess the quality of prevention and public health programs provided to the public. The RSN system tracks various quality measures to assess the performance of services provided.

Current Quality Performance Indicators

All payers use HEDIS measures to track the quality of care in their book of business, but a standard set of key quality indicators is not used across all payers, a key gap noted in the Innovation Plan. Washington's Medicaid requires all managed care plans to collect HEDIS measures on an annual basis. A report is published on the results, which provides aggregate and plan-specific performance data on process measures such as immunization and well child care visits, as well as clinical outcomes such as diabetic cholesterol control. Results for some measures are parsed by relevant client characteristics such as race/ethnicity and geographic location. Key points from the 2012 Healthy Options Performance Measurement Comparative Analysis Report^{xliii} include:

- **Immunization rates:** Statewide immunization rates remain significantly below the U.S. Medicaid averages for the majority of the 19 vaccines and combinations reported. Following the significant declines reported in 2011, the managed care organizations (MCOs) stabilized their performance on most indicators in 2012. Exceptions were a significant improvement in the Rotavirus immunization rate and a significant decline in the Hepatitis B rate.
- **Comprehensive diabetes care:** The MCOs significantly underperformed the national Medicaid averages on six of the nine indicators, however for the two indicators of blood pressure control in diabetes care, the 2012 statewide average rates were significantly higher than the national Medicaid averages. The only significant change from 2011 in the aggregate was a decline in the delivery of dilated retinal exams.

- **Well-child care (WCC) visits:** Despite some improvement in 2012, including average WCC visit rates for infants and adolescents showing significant gains in 2012, the statewide averages for these three indicators remain significantly below the U.S. averages.
- **Emergency Room visits:** The statewide average rate of emergency room (ER) visits by managed care enrollees fell significantly for the second straight year. ER utilization has remained significantly below the U.S. Medicaid average since 2006.
- **The use of high-risk medications for WMIP** (Washington Mental Health Integration Program) enrollees age 65 or older using at least one prescription or at least two different prescriptions has declined significantly over the past five years.

Commercial Market. Not all plans in Washington publicly report their HEDIS and CAHPS measures, although several do. In 2012, most (Group Health, Aetna, Cigna, UnitedHealthcare, and Regence BlueShield) but not all of the regions' commercial carriers participated in eValue8™, a common process organized by the Washington Health Alliance to measure the performance of health plans. eValue8 was created by business coalitions and employers like Marriott and General Motors to measure and evaluate health plan performance. eValue8™ asks health plans probing questions about their capabilities in the following areas:

- Provider measurement
- Consumer engagement
- Prevention and health promotion
- Chronic disease
- Behavioral health
- Pharmacy management
- Health plan profile including HEDIS accreditation

High-level summary results from the eValue8 process are shared with the public^{xliv}, but the most detailed results are not publicly available. They are shared only with each health plan and the participating purchasers. This enables comparison of plans against regional and national benchmarks and provides a roadmap for improvement. As a result of face-to-face discussions of findings and improvement recommendations, plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and ultimately, improve health and quality of care.

Regional Support Networks (RSNs) track the performance of behavioral health providers using access, timeliness, and quality measures. However, the current measures will be expanded. Recent legislation requires HCA and DSHS to incorporate mutual accountability measures and outcomes into their contracts with MCOs, RSNs, area agencies on aging, and county substance abuse programs by July 1, 2015. Outcomes must include:

- Improvements in client health status
- Increases in client participation in meaningful activities
- Reductions in clients' criminal justice involvement
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons
- Increases in stable housing
- Improvements in client satisfaction with quality of life
- Reductions in population-level health disparities

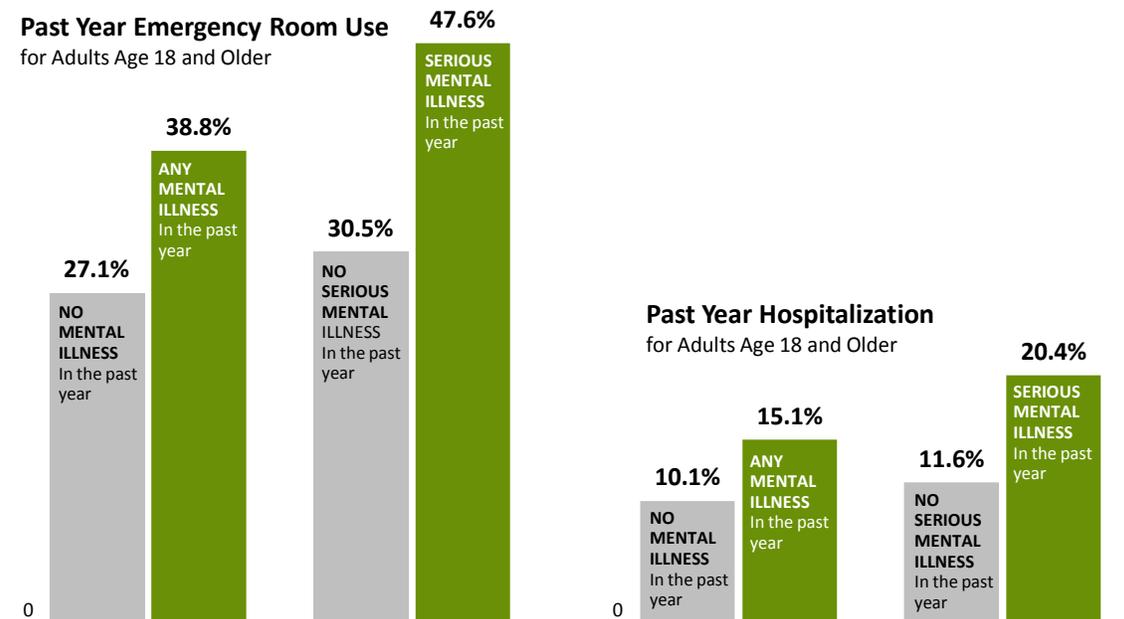
The agencies must develop strategies to identify programs that are effective with ethnically diverse clients. Reporting of outcome and performance data must be phased in and must allow for comparisons between geographic regions.

Behavioral and Physical Health Co-Occurring Conditions: Environmental Overview

The Medicaid expansion underscores both the need and the opportunity to adequately address behavioral health issues as part of total health. In Washington, 29 percent of adults with medical conditions have mental disorders. Behavioral health conditions, often co-occurring with chronic physical conditions, are expected to be highly prevalent among the working age populations entering Medicaid in 2014.

Mental illness is the key driver of caseload growth in Washington States Supplemental Security Income (SSI) program. Among working age SSI recipients, mental illness is by far the most prevalent primary disabling condition, accounting for almost half the caseload in 2009 and more than three-fourths of the caseload growth from 2002 to 2009. Washington has the eighth highest proportion of working age SSI clients with a primary disability of mental illness, according to Social Security Administration records.^{xiv}

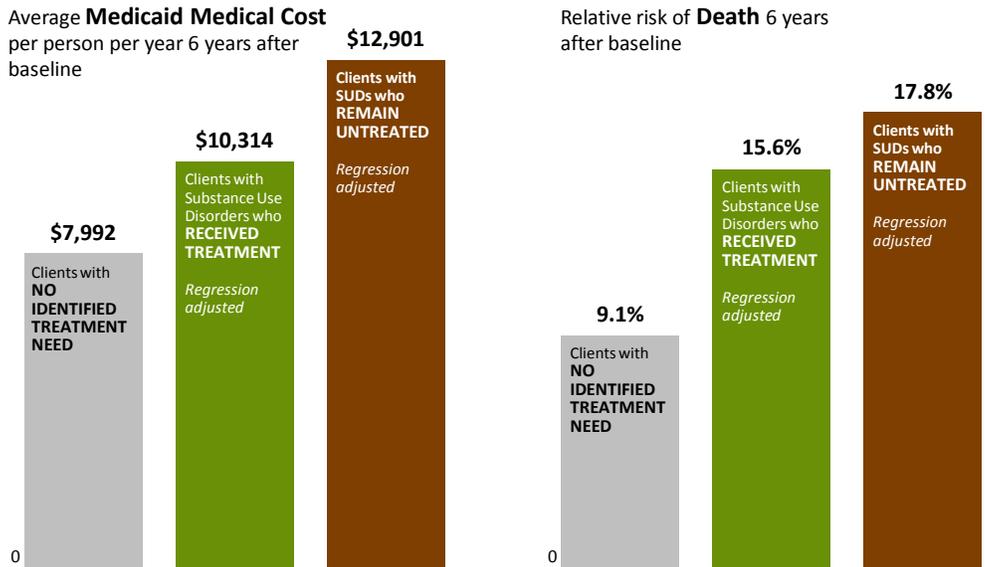
Americans with serious mental illness (SMI) on average die eight to 25 years earlier than those without SMI. The two leading causes of death are often preventable “physical” illnesses—heart disease and cancer. Health care expenditures for Americans with serious mental illness are two to three times higher than for others, and current Medicaid enrollees with major depression and a chronic medical condition (e.g., diabetes) have more than twice the overall health care costs than those without depression. Average Medicaid spending on behavioral health for people with schizophrenia is nearly \$12,000, plus another \$5,700 in other health costs as compared to an average of \$4,000 for other adults. Failure to proactively identify and treat persons with co-morbid behavioral medical conditions leads to significantly higher use of emergency department and hospital care.



Source: NSDUH REPORT, Physical Health Conditions among Adults with Mental Illnesses (SAMHSA, 2012)

Similarly, untreated substance abuse is a key driver of chronic physical disease progression that results in preventable suffering and poor health outcomes, and progression to disability-related Medicaid coverage.

Alcohol/drug treatment reduces the risk of mortality, delays the onset of hypertension/cardiovascular disease, and slows the progression of cardiovascular disease for substance users over time.



Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, *The Health Impact of Substance Abuse: Accelerating Disease Progression and Death* (Mancuso, Ford Shah, Huber, Felver, 2011)

The Innovation Plan aims to provide person-centered, effective collaborative care that will improve lives, enable recovery, and avoid progression of thousands of Washingtonians into serious disability and chronic illness, including co-morbid physical illnesses, mental illnesses, and substance use disorders. To do this, change must occur at the clinical, community, and administrative levels.

Washington, like many states, has delivery systems and services that treat mental illnesses, substance use disorders, and “physical” illnesses through separate systems and approaches. However, effective and innovative models of integrated physical and behavioral health care are operating in Washington today, including Collaborative Care primary care sites evaluated in the IMPACT study, as well as behavioral health models such as those exemplified by Kitsap Mental Health Services (a CMMI Innovation Award grantee), Asian Counseling and Referral Services, the Downtown Emergency Service Center, and Navos—all SAHMSA-HRSA Center for Integrated Health Solutions Primary and Behavioral Healthcare Integration Program awardees.

Many of these innovation leaders are following practices developed and elaborated by the University of Washington AIMS center, following the principles of: measurement-based care, treatment to target, stepped care, and other aspects of the chronic care model developed by the Group Health Research Institute’s MacColl Center for Healthcare Innovation, located in Seattle.

Washington’s current Medicaid administrative and service system is complex, and reflects the historical division of labor in health and recovery settings. Benefits and services are

administered by two different state agencies—the DSHS and the HCA. There are two sets of mental health benefits and three different ways that these services are provided. DSHS contracts with 11 RSNs that manage outpatient and inpatient mental health services for Medicaid enrollees who meet access to care standards defined by diagnosis and level of functioning criteria.

Administering Entity	Medicaid Benefits
Health Care Authority (HCA)/ State Medicaid Agency	<ul style="list-style-type: none"> • Physical health • Limited mental health (12/20 visits, will change post Jan. 1, 2014) • Prescription drugs (excludes opiate substitution) • Targeted health home services (high cost/high risk)
Department of Social and Health Services (DSHS)/ Division of Behavioral Health and Recovery (DBHR)	<ul style="list-style-type: none"> • Chemical dependency (inpatient and outpatient) • Mental health for people with serious mental illness (SMI), through Regional Support Networks
Department of Social and Health Services (DSHS)	<ul style="list-style-type: none"> • Long-term services and supports • Supports for people with developmental disabilities • Targeted health home services (high cost/high risk)
Counties (under contract with DSHS/DBHR)	<ul style="list-style-type: none"> • Regional Support Networks (as single counties or county partnerships) • Outpatient chemical dependency
Tribes	<ul style="list-style-type: none"> • Outpatient physical health • Outpatient mental health • Outpatient chemical dependency (under contract with DSHS/DBHR)

Under what is referred to as *rehabilitative mental health services*, Medicaid clients have access to 19 different “treatment or service modalities.” Importantly, these services include crisis services. Unlike the current (pre-parity) *medical mental health benefit*, these services do not have specific limits on the number of visits. Services may be provided as long as the client presents with medical necessity for care. However, individuals can only get these services if they meet *Access to Care Standards* and have a covered mental health diagnosis.^{xlvi} These services are administered by DSHS through the RSNs.

Community mental health services reach 129,000 people each year and include outpatient and residential treatment, crisis and commitment services, crisis stabilization, family treatment, medication management, peer supports, and employment and housing supports. State hospitals provide intensive inpatient psychiatric treatment.

DSHS also administers chemical dependency services for all Medicaid enrollees through a separate program, through contracts with counties and Tribes to provide outpatient services, including opiate substitution treatment. DSHS contracts directly with residential treatment agencies to provide residential chemical dependency services.

HCA administers physical health services, including prescription drug coverage, for all Medicaid enrollees in all systems of care. HCA contracts with Healthy Options (HO) plans for Medicaid managed care enrollees, and additionally contracts directly with mental health providers for fee-

for-service (FFS) enrollees. HCA administers mental health benefits for enrollees who do not meet RSN Access to Care Standards. Medicaid enrollees who have mental health needs but do not meet the access to care standard historically have had a limited number of mental health therapy visits through their Medicaid medical benefit, although this is changing in 2014 with the onset of mental health parity.

Mental illness and substance use effects and is also affected by outcomes and costs in other human service areas. Individuals with serious behavioral health issues are more likely to be involved in the criminal justice system. Frail elderly people with mental illnesses are more likely than other groups to have difficulties continuing to live at home as they age. Nearly 50 percent of residential chemical dependency treatment clients and 30 percent of state mental hospital clients are homeless or have unstable housing in the 12 months after discharge, thus making effective treatment of their physical and behavioral conditions far more challenging.^{xlvii} Low-income parents with mental health needs are more likely to have longer stays on family cash assistance programs due to difficulties getting or keeping employment. Family homelessness is also compounded by untreated behavioral health problems. Individuals with severe behavioral health issues are more likely to be involved in child abuse and neglect investigations and to have children in foster care. This perpetuates a cycle of predisposition to behavioral health and chronic illness in subsequent generations.

Washington has made progress in the integration of allied services, such as behavioral health, substance abuse, developmental disabilities, elder care and community health, and home and community based support services. Please note the list below is not exhaustive and some programs are addressed in the section regarding Federal Demonstrations and Waivers.

1. **Health Path Washington:** Medicare and Medicaid Integration (described more fully below).
2. **HB 1738:** In 2011, the Legislature demonstrated its commitment to integrating care across systems when it passed HB 1738, requiring HCA and DSHS to conduct a community-based process to more effectively coordinate “ . . . *the purchase and delivery of care, including the integration of long-term care and behavioral health services.*” The agencies’ report included concrete steps to purchase health care through MCOs that “. . . compete based on service, access, quality and price and . . . [through] robust health home functions...”
3. **Chronic Care Management (CCM):** CCM provides high-risk clients with enhanced nurse care management services in five pilot sites across Washington State. Early results have showed reduced inpatient and ER utilization, resulting in net savings of \$27 PMPM, as well as longer lifespans and less care in institutional settings.
4. **Washington Screening, Brief Intervention, and Referral to Treatment (WASBIRT):** Evidence-based public health practice training providers, including primary care, have been directed to conduct routine alcohol and drug screening. Results show more rapid access to treatment leading to better health outcomes.
5. **Ageing and Disability Resource Centers (ADRCs):** Washington State was awarded a grant to develop a five year plan to expand the state’s ADRCs’ capacity to provide comprehensive education and referral services. Currently, Washington has four ADRCs.

Federal Demonstrations and Waivers

The many initiatives, projects, and waivers in Washington speak to the creative and innovative spirit found across the state. Below please find an overview of programs. Note this list is not exhaustive.

Washington has 10 current waivers and one pending waiver with CMS including:^{xlviii}

- **A 1915 (b) Managed Care Waiver** for Washington's mental health system to provide comprehensive coordination of mental health services through a county based managed care system.
- **Nine programs under 1915(c) Home and Community Based Service Waiver** that support access to non-institutional services.
- **Washington's Take Charge**, an 1115 FP Waiver providing family planning-related services to women and men of childbearing age; who have family incomes at or below 200 percent of the FPL; and who are not otherwise eligible for Medicare, Medicaid, the Children's Health Insurance Program and other health insurance coverage that provides family planning services.

Washington has taken advantage of many federal and philanthropic grant opportunities to test improvements to health care system, current examples include:

- **Health Path Washington:** Medicare and Medicaid Integration in Washington State proposal to CMS to accelerate integration of these services under §2703 of the Affordable Care Act, including improved care for individuals who are dually eligible. This proposal requires providers serving high-risk populations to identify a lead caregiver and coordinate the care provided. Two strategies are currently rolling out to serve this population: Strategy 1 as a FFS model in the seven health home regions across the state and Strategy 2 is a fully capitated model in King and Snohomish Counties.
- **Community Transformation Grants** awarded by the CDC as a part of the ACA to make strategic changes to where Washingtonians live, work, and play focusing on four key areas including active living, healthy eating, preventative health care services, and tobacco free living. Various Washington governmental entities and organizations received six of these grants: the Washington State Department of Health, Tacoma Pierce County Health Department, Seattle Children's Hospital, Inland Northwest Health Services, Confederated Tribes of Chehalis Reservation, and Sophie Trettevick Indian Health Center.
- **The Medicaid Emergency Psychiatric Demonstration** was established under Section 2707 of the Affordable Care Act to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable due to the IMD exclusion.
- **Section 1902(k)(2), Washington's Transitional Bridge Demonstration** waiver used Medicaid matching dollars to help sustain Disability Lifeline and ADATSA programs to maintain coverage for low-income individuals enrolled in Basic Health and Medical Care Services programs until the full expansion of the Medicaid program takes effect in 2014.
- **Money Follows the Person Demonstration: Roads to Community Living.** DSHS is the lead for this project to investigate and test what services and support will successfully help people with complex, long-term care needs transition from institutional to community settings. The state's aging and disability services already has extensive experience providing flexible funds to seniors and people with disabilities to enable them to select those services that will best support their lives in the community.

Washington has a host of CMMI funded projects. These ideas and innovations inform the Innovation Plan:

- **Seven Round One Innovation Grants** operating across the state in their second year. Some highlights include:
 - Kitsap Mental Health Services that is working on care integration for 1,000 seriously and persistently mentally ill adults.
 - The IMPACT model, developed and operating in collaboration with community health centers, the University of Washington, community mental health centers, and RSNs, has provided appropriate mental health care in a primary care setting with demonstrated improved health outcomes and reduced state costs.
 - Prosser Public Hospital District Community Paramedic to visit patients of concern, providing in home medical monitoring, patient education, and follow up after discharge.
- **Washington also has been tracking organizations and institutions that applied for the second round of Innovation Grants** to inventory, learn, and align from innovative efforts across the state as well as align whether or not they receive the grant.

In addition to the Innovation grants, CMMI has provided a number of other grant opportunities to specific promising practices

- **Four Community-based Care Transitions cooperative agreements** (Medicare focused), which are test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- **Seven FQHC Advanced Primary Care Practice Demonstrations** (Medicare focused), which hope to show how the patient-centered medical home model can improve quality of care, promote, better health, and lower costs.
- **Two Innovation Advisor Program Grantees** funded to dedicated, skilled individuals in the health care system to deepen several key skill sets including health care economics and finance, population health, systems analysis and operations research, act as a support for the federal Innovation Center, and pursue changes within their own organizations.

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■ Appendix B

Washington State Health Care Innovation Plan Glossary of Terms

Accountable Care Organization (ACO)

An organization using a payment and delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Accountable Community of Health (ACH)

A regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations.

Adverse Childhood Experiences (ACEs)

Stressful or traumatic experiences, including abuse, neglect, and a range of household dysfunction such as witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home. ACEs, when not countered with measures building greater resiliency, are strongly related to development and prevalence of a wide range of disease, disability, and social problems throughout the lifespan, as well as premature death.

Accountable Risk Bearing Entities (ARBES)

Managed care plans, risk bearing public/private entities, county governmental organizations, or other community-based organization with a risk bearing partner or the direct capacity to assume full financial risk (for physical and/or behavioral health). This term is used specifically in reference to future Medicaid procurement.

All-Payer Claims Database (APCD)

An APCD provides transparent data to support improving health, health care quality, and containing costs by securely compiling claims data from private and public insurance carriers to provide a comprehensive picture of health care costs and utilization in a state.

Behavioral Health

A term used to refer to both mental health and substance abuse.

Bi-Directional Integration

Physical-behavioral health services integration and delivery. “Bi-directional” refers to inclusion of behavioral health services in primary care settings and physical health services in behavioral health settings.

Bree (The Dr. Robert Bree Collaborative)

A statewide public-private consortium established in 2011 by the Washington State Legislature "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Annually, the Bree identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB).

Center for Medicare and Medicaid Innovation (CMMI)

CMMI was created by Congress for the purpose of testing "innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program Benefits.

Choosing Wisely Campaign

An initiative of the ABIM Foundation, Choosing Wisely encourages physicians, consumers, and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary and, in some instances, harmful.

Collaborative Care Model

An approach to physical and behavioral health integration in which primary care providers, care managers, and behavioral health providers work together to provide care and monitor patients' progress. Pioneered and used successfully in Washington and elsewhere, these programs have been shown to be both clinically-effective and cost-effective for a variety of mental health conditions, in a variety of settings, using several different payment mechanisms.

Community Health Workers (CHWs)

Frontline workers who help individuals and communities improve their health. The CHW model is founded on natural helping systems within communities and is based on peer-to-peer relationships rather than provider-client relationships. A key feature of CHWs is that they are individuals who have a relationship with and understanding of the community in which they serve, often belonging to the same culture, speaking the same language, and having similar life experiences. They "gain their core experience from local forms of knowledge." As a result, they are in a unique position to engage individuals and populations that medical professionals have difficulty reaching.

Continuity of Care Document (CCD)

This is an electronic document that is in a structured and standardized format and is used for clinical information exchange. The CCD is used to share and provide summary information about the patient. The format and content are in harmonized standards that support greater streamlined exchanges with electronic medical records (EMR) and electronic health record (EHR) systems as well as various healthcare providers. The CCD enables greater interoperability for healthcare information absorption, timely use of clinical data and allows providers to send electronic medical information to other providers without loss of meaning.

eValue8

A system of measuring and evaluating health plan performance created by business coalitions and employers, such as Marriott and General Motors. eValue8™ asks health plans probing

questions about their capabilities in several key driver areas. Locally, the Washington Health Alliance (formerly the Puget Sound Health Alliance) has worked with major purchasers to deploy eValue8 to measure the performance of health plans.

Geo-Mapping or GIS Mapping

In the health care context, a computerized and typically real-time geographic information system that is used to show on a map where and what health events or conditions occur in a geographic area. It provides tools and applications to place and display items on a map with alternative ways to filter or amplify objects or conditions and view changes over time. This technology provides local contextually relevant information and can help support planning, interventions, identify potential health threats and trends, and a valuable tool for collaborative health ventures.

Fee-for-Service (FFS)

Health care providers are paid for each service like an office visit, test, or procedure; currently, the predominant reimbursement methodology in the United States and in Washington.

Health Information Exchange (HIE)

A secure, interoperable, standards-based health information infrastructure to enable timely exchange of clinical data between providers at the point of care.

Health Benefits Exchange (HBE)

A marketplace through which consumers can research health insurance options and purchase coverage. Washington's HBE is called the Washington Healthplanfinder.

Hot spotting

Typical GIS-based studies include an analysis such as "hot spot" analysis. Hot spots are detected clusters of chronic illness, infectious disease, simulation of disease spread, risk factors, or supply and demand analysis that identifies patterns within geographical areas. Hot spotting will be used in Washington to identify small area variations at the census tract level.

Medical Home

A team based primary care model that provides comprehensive and continuous care to consumers over time; its goal is to improve health, health care, and costs.

Mental Health Integration Program (MHIP)

A systems integration model of care developed and implemented within the State of Washington by which health care needs are served in a physical health care setting. Behavioral health services are co-located in the physical health care setting and include access to psychiatric consultation and services to rural primary care offices for low/moderate behavioral health needs.

National Quality Forum (NQF)

A nonprofit, nonpartisan, public service organization committed to transformation. NQF reviews, endorses, and recommends use of standardized health care performance measures. Performance measures, also called quality measures, are essential tools used to evaluate how well health care services are being delivered.

National Committee for Quality Assurance (NCQA)

A private 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, through voluntary membership, helping to elevate the issue of health care quality to the top of the national agenda.

Public Employee Benefit plan (PEB)

Washington's state employee benefits plan featuring fully insured and self-funded health plans provided to eligible state and higher-education employees and retirees as a benefit of employment and administered through the Washington State Health Care Authority's Public Employees Benefits Board (PEBB) program.

Reference Pricing

An innovative payment/benefit design element successfully used by several major purchasers including CalPERS and Intel. It is similar to a reverse deductible with the insurer paying the first part of the total allowed charge, and the enrollee pays the remainder. This requires price transparency to the enrollee. Typically used where there is significant variation in cost in the same markets without a difference in quality, and with procedures that can be scheduled.

Social Determinants of Health

The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

State Innovation Models Initiative

An initiative of the Center for Medicare and Medicaid Innovation (CMMI) to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states.

Testing Grant

A response to a CMMI State Innovation Models competitive funding opportunity that sets forth a state proposal to design and test multi-payer payment and delivery models that aim to deliver high quality health care and improve health system performance.

State Health Care Innovation Plan (SHCIP)

A State Innovation Models deliverable that describes a state's strategy to use the levers available to it to transform its health care delivery system through multi-payer payment reform and other state-led initiatives to improve health and health care while reducing costs.

Tiered Networks

A health plan delivery system and benefit design structure through which purchasers can continue to offer a larger health plan network to enrollees, but out-of-pocket costs will vary based on the ability of the chosen facility or service provider to deliver value (better outcomes and lower costs).

Transformation Support Regional Extension Service

A convener and coordinator of practice transformation services and clearinghouse of tools and resources modelled after the “primary care extension program” outlined in section 5405 of the Affordable Care Act. The extension service design envisions a central coordinating “hub,” and community based “spokes.” Local extension agents will provide supports required for practice transformation through facilitating and providing assistance for implementing quality improvement or system redesign necessary for high-quality, cost-effective, efficient, and safe person-centered care.

Triple Aim

Originally coined by the Institute for Healthcare Improvement, the “Triple Aim” is a framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience), and reduce cost.

Value Based Payment

Value-Based Payment (VBP) is a broad class of strategies used by purchasers, payers and providers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to health outcomes. Examples of such payments include pay-for-performance programs that reward improvements in quality metrics; bundled payments that reduce avoidable complications; global arrangements that tie upside and downside payments to specific quality targets in addition to actual target cost trend rate. VBP programs share a common objective of slowing the increase in the total cost of care by encouraging a reduction in the reported 30% of wasted health care dollars.

Whole Person Centered

An approach to care that places the person at the center of their care, encourages self-management, and takes into account the full set of medical, behavioral, oral health, and long term services and supports that contribute to health.



■ Appendix C

Washington State Public/Private Transformation Action Strategy

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Planning for the Future of Health Care in Washington State

Triple Aim Goals for Delivery System Transformation in Washington State

By 2019, Washington state will be among the best five states in the U.S. in:

Washington state will have **high quality health care.**

- Effective primary prevention and screening for preventable conditions
- Effective management of chronic conditions, including chronic physical health conditions and behavioral health conditions
- Quality of care for the most common acute conditions
- Avoiding unwarranted variation in health care quality and disparities in quality by race, ethnicity, gender, age, disabilities, language, geography, income, health conditions, and other factors

Washington state will have **affordable health care.**

- Total risk-adjusted per capita cost of care for commercially insured individuals, Medicaid recipients, and Medicare beneficiaries
- Lowest 5-year growth rate in the total risk-adjusted per capita cost of health care
- Risk-adjusted per capita spending on
 - Treatment of preventable health conditions
 - Chronic conditions
 - Episodes for major acute procedures

Washington state will have **a healthy population.**

- Health of its residents for all major demographic and income groups
- Avoiding disparities in health status by race, ethnicity, gender, age, disabilities, language, geography, income, and other factors

Key Objectives for Health Care Delivery System Transformation:

1. Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening.
2. Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients.
3. Use the lowest cost, highest quality care for acute, non-emergency conditions.

Potential Measures of Progress on the Objectives

These are suggested as potential measures for consideration. Other potential measures exist. The goal is to have the list be of a manageable size, to focus on system outcomes, to use nationally available measures where available, to consider the cost of data collection compared to the value of the information, and to include measures that are possible given data availability from multiple sources.

Prevention and Screening	Chronic Conditions	Acute Conditions
<ol style="list-style-type: none"> 1. Proportion of adults with a healthy weight 2. Proportion of adults with healthy blood pressure 3. Proportion of children with a healthy weight 4. Proportion of the state population <ul style="list-style-type: none"> ▪ That is tobacco-free ▪ With no substance abuse ▪ Current on evidence-based immunizations ▪ Screened for serious infectious disease (HIV, Hepatitis C) ▪ Screened for behavioral health issues ▪ Assessed for oral health problems ▪ Current on evidence-based cancer screening ▪ With a designated primary care provider 5. Infant mortality rate 6. Incidence rates of newly diagnosed advanced stage cancer 7. Death rates from cervical, breast, colon, and lung cancer 8. Death rate from drug and alcohol abuse 9. Death rate from suicide 10. Projected life expectancy and quality of life 11. Per capita spending on treatment of preventable conditions 	<ol style="list-style-type: none"> 1. Proportion of individuals with one or more chronic conditions whose health care is being well managed 2. Proportion of individuals with a chronic condition who have a medical/health care home 3. Proportion of individuals with depression, mental illness, or chemical dependency participating in a treatment program 4. Rates of avoidable emergency room usage for individuals with chronic conditions 5. Rates of avoidable hospitalizations for individuals with chronic conditions 6. Rates of avoidable hospital readmissions for individuals with chronic conditions 7. Ratings by individuals of their experience with the care they have received 8. Use of palliative care vs. treatment at end of life 9. Ratings by individuals with chronic conditions of their health and ability to function 10. Activation (patient engagement) level of individuals with chronic conditions 11. Total cost of care for individuals with chronic conditions, risk adjusted 	<ol style="list-style-type: none"> 1. Rates of ER usage for non-urgent conditions 2. Proportion of generic drugs prescribed (when generic alternatives exist) 3. Proportion of initial births delivered vaginally 4. Proportion of babies born full term and at normal birth weight 5. Rates of high-tech diagnostic imaging, particularly for conditions such as low back pain 6. Proportion of patients <ul style="list-style-type: none"> ▪ Reporting good outcomes from procedures ▪ Who die following major procedures 7. Proportion of providers with published episode prices for common procedures 8. Total spending (by purchaser and by patient) per episode on common procedures, risk adjusted 9. Variation in total risk-adjusted spending by provider organization (cost of care) per episode on common procedures 10. Per capita rates of procedures, risk adjusted, for procedures where evidence exists that there is overuse nationally 11. Per capita spending on most common acute conditions, risk adjusted

Four-Part Strategy to Achieve Each of the Three Objectives

NOTE: All four parts of the strategy – redesigned delivery systems, restructured payment systems, restructured benefit designs, and education efforts – must all be implemented together, in complementary ways, in order for any of them to be successful in achieving the objectives.

Strategy	Vision/Guiding Principles
<p>A</p> <p>Redesign health care delivery to improve access, reduce cost, improve quality, and improve patient experience</p>	<ul style="list-style-type: none"> • STRENGTHEN PRIMARY CARE: High quality, affordable, patient-centered primary care is the foundation of accountable care; it will be accessible to all residents and will play a central role in coordinating care for individuals and encouraging the use of high-value treatment options. • DELIVER HIGH-QUALITY, EFFICIENT PATIENT AND FAMILY-CENTERED CARE: All health care providers will seek to deliver high quality, evidence-based care as efficiently as possible in ways that are culturally and linguistically appropriate, convenient, and responsive to patient and family needs. Unwarranted variation in care across providers and delivery of unnecessary care will be reduced or eliminated, starting with the Bree Collaborative’s areas of focus. • PROVIDE ACCESS TO HIGH VALUE SERVICES FOR ALL INDIVIDUALS: Individuals in all parts of the state and from all demographic and income groups will be able to access high-value primary care, specialty care, dental care, behavioral health care, and community support services needed to maintain and improve their health. • COORDINATE ALL ASPECTS OF EACH PATIENT’S CARE: All providers involved in a patient’s care, including primary care, specialty care, dental care, mental health care, and chemical dependency care providers, will work as a team to improve quality, reduce waste and duplication, and improve patient experience and outcomes. Organizational structures such as Accountable Care Organizations will support the ability of different providers to coordinate care and to accept bundled and global payments. Providers will have access to timely, complete, accurate information on their patients’ needs and services with appropriate protections for patient privacy.
<p>B</p> <p>Restructure health care payment systems to support and reward providers who deliver high-value health care</p>	<ul style="list-style-type: none"> • PROVIDE SUFFICIENT, FLEXIBLE PAYMENT TO ENABLE DELIVERY OF HIGH QUALITY, EFFICIENT, COORDINATED, PATIENT-CENTERED CARE: Providers who are delivering care as efficiently as possible will receive adequate payment to cover the costs of quality care with the flexibility to continue innovating to improve quality and control costs. • EXPECT PROVIDERS TO TAKE ACCOUNTABILITY FOR COST, QUALITY, AND PATIENT EXPERIENCE OF CARE: Providers will take accountability for controlling the total cost of care for their patients, and providers will not be paid for unnecessary care, inefficient care, medical errors, or avoidable complications. Providers will not be expected to ration care to patients or take <i>insurance</i> risk (i.e., being required to care for sicker individuals without sufficient resources), but providers will be expected to accept <i>performance</i> risk (i.e., to deliver high quality, cost-effective care). • ALIGN PAYMENT SYSTEMS AND BENEFIT DESIGNS: The incentives for individuals under their health insurance benefit designs will be aligned with the incentives for providers under payment systems so that patients and providers can work together to improve quality and control costs.

Four-Part Strategy to Achieve Each of the Three Objectives, *continued*

Strategy	Vision/Guiding Principles
<p>C</p> <p>Restructure health care benefit design to enable and encourage individuals to improve their health and use high-value health care services</p>	<ul style="list-style-type: none"> • ENCOURAGE INDIVIDUAL RESPONSIBILITY FOR MAINTAINING AND IMPROVING HEALTH: Individuals will be responsible for maintaining a healthy lifestyle and obtaining appropriate preventive care when they have access to preventive care services and the resources needed to support health. • ENCOURAGE USE OF PRIMARY CARE: All individuals who have access to primary care will choose and use a primary care provider to help them maintain and improve their health, to help them choose other providers and services wisely when health care is needed, and to coordinate health care services from multiple providers. • REQUIRE DESIGNATION OF ACCOUNTABLE PROVIDERS FOR NON-EMERGENCY CARE: All individuals will designate in advance the provider or provider organization they expect to take accountability for coordinating the care they need for a non-emergency health condition or set of conditions. • SUPPORT VALUE-BASED CHOICES ABOUT NON-EMERGENCY CARE: Individuals will be responsible for paying more if they choose a higher-cost service or provider of care for non-emergency needs when a lower-cost, high-quality service or provider is available to them. Cost-sharing for high-value services such as preventive care and medications to control chronic conditions will be reduced or eliminated. • PROVIDE ASSISTANCE WITH NON-MEDICAL NEEDS THAT AFFECT HEALTH CARE: Individuals who have challenges in obtaining or using health care services due to lack of income, language barriers, lack of social supports, lack of transportation, etc. will have access to services to help them overcome these barriers.
<p>D</p> <p>Educate and encourage state residents to improve their health and use high-value health care services</p>	<ul style="list-style-type: none"> • EDUCATE AND ASSIST INDIVIDUALS TO IMPROVE HEALTH, PLAN FOR FUTURE HEALTH CARE NEEDS, AND CHOOSE HEALTH CARE SERVICES WISELY: Employers, schools, social services agencies, media, and communities will organize programs designed to educate and assist employees, students, service clients, and residents about ways to improve their health, to provide them with resources and self-help tools to improve their health, and to educate them as to how to use information on quality and cost to make wise choices about health care providers and services. Individuals will be encouraged to plan for end-of-life decision-making while they are still healthy. • GIVE PEOPLE ACCESS TO THEIR OWN HEALTH CARE RECORDS: Individuals will have easy access to complete and understandable information about the health care services they have received, ideally in an electronic format, in order to help them and their health care providers identify gaps in their care and avoid duplication of services. • GIVE PEOPLE ACCESS TO INFORMATION ON THE QUALITY AND COST OF HEALTH CARE PROVIDERS AND SERVICES: Individuals will have easy access to accurate, current, comparable, and understandable information about the quality and cost of health care providers and will have access to assistance in using the information to make decisions about care.

Action Guides for Implementation – Aligning the Strategies

The principles and actions listed on the following pages represent one desirable approach to health care delivery, payment, and benefit reform. Alternative approaches that achieve better outcomes at a lower cost will be encouraged, **but in all cases, alignment of care delivery, payment, and benefit design is KEY to successful transformation.**



OBJECTIVE: Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening.

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
<p>Primary care practices will proactively monitor patients to ensure they are receiving evidence-based preventive services and screening when appropriate and in ways that are culturally appropriate for the patients and to identify any barriers the patients are facing in obtaining those services. Through health information exchange, primary care practices will have access to information on the preventive care services that patients receive from providers other than their primary care practice. Unwarranted variation and unnecessary care will be eliminated. Data will be analyzed and used to support continuous improvement.</p>	<p>Primary care practices will receive non-visit based payments to cover the costs of outreach to individuals to encourage evidence-based preventive services, screening, and counseling. Practices that are effective in achieving high rates of evidence-based preventive care for their patients will be rewarded financially.</p>	<p>Individuals will choose a primary care practice to help them maintain and improve their health and ensure they receive evidence-based primary prevention services. Individuals will not be required to obtain all preventive services from their primary care practice -- they may obtain them from other qualified providers, including non-medical organizations.</p>
<p>Primary prevention services and screenings will be designed to be as culturally appropriate, convenient, and affordable as possible for people to use, including through non-medical providers. Outreach and follow-up by phone, email, or visit will support patient efforts to live a healthy life.</p>	<p>Higher payments will not be made to higher cost providers for preventive services and screenings when lower cost options are available, but higher payments may be appropriate for services in communities with poor access and/or many high-risk patients.</p>	<p>Individuals will receive information on the most affordable, accessible opportunities for evidence-based screening and preventive services. Patients will have low or no-cost sharing for evidence-based preventive services and screenings and will receive assistance in obtaining services if they are not easily accessible.</p>
<p>Providers will work in partnership with employers to improve access to preventive care and to promote employee wellness. Partnerships will be created among health care providers, community organizations, and public health agencies to reduce disparities in the rates at which residents receive preventive services and screenings and to remove barriers to healthy living. Primary care practices will partner with others in the community to support special outreach to encourage individuals with health risk factors, minorities, and residents of rural areas to obtain evidence-based preventive services and screenings.</p>	<p>Additional payments will be made to support outreach to and access for high-risk residents, residents of under-served communities and rural areas, and individuals who have high rates of utilization of services for preventable conditions; payments will be flexible enough to support innovative, culturally-appropriate, community-based approaches.</p>	<p>Barriers that individuals face in accessing evidence-based prevention and screening will be identified and addressed.</p>

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

OBJECTIVE: Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening, *continued*

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
All providers (not just PCPs) will encourage individuals to obtain necessary preventive services and screenings.	Payments to support outreach to patients for preventive services, screenings, and counseling will be shared among the providers which have the greatest ability to successfully reach and encourage patients to obtain services.	Employers and other purchasers will educate and incentivize their employees and members in culturally and linguistically appropriate ways about obtaining necessary preventive care and screenings and about maintaining and improving health, e.g., through wellness programs, recognition, lower insurance premiums, etc. Community-wide culturally and linguistically appropriate education will encourage all citizens to obtain appropriate preventive health services. Education will stress the impacts on health, quality of life and expenses when evidence-based prevention and screening is not used.
	Mechanisms for investing in primary prevention services will be studied and, if appropriate, implemented.	

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

OBJECTIVE: Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
Primary care practices will design treatments and support programs to meet the health needs of individuals with chronic conditions and customize care based on social needs.	Primary care practices will receive adequate payment to diagnose and develop an effective plan of care for individuals with chronic conditions.	Individuals with chronic conditions will choose and use a primary care provider to help them coordinate their care.
Primary care practices will develop a culturally appropriate plan of care for each patient with chronic conditions, including an Action Plan developed jointly with the patient for intervening early when problems arise, and will proactively monitor patients' care and health status in order to avoid the need for higher-cost services (e.g., hospitalizations).	Primary care practices will receive adequate non-visit based payment to deliver effective care management services to patients with chronic conditions, and payments will be risk-adjusted to allow services to be appropriately targeted to higher-risk patients. Practices will analyze data to ensure that their patients are receiving the most effective services.	Individuals will learn how to manage their chronic conditions effectively and take the steps recommended in their Action Plan (developed jointly with their primary care provider) to get help early when problems arise.
Primary care practices will use team-based approaches with physicians, nurses, pharmacists, diabetes educators, nutrition specialists, dentists, behavioral health specialists, etc., where appropriate to deliver care efficiently and customized to patient needs.	Payments to primary care will be flexible to allow non-physician care where appropriate to deliver care efficiently and customized to patient needs.	Patients will have lower cost-sharing for any additional services that are defined in a treatment plan developed with their primary care provider as being needed to help manage their chronic conditions.
Primary care practices will recommend and assist with arranging for community-based, non-medical services for individuals who need them to successfully manage chronic conditions.	Payments to primary care will be flexible to allow payment for community-based, non-medical services where necessary.	Community agencies will develop support services for individuals facing non-medical barriers to maintaining and improving health.
Primary care practices will involve non-primary care specialists when necessary or appropriate to assist in planning and managing care for complex patients.	Specialists will be paid to consult and coordinate with primary care practices without requiring an office visit by the patient if an office visit is not necessary.	Patients will have lower cost-sharing for consultations or office visits with specialists recommended by their primary care provider to assist in managing their chronic conditions.
A primary care practice or other provider will coordinate the services of multiple specialists and other providers (such as hospitals and long-term care facilities) for patients with complex conditions who need to use many providers. Patients will not receive duplicate or uncoordinated services from multiple providers.	Primary care practices and specialty practices will receive adequate payment to support the time and work involved in coordination of care and proactive outreach to patients.	Individuals will pay less if they use providers who agree to coordinate care with their PCP (or other care coordinator).

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

OBJECTIVE: Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients, *continued*

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
Primary care practices and behavioral health providers will coordinate their services for patients with chronic physical health and behavioral health conditions, and providers will move toward integrated care models that address both physical and behavioral health needs of patients.	Primary care practices and behavioral health providers will receive flexible, adequate payment to support the work involved in coordinating the care of patients with complex medical and behavioral health needs.	Individuals will pay less if they use a primary care practice and behavioral health provider who coordinate care (when this option is available).
Where appropriate, care management and coordination responsibility for patients with chronic conditions may be shared with or transferred to a non-primary care specialist by a primary care practice.	Specialists will be able to receive care management payments equivalent to those received by PCPs if the specialists accept accountability for care management/coordination for patients with chronic conditions.	Individuals with chronic conditions will have the flexibility to choose a specialist as their primary care provider if the specialist has the necessary training and resources to provide effective primary care and is willing to accept responsibility for care management and coordination.
All of the providers involved with a patient’s care will work together to take responsibility for controlling and reducing the overall cost of care related to their patient’s chronic conditions. Unwarranted variation and unnecessary services will be eliminated. Data will be analyzed and used to support continuous improvement.	Payment amounts will be higher for providers with better outcomes and lower overall costs after adjusting for differences in patient acuity and risk factors.	Individuals will pay less if they choose a primary care provider who has higher quality and lower costs if there are choices of providers available.

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

OBJECTIVE: Use the lowest cost, highest quality care for acute, non-emergency conditions

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
<p>Provider organizations will assist individuals in gaining access to evidence-based, culturally and linguistically appropriate information and advice (preferably from a neutral source, i.e., an individual or organization which will not perform a procedure or benefit financially from whether a patient does or does not receive a procedure) to help the patient choose which types of testing and treatment are appropriate for acute, non-emergency conditions.</p>	<p>Health care providers will be paid for time spent in shared decision-making processes with patients about care decisions.</p>	<p>Individuals will have financial incentives to seek information and advice on the most appropriate and cost-effective treatments and providers for an acute condition. Purchasers, health plans, and health care providers will all encourage individuals to engage in shared decision-making processes with health care providers before choosing specific services to address a non-emergency health care condition.</p>
<p>Efficient systems will be developed in each community for diagnosing and treating minor acute conditions to avoid unnecessary treatments in an emergency room. This may include a combination of services delivered by primary care practices or urgent care centers.</p>	<p>Payments to primary care providers will be sufficient to support after-hours access for individuals and flexible enough to allow phone calls and emails with individuals instead of office visits. Primary care providers will be paid more if their patients have low rates of using emergency rooms for minor acute care.</p>	<p>Individuals with minor acute conditions will have lower cost-sharing if a provider that delivers quality services at a lower total cost is available and used by the individual to deliver care.</p>
<p>Provider organizations delivering acute procedures or services will take responsibility for coordinating all of the services the patient receives during a full episode of care (e.g., including post-acute care), for avoiding errors and complications, and for eliminating inefficiencies and unnecessary services.</p>	<p>Provider organizations that care for patients with acute conditions will receive a single payment or budget to cover the costs of all services in a single episode of care for treating the acute condition, including the costs of treating any errors or preventable complications that may occur, unless they are receiving a single payment or budget to manage all of the care for the patient for a defined period of time, including care for non-emergency acute conditions. The payment amount will be higher for patients with more health problems or more severe health problems.</p>	<p>Individuals with an acute (non-emergency) condition will be expected to designate a provider organization that will take accountability for both the quality and cost of caring for the acute condition. Individuals can either (a) select a specific provider organization in advance to deliver all of the care they need for any condition if and when it arises, or (2) select a provider for each acute condition as it arises. Patients will only be required to pay a single cost-sharing amount for all of the care they receive from a provider for care of an acute condition, rather than cost-sharing on each individual service. Individuals will be educated about the advantages of receiving care from a provider which offers a warranty (i.e., does not charge extra for preventable complications) or from a provider which accepts an episode or global payment and agrees to coordinate all services.</p>

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

OBJECTIVE: Use the lowest cost, highest quality care for acute, non-emergency conditions, *continued*

How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN	How PAYMENT TO PROVIDERS Will Support This Type Of Care	How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care
<p>Provider organizations will redesign care so it is delivered at the lowest cost possible consistent with high quality and appropriate safety for the patient. Unwarranted variation and unnecessary care will be eliminated. Data on quality, cost, and patient experience and outcomes will be analyzed and used to support continuous improvement.</p>	<p>Provider organizations will publish the total episode price they will charge a self-pay patient who has a particular acute condition or who needs a specific procedure or treatment. Purchasers/payers and providers will negotiate to establish fair prices for insured individuals. Unwarranted variation in prices will be reduced or eliminated.</p>	<p>Individuals will have access to comparable, current, easy-to-understand information from a neutral source on the quality and cost of different provider organizations which offer the types of care patients need. Purchasers and payers will seek to give individuals choices of multiple provider organizations for care wherever possible, but the patient will pay significantly less if they use a provider organization with lower costs and equal or higher quality.</p>

NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.

Overarching Strategies to Encourage and Support Delivery System Transformation

These strategies are intended to inform the State of Washington about the tools and levers that can be utilized to support and accelerate delivery system transformation.

Strategy	Vision/Guiding Principles
<p>E</p> <p>Measure progress across the state to identify successes and opportunities for improvement</p>	<ul style="list-style-type: none"> <p>CREATE A COST-EFFECTIVE STATEWIDE MECHANISM TO MEASURE PROGRESS ON OBJECTIVES: Statewide data will be collected from multiple sources and made accessible to stakeholders for measurement and analysis of the status and progress on goals and objectives and to support continuous improvement and elimination of unwarranted variation by providers. The data collection mechanism(s) will be chosen with consideration for the cost and time involved in data collection, the benefits to be achieved from measurement, and the impacts of changes in payment systems, HIT, and modes of care delivery, drawing on the experiences of other states.</p> <p>USE COMMON, HIGH-VALUE, CONSENSUS MEASURES OF OBJECTIVES, DRAWING ON MEASURES FROM NATIONALLY-ENDORSED SOURCES WHERE POSSIBLE: Key stakeholders will agree on and use the most important measures of quality, cost, and patient experience. Measures will be selected considering the needs of different stakeholders and different parts of the state, considering the costs of data collection and the likely impact of improvement on the measures, and choosing nationally endorsed measures to the maximum extent possible. Measures of progress in improving care delivery, payment systems, benefit designs, and patient engagement will also be selected or developed.</p> <p>IDENTIFY SUCCESSFUL PROGRAMS AND PRIORITIZE OPPORTUNITIES TO IMPROVE COST AND QUALITY: Analyses will be conducted and publicly shared to (1) identify and celebrate providers and health systems that are delivering efficient, high-quality care and (2) identify unnecessary variations in care and other opportunities to improve quality of care for individuals and/or reduce costs of care for purchasers and patients.</p> <p>IDENTIFY AND ADDRESS DISPARITIES: Wherever possible with the data available, cost and quality measures will be analyzed in detail by demography, income, health status, and geography to identify both disparities in care and successful efforts to reduce disparities.</p> <p>PROTECT PATIENT PRIVACY AND PREVENT MISUSE OF DATA: All data with patient-specific information will be stored and used in ways that protect patient privacy, and potentially harmful uses of data will be controlled or prohibited.</p>

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Vision/Guiding Principles
<p>F</p> <p>Encourage innovation and market-based approaches that support progress on goals</p>	<ul style="list-style-type: none"> <p>• MAKE THE QUALITY AND COST OF PROVIDERS AND SERVICES TRANSPARENT FOR ALL STAKEHOLDERS USING COMMON MEASURES: Patients, purchasers, providers, and payers will have access to accurate, current, comparable, actionable information about the quality and cost of all providers and services using a common set of high-value measures.</p> <p>• MAXIMIZE THE USE OF MARKET-BASED APPROACHES TO ENCOURAGE DELIVERY OF INNOVATIVE, HIGH-VALUE CARE: Purchasers and patients will select and use providers who innovate to deliver the highest-quality, lowest-cost care as determined using common, transparent measures, with support from appropriate payment systems, benefit designs, and accessible data. Delivery systems, payment systems, and benefit systems will be adapted to the unique needs of different geographic areas and low-income individuals. Payment and choices for patients will increasingly be based on larger bundles of coordinated care, with costs and quality compared using standard measures.</p> <p>• USE GOVERNMENTAL POWERS WHERE NECESSARY TO ENSURE AN EFFECTIVE HEALTH CARE MARKETPLACE: State regulations and programs will be used to ensure transparency of information on quality and cost, to correct anti-competitive behaviors and protect consumers, to facilitate successful participation of Medicaid beneficiaries and State employees in the health care marketplace, to encourage and remove barriers to integration of physical and behavioral health services, and to remove regulatory barriers to changing the delivery of care in ways that would improve access, improve quality, or reduce costs. The state will serve as a leader among purchasers by requiring use of new payment models and benefit designs for State financed health benefits.</p> <p>• SUPPORT VOLUNTARY MECHANISMS FOR COORDINATION AND COLLABORATION: Both public and private sector leaders will encourage and support voluntary mechanisms for coordination and collaboration in order to facilitate progress in key areas, including: guidelines to reduce unwarranted variation in high value care, alignment on payment systems, benefit structures, health information exchange, infrastructure sharing (particularly for smaller practices), and sharing of best practices.</p>

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Vision/Guiding Principles
<p>G</p> <p>Help rural areas, small providers, and providers with unique needs to transform their care delivery systems</p>	<ul style="list-style-type: none"> • BUILD ON NATURALLY OCCURRING CONVENERS IN RURAL AREAS TO SUPPORT COLLABORATION, ALIGNMENT, AND TRANSFORMATION. Many rural communities have organizations that are serving, could serve, or have served in the past in roles that support collaboration among stakeholders, provide technical assistance to providers, etc., including public health departments, hospitals, Area Agencies on Aging, regional health collaboratives, etc. • HELP SMALL AND RURAL PROVIDERS OBTAIN TECHNICAL ASSISTANCE IN TRANSFORMING CARE. Small and rural providers will face unique challenges in transforming care, and they could obtain technical assistance more cost-effectively through joint efforts, learning collaboratives, etc. For example, a “Primary Care Extension Service” could be created to work with small and rural primary care provider organizations to help them redesign care and adapt to new payment and delivery models. • PROVIDE STABILITY AND PREDICTABILITY OF TOTAL REVENUES FOR SMALL AND RURAL PROVIDERS WHILE THEY WORK TO REDESIGN CARE DELIVERY SYSTEMS. It is very difficult for small providers with limited reserves to take time away from their day-to-day operations to redesign care or to make upfront investments in new care delivery methods that could cause them short-term losses in revenues. Protections against large swings in revenue could give them the “breathing room” needed to innovate. • PROVIDE LOANS AND TRANSITIONAL FINANCING TO HELP SMALL PROVIDERS MAKE INVESTMENTS IN BETTER DATA SYSTEMS. Even where there is a clear business case for the return on investments in new systems, small providers will likely need help in obtaining upfront capital. • ASSIST THE HEALTH CARE WORKFORCE TO RETRAIN AND OBTAIN WORK IN NEW HEALTH CARE ROLES. A shift to more primary care, preventive care, and outpatient care and away from inpatient care will require the health care workforce to have different sets of skills and to work in different settings and potentially for different organizations. Facilitating this transition will help speed implementation of health care improvements. • DEVELOP METHODS OF PAYING FOR MEDICAL EDUCATION, RESEARCH, AND CARE FOR THE UNINSURED THAT DO NOT PENALIZE PROVIDERS THAT SUPPORT SUCH FUNCTIONS. As greater attention is focused on the cost of care, purchasers and patients could avoid using teaching hospitals and hospitals which serve large numbers of the uninsured unless their higher costs can be supported in ways other than the prices of their services to insured patients. This may require a focus on federal policy change.

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

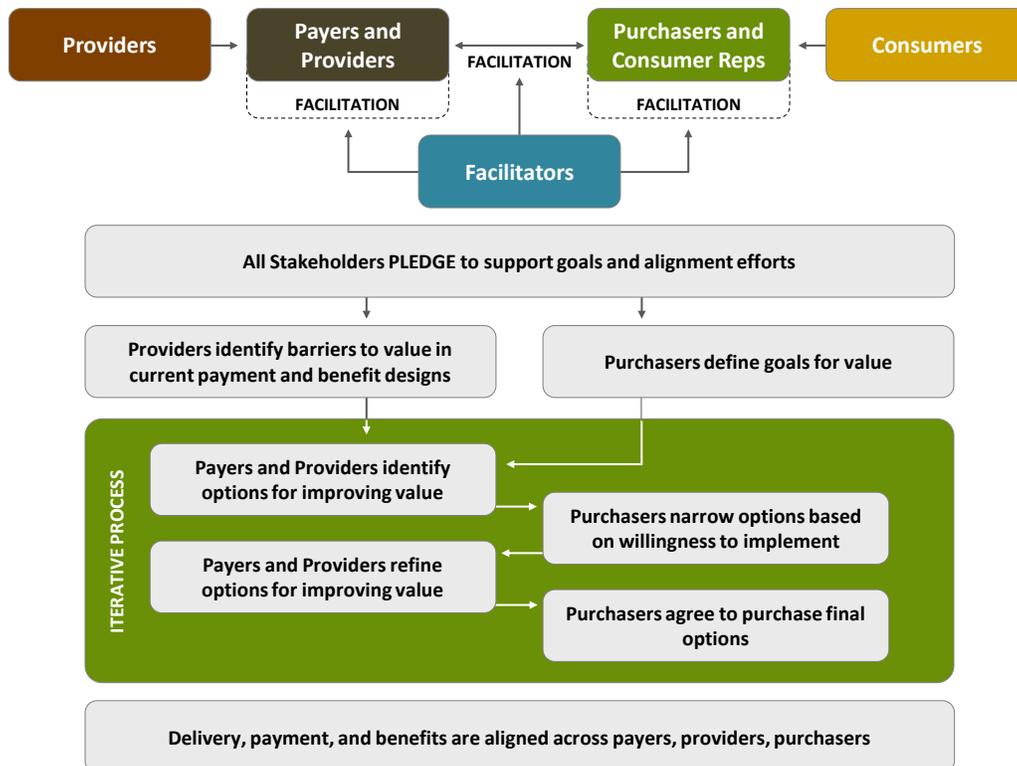
Strategy	Vision/Guiding Principles
<p>H</p> <p>Align the efforts of all stakeholders in implementing the strategies</p>	<ul style="list-style-type: none"> • USE A NEUTRAL FACILITATOR TO SUPPORT DISCUSSION AND ALIGNMENT AMONG PAYERS AND WITH OTHER COMPETING STAKEHOLDERS. Payers see benefits to aligning but will not align on their own without a neutral entity to convene and facilitate alignment. The state should recognize one or more facilitators to perform this function. • USE STATE ACTION EXEMPTION POWERS TO CREATE ANTI-TRUST SAFE HARBORS IF STAKEHOLDERS SEE ANTI-TRUST ISSUES AS A BARRIER TO ALIGNMENT PROCESSES. Assess this early and take action if needed. Creating anti-trust safe harbors can take time. • ASK EACH STAKEHOLDER TO COMMIT TO THE ALIGNMENT PROCESS, DEFINING WHAT IT IS PREPARED TO CONTRIBUTE TO IMPLEMENTATION AND WHAT IT NEEDS FROM OTHER STAKEHOLDERS IN ORDER TO DO SO. Differences in the “gives and gets” defined by each stakeholder will need to be discussed and aligned through facilitated discussion. (Please see Appendix D for <i>sample</i> commitment statements for purchasers, payers and providers.) • EXPECT INDIVIDUALS WITH AUTHORITY TO MAKE DECISIONS TO REPRESENT EACH STAKEHOLDER IN THE ALIGNMENT PROCESS. This is a time for organizations to commit the time and energy of staff that have both good ideas to offer <u>AND</u> have the authority to make commitments on behalf of their organization. To be most effective, the alignment process needs to be an active participatory process that results in <u>decisions</u> in a timely manner. • ASK PURCHASERS TO INITIATE THE ALIGNMENT PROCESS BY DEFINING GOALS AND A WILLINGNESS TO SUPPORT CHANGES IN PAYMENT SYSTEMS AND BENEFIT DESIGNS. Providers and payers need to know the goals that their customers – purchasers – are seeking to achieve and the kinds of changes they will and will not support as demonstrated by their own commitments <i>and actions</i>. • AVOID TRYING TO ALIGN PAYMENT SYSTEMS WITHOUT INVOLVEMENT AND SUPPORT FROM BOTH PAYERS AND PROVIDERS. Payment systems must support delivery system changes and vice versa. Facilitation is needed to enable payers and providers to develop mutually reinforcing strategies that achieve the Triple Aim goals. • ASK PROVIDERS TO IDENTIFY AND PRIORITIZE THE BARRIERS TO CARE DELIVERY IMPROVEMENT CAUSED BY PAYMENT SYSTEMS AND BENEFIT DESIGNS. Alignment among payers is most feasible where there is an economic rationale for alignment; providers must be able to show the costs of non-alignment and the potential savings or improvements through alignment.

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Vision/Guiding Principles
<p>H</p> <p>Align the efforts of all stakeholders in implementing the strategies, <i>continued</i></p>	<ul style="list-style-type: none"> • INVOLVE CONSUMERS IN SETTING GOALS FOR HEALTH CARE IMPROVEMENT AND IN DESIGNING CHANGES IN DELIVERY SYSTEMS AND BENEFIT STRUCTURES. Patient-centered health care must be guided, at least in part, by patients’ perspective of the care experience, including the quality and financial outcomes that have a direct impact on patient well-being. • BUILD ON THE SUCCESSFUL ALIGNMENT EFFORTS OF THE WASHINGTON HEALTH ALLIANCE (FORMERLY THE PUGET SOUND HEALTH ALLIANCE), THE BREE COLLABORATIVE, THE FOUNDATION FOR HEALTH CARE QUALITY, QUALIS HEALTH, AND OTHER COLLABORATIVES AND QUALITY IMPROVEMENT ORGANIZATIONS. Washington enjoys the benefits of several organizations that have made important contributions – each in their own way – to aligning the efforts of purchasers, providers and/or payers in improving health and health care. The State Innovation Plan maximizes leverage of these various activities.

Aligning Stakeholder Efforts to Achieve the Triple Aim

Aligning stakeholder interests is an iterative process, wherein each step has the potential impact of shaping the next step, and this level of understanding of “gives and gets” represents an important underpinning of facilitated agreement.



Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Action Step	Responsibility
<p>Getting started and sustaining progress</p>	<p>1. Ask all key stakeholders – major purchasers, providers, payers, and consumer/patient representatives – to commit to implementing the strategy defined in this plan and to achieving its objectives.</p> <ul style="list-style-type: none"> • Each stakeholder should define what it is prepared to contribute to implementation and what it needs from other stakeholders in order to do so. • Purchasers should be asked to make their commitments first, since they will drive the rest of the market. • The largest organizations in other stakeholder groups in each market (e.g., population centers) should be asked to commit next. • Eventually, all organizations should be asked to make commitments. • All organizations and parts of the state should be included, including the military and tribal health systems. 	<p>State government will finalize the commitment documents and request commitments from stakeholders</p> <p>There will need to be a process in place to follow-up with needed explanation and dialogue to achieve widespread response to commitment documents</p>
	<p>2. Appoint facilitators and begin convening the stakeholders who have made commitments for aligned action to implement the strategies in the plan</p>	<p>State government will identify one or more private and/or regional community entities to serve as facilitators of stakeholder discussion and alignment</p> <p>Each stakeholder should appoint a high-level decision-maker to participate</p>
	<p>3. Obtain and/or make data available to measure variations in care, compare performance to benchmarks, and to measure progress against goals</p>	<p>State government will identify one or more neutral and trusted entities to assemble and make data available to stakeholders.</p> <p>State government may need to take legislative or regulatory action to ensure transparency of information on quality and cost, ensuring that all major data suppliers participate equitably</p>
	<p>4. Affirm an initial goal for reduction in health care spending that is ambitious but feasible based on available data</p>	<p>State government will solicit input from stakeholders and finalize the goal</p>

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Action Step	Responsibility
Getting started and sustaining progress, <i>continued</i>	5. Call on all stakeholders to identify actionable opportunities for achieving the goal.	State government will issue the call for opportunities
	6. Prioritize opportunities within each of the three objectives that would enable the goal to be achieved. Criteria for prioritization include: <ul style="list-style-type: none"> • Potential for savings for all payers • Existence of opportunity statewide rather than in selected communities • Opportunities are actionable 	Some opportunities are explicitly called out in the State Health Innovation Plan for more immediate action by the State as first mover; analyses commissioned by State government may include further rating/ranking of opportunities State government will solicit input from stakeholders to develop final priorities not explicitly included in the State Health Innovation Plan
	7. Identify barriers to implementing the priority activities and develop a coordinated strategy for overcoming them. Use existing models of effective care delivery, payment systems, benefit designs, etc. to facilitate solutions (e.g., Wagner Chronic Care model)	Facilitators would convene stakeholders to identify barriers and solutions
	8. Implement the elements of the strategy	State government asks for more detailed commitments from individual stakeholders to implement relevant aspects of the strategy, e.g.: <ul style="list-style-type: none"> • Purchasers: changing benefit designs for employees or members; choosing health plans that implement payment and benefit changes • Payers: implementing payment and benefit changes • Providers: changing care delivery processes • State and media: educating the public about needed consumer, patient support

Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

Strategy	Action Step	Responsibility
<p>I</p> <p>Getting started and sustaining progress, <i>continued</i></p>	<p>9. Measure and report on progress quarterly</p> <ul style="list-style-type: none"> • in implementing planned solutions • in achieving the identified opportunities 	<p>State government surveys stakeholders as to implementation progress and issue status reports</p> <p>State government commissions regular analyses of progress on targeted opportunities and issue progress reports</p> <p>Stakeholders have access to timely data to measure their own progress</p>
	<p>10. Call on all stakeholders to identify actionable opportunities for achieving the goal.</p>	<p>Coordinated action by all stakeholders</p>
	<p>Repeat the process of soliciting and prioritizing actionable opportunities and developing strategies for implementing them.</p>	<p>State government with input by all stakeholders</p>



Appendix D

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan

- Employers/Purchasers
- Provider Organizations
- Payers



Payers

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan



Provider Organizations

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan



Employers/Purchasers

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan

I, the INSERT TITLE (e.g., Administrator, Chief Executive Officer, President), and on behalf of all at the INSERT NAME OF ORGANIZATION (e.g., Washington State Health Care Authority), recognize that health care purchasers—those organizations (employers and union trusts) that buy health care and/or health care insurance for their employees and/or members and their dependents—have a critical role in achieving the Triple Aim of having a healthy population and offering high quality, affordable health care. I further recognize that it is essential that purchasers align their organization's related purchasing decisions, programs, and activities with the broader health care innovation goals of Washington State in order to accelerate system-wide improvement.

I, therefore, commit my organization to support Washington State's Health Care Innovation Plan in the following ways:

- We recognize improved health and use of high-value health care as priorities and actively support the specific objectives of the State Health Care Innovation Plan by aligning our organization's activities with these objectives to the greatest extent possible.
- I will participate personally, or appoint a senior member of my organization with the authority to represent me, in meetings and activities designed to accelerate implementation of the Plan including achieving greater alignment of efforts with other purchasers and with other stakeholders, including providers and health plans.
- We will seek input from other stakeholders before taking any actions that would impede progress on the Plan, reduce alignment with other stakeholders, or jeopardize actions taken by other stakeholders to support implementation of the Plan.

As an employer/purchaser:

- We will ensure our organization has programs and user-friendly tools in place to educate, encourage, and facilitate the ability of employees/members to maintain and improve their health and to choose and use high-value healthcare providers and services.
- We will develop and use Requests for Proposals for evaluating and selecting health insurance and/or Third Party Administrator services that explicitly utilize the following four elements as decision criteria:
 - Payer/TPA commitment to use measures of quality, cost and patient experience that are developed/agreed to in common with other purchaser, payer and provider stakeholders;
 - Payer/TPA use of provider payment systems that have been developed in collaboration with providers and give providers the flexibility and accountability needed to improve quality, cost and patient experience outcomes, as defined by common measures noted above;
 - Payer/TPA offers value-based benefit designs that clearly incentivize employees/members to use high-value providers and services for all aspects of their care;
 - Payer/TPA agrees to routinely provide medical claims data (to include enrollment, utilization and cost information) to a statewide data collection mechanism for the purpose of enhancing transparency of performance and measuring statewide progress on the objectives.
- We will offer value-based benefit designs that clearly incentivize employees (and their dependents) to:
 - Maintain and improve their health
 - Choose and use a primary care team to help maintain their health and coordinate their care; and,
 - Use high-value providers and services for all aspects of their care.

Signature

Printed Name



Employers/Purchasers

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan

I, the INSERT TITLE (e.g., Administrator, Chief Executive Officer, President), and on behalf of all at the INSERT NAME OF ORGANIZATION (e.g., Washington State Health Care Authority), recognize that health care purchasers—those organizations (employers and union trusts) that buy health care and/or health care insurance for their employees and/or members and their dependents—have a *critical* role in achieving the Triple Aim of having a healthy population and offering high quality, affordable health care. I further recognize that it is *essential* that purchasers align their organization’s related purchasing decisions, programs, and activities with the broader health care innovation goals of Washington State in order to accelerate system-wide improvement.

I, therefore, commit my organization to support Washington State’s Health Care Innovation Plan in the following ways:

- We recognize improved health and use of high-value health care as priorities and actively support the specific objectives of the State Health Care Innovation Plan by aligning our organization’s activities with these objectives to the greatest extent possible.
- I will participate personally, or appoint a senior member of my organization with the authority to represent me, in meetings and activities designed to accelerate implementation of the Plan including achieving greater alignment of efforts with other purchasers and with other stakeholders, including providers and health plans.
- We will seek input from other stakeholders before taking any actions that would impede progress on the Plan, reduce alignment with other stakeholders, or jeopardize actions taken by other stakeholders to support implementation of the Plan.

As an employer/purchaser:

1. We will ensure our organization has programs and user-friendly tools in place to educate, encourage, and facilitate the ability of employees/members to maintain and improve their health and to choose and use high-value health care providers and services.
2. We will develop and use Requests for Proposals for evaluating and selecting health insurance and/or Third Party Administrator services that *explicitly* utilize the following four elements as decision criteria:
 - a. Payer/TPA commitment to use measures of quality, cost and patient experience *that are developed/agreed to in common* with other purchaser, payer and provider stakeholders;
 - b. Payer/TPA use of provider payment systems that have been developed in collaboration with providers and give providers the flexibility and accountability needed to improve quality, cost and patient experience *outcomes*, as defined by common measures noted above;
 - c. Payer/TPA offers value-based benefit designs that clearly incentivize employees/members to use high value- providers and services for all aspects of their care.
 - d. Payer/TPA agrees to routinely provide medical claims data (to include enrollment, utilization and cost information) to a statewide data collection mechanism for the purpose of enhancing transparency of performance and measuring statewide progress on the objectives.
3. We will offer value-based benefit designs that clearly incentivize employees (and their dependents) to:
 - a. Maintain and improve their health
 - b. Choose and use a primary care team to help maintain their health and coordinate their care; and,
 - c. Use high-value providers and services for all aspects of their care.

SIGNATURE

DATE

PRINTED NAME



Provider Organizations

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan

I, the [INSERT TITLE (e.g., Administrator, Chief Executive Officer, Chief Medical Officer)], and on behalf of all at the [INSERT NAME OF ORGANIZATION (e.g., XYZ Medical Group of Hospital)], recognize that health care providers—those institutions or medical practices that directly offer health care services to individuals—have a critical role in achieving the Triple Aim of having a healthy population and offering high quality, affordable health care. I further recognize that it is essential that health care providers align their organization’s systems, processes and tools for delivering health care with the broader health care innovation goals of Washington State in order to accelerate system-wide improvement.

I, therefore, commit my organization to support Washington State’s Health Care Innovation Plan in the following ways:

- We recognize improved health and use of high-value health care as priorities and will actively support the specific objectives of the State Health Care Innovation Plan by aligning our organization’s activities with these objectives to the greatest extent possible.
- I will participate personally, or appoint a senior member of my organization with the authority to represent me, in meetings and activities designed to accelerate implementation of the Plan including achieving greater alignment of efforts with other providers and with other stakeholders, including purchasers and health plans.
- We will seek input from other stakeholders before taking any actions that would impede progress on the Plan, reduce alignment with other stakeholders, or jeopardize actions taken by other stakeholders to support implementation of the Plan.

As a provider organization:

1. We will redesign delivery of health care within our institution and/or practice so that:
 - a. High quality, evidence-based care is delivered at the lowest cost possible while ensuring appropriate safety for the patient;
 - b. Errors and complications are minimized to the greatest extent possible; and,
 - c. Unwarranted variation and unnecessary care, that does not add value and may increase the risk of harm and/or excessive cost to the patient/purchaser, will be eliminated.
2. We will take responsibility for coordinating the services the patient receives during a full episode of care, and will further coordinate care for the patient—including sharing clinically relevant information about the patient—when care is delivered across multiple sites, including other health care and community-based organizations.
3. We will work with purchasers/payers to design and use payment systems that appropriately tie payment to cost, quality and patient experience outcomes. We will not expect additional payment for the cost of treating any errors or complications that may occur during the course of care.
4. We will collect and publish information about the quality and cost of care offered by our institution and/or medical practice. We will not object to the provision of medical claims and clinical data to a statewide data collection mechanism in ways that protect patient privacy for the purpose of enhancing transparency of performance and measuring statewide progress on objectives.

SIGNATURE

DATE

PRINTED NAME



Payers

Commitment to Take Action in Support of the Washington State Health Care Innovation Plan

I, the [INSERT TITLE (e.g., Chief Executive Officer, President)], and on behalf of all at the [INSERT NAME OF ORGANIZATION (e.g., XYZ Health Plan)], recognize that health insurers have a critical role in achieving the Triple Aim of having a healthy population and offering high quality, affordable health care. I further recognize that it is essential that health insurers align their organization's contracting and payment methods with the broader health care innovation goals of Washington State in order to accelerate system-wide improvement.

I, therefore, commit my organization to support Washington State's Health Care Innovation Plan in the following ways:

- We recognize improved health and use of high-value health care as priorities and actively support the specific objectives of the State Health Care Innovation Plan by aligning our organization's activities with these objectives to the greatest extent possible.
- I will participate personally, or appoint a senior member of my organization with the authority to represent me, in meetings and activities designed to accelerate implementation of the Plan including achieving greater alignment of efforts with other health plans and with other stakeholders, including providers and purchasers.
- We will seek input from other stakeholders before taking any actions that would impede progress on the Plan, reduce alignment with other stakeholders, or jeopardize actions taken by other stakeholders to support implementation of the Plan.

As a payer:

We agree to use measures of quality, cost and patient experience that are developed/ agreed to in common with other purchaser, payer and provider stakeholders.

1. We agree to work with provider organizations to develop and use payment methods other than traditional fee-for-service payment so that, within five years, at least XX% of our provider contracting and payment mechanisms:
 - a. Use larger bundles of care, and give providers appropriate accountability for achieving quality, cost and patient experience outcomes, as defined by common measures noted above;
 - b. Do not provide additional payment for treating errors or complications that may occur during the course of care; and,
 - c. Give providers greater flexibility to redesign care, such as paying for non-visit based care and care coordination.
2. We agree to work with purchasers to develop and implement value-based benefit designs that clearly encourage members to use high-value providers and services and discourage use of low-value providers and services.
3. We agree to routinely provide medical claims data (to include enrollment, utilization and cost information) to a statewide data collection mechanism for the purpose of enhancing transparency of performance and measuring statewide progress on the objectives.

SIGNATURE

DATE

PRINTED NAME



■ Appendix E

Accountable Communities of Health

In the community context, cross-sector collaboration is a vital adjunct to a vibrant and market-driven health economy. This is particularly the case when serving vulnerable populations with complex needs, when addressing community prevention, and in resource-stretched regions of the state.

Accountable Communities of Health (ACHs) embody a paradigm shift that emphasizes the role and influence of regional partners in shaping a health system responsive to local population health and health care delivery needs while addressing critical social determinants of health. Washington is seeking to transform more than clinical care, because much of health is determined by the physical and social environments in which individuals and families live. Often, achieving better clinical outcomes requires support from human services and community partners. Today, however, addressing these interdependent issues—ensuring individuals and families have person-centered, coordinated health and social services, and addressing community determinants of health—is unnecessarily difficult. Transformative results can be achieved if actors bring their combined resources to bear to achieve common outcomes, steward scarce resources, and support upstream prevention at the community level.

ACHs provide the organizational support to foster this needed strategic focus across sectors (including health care delivery, public health, behavioral health, education, social, human and community based services, community development, etc.) Community leaders, however, need more than just organizational and planning support. Improved cross-sector results at the local and regional level demand aligned state policies, a collaborative and supportive approach to determining regional boundaries and Medicaid procurement, actionable data and transformation support, and investment funding to jumpstart high value collaborative initiatives.¹

To better enable the ACHs to drive health improvement in a region, the State proposes to:

- **Invest in the Accountable Communities of Health** by providing funding and technical support for organizational development and maturation.
- **Ensure the process for determining regional service areas is highly collaborative and consensus driven**, and a first priority of Innovation Planning implementation.
- **Deepen its “Health in All Policies” approach that applies consistent health priorities across multiple state agency policies.**² Greater consistency in policy will be accompanied by greater consistency in state agency regional service areas, increasingly aligning with the regional contours of the ACH areas. A heightened level of consistency in state government

¹ Sanne Magnan, Elliott Fisher, David Kindig, George Isham, Doug Wood, Mark Eustis, Carol Backstrom, and Scott Leitz; https://www.icsi.org/_asset/hkt4a4/Accountable-Health-Communities-White-Paper.pdf

² <http://www.euro.who.int/en/health-topics/health-determinants/social-determinants/policy/entry-points-for-addressing-socially-determined-health-inequities/health-in-all-policies-hiap>

priorities and approaches will improve the ability for ACH participants to coordinate at a regional level across sectors.

- **Engage ACHs in Medicaid procurement design, assessment and meaningful oversight.** Driving better health outcomes for Medicaid clients, particularly those with or at risk for physical and behavioral co-morbidities demands local cross-sector innovation and collaboration and greater partnership between state and local government. Local context is particularly important as the state drives toward supporting whole person care through its procurement practices. A voice for ACH representatives in procurement will enable communities to influence how Accountable Risk Bearing Entities (ARBES) can best support improved health outcomes for clients whose health and wellbeing is best supported through multiple services and sectors, including nutrition, housing, and behavioral and physical health settings, and early learning (to name a few).
- **Ensure the Washington Health Mapping Partnership is designed with local public health and community leaders** to provide the data and tools needed to support community hot spotting efforts and cross sector policy decisions.
- **Cultivate and provide access to “best in class” transformation support tools** through a combination of regional and statewide resources and learning collaboratives that encourage the capturing, sharing and spread of best practices.
- **Develop a new financing toolkit** for cross sector innovation in partnership with regional partners.

Below is a proposed framework with key ACH principles, structure, responsibilities, and accountability mechanisms. Successful ACH development will require additional engagement of the relevant stakeholders, Tribes, and local jurisdictions to further refine this framework and build an implementation plan.

ACH Core Elements

An ACH is a regionally governed, public-private collaborative or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations.³ An ACH acts as the facilitator to bring out the strengths of each participant and develop mutually reinforcing actions in support of a shared vision and agreed-upon goals for the region. Through its emphasis on collaboration, it can streamline activities and reduce duplication. The ACH must be flexible to adapt and respond to the needs of the communities and populations it serves.

An ACH will be a valuable tool in innovation. However, it is useful to note that ACH is *not* intended to:

- Be one-size fits all.
- Add “approval” layers or act as a regulatory body.
- Supplant government entities, such as local public health jurisdictions.
- Divert state general funds otherwise going to local entities.

³ Erickson, Ian Galloway, and Naomi Cytron, “Routinizing the Extraordinary,” *Investing in What Works for America’s Communities: Essays on People, Place and Purpose*, Federal Reserve Bank of San Francisco and Low Income Investment Fund, 2012

Partnership at the Foundation

As non-regulatory bodies, ACH participants will need to rely on partnership and mutual cross-commitments as outlined in the Collective Impact Model.⁴ Five conditions will create successful and sustainable change:

- **Common Agenda.** All participants work towards a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. A common agenda establishes boundaries so that the group has focus and can achieve measurable change.
- **Shared Measurement.** Participants use data and measure results consistently across the community to ensure efforts remain aligned and to drive accountability.
- **Mutually Reinforcing Activities.** Participant activities are differentiated while still being coordinated through a mutually reinforcing plan of action.
- **Continuous Communication.** Consistent and open communication across many players assures ongoing mutual commitment, progress, and problem solving.
- **Backbone Support.** Creating and managing collective impact requires adequate staffing with a specific set of skills enabling the ACH to serve as the backbone for the shared initiatives and to coordinate participating organizations and agencies.
 - This supportive infrastructure may in some instances already be in place, or be available through loaned resources, but in all cases dedicated resources are important to drive success of cross sector activities.

Governance and Organization

The precise organizational and governance structures will not be dictated at the state level, because they can and should be tailored to fit the needs of the communities and thus developed in collaboration with parties in the region. Below are some initial key principles for the formation of ACHs, recognizing that additional parameters will be established through an engagement process during Innovation Plan implementation:

- The organizational structure must enable public-private partnership and cross - organizational priority setting. Acceptable structures may include a quasi-governmental arrangement, a 501(c)3 or (c)4 non-profit corporation or cooperative, or other form that enables cross sector engagement, commitment, and decision-making.
- No one single entity or common group of entities (i.e., hospitals, risk bearing entities, etc.) may control the direction, agenda, and decision-making within an ACH.
- Representation from across the health sector, community-at-large, and consumers should be present within the organization's decision-making structure so that it reflects the values of the community. Tribal representation will be sought by the ACH.
- The success of an ACH and an ARBE are linked, so it will be important that these entities form strong partnerships and working relationships. ARBEs therefore must be full ACH participants, except on matters related to procurement/oversight as described below.

⁴ Hanleybrown, F., Kania, J., & Kramer M. *Channeling Change: Making Collective Impact Work*, Stanford Social Innovation Review. (January 2012) Collective Impact Model; John and Mark Kramer, *Embracing Emergence: How Collective Impact Addresses Complexity*, Stanford Social Review <http://www.fsg.org/tabid/191/ArticleId/837/Default.aspx?srpush=true>

- Each regional service area will have *one* regional ACH, not multiple. This does not in any way suggest that local communities cannot have or continue additional improvement organizations or initiatives. In many cases, such organizations and initiatives will provide increased opportunity to drive action at the local level and leverage best practices across regional systems.
- Currently, existing entities may be able to fulfill the ACH role, however, in most cases their structure, geographic reach, and/or membership may need to evolve.

Potential Accountable Community of Health Responsibilities

Accountable Communities of Health will have multiple roles in driving transformation.

Partner in Procurement

Medicaid procurement, particularly as it moves to support whole-person care and the needs of many more adults and families, will demand greater partnership among state and local government, physical and behavioral health providers, and community-based organizations. Today’s behavioral health systems and supports are particularly interdependent, and these interdependencies must be reflected in procurement design, assessment, and subsequent oversight. Medicaid procurement therefore will be reorganized into regional service areas that correspond with boundaries defined for ACHs. This regionalization will enable anticipated direct ACH representative engagement in development of statewide procurement objectives to assure they address regional needs and perspectives, including those of local government, public health, providers, and communities. Washington also would like to engage ACHs in assessment of ARBE RFP responses for their specific regions to inform the State’s decisions around which ARBEs best meet the needs of the community. Additionally, the plan envisions that the regional ACH will be a meaningful partner with the state in providing on-going oversight of the effectiveness of the ARBEs in its communities to address gaps in service and quality.

This expanded role for the ACHs in Medicaid will require thoughtful development and application of strict conflict of interest policies to exclude any potential bidder involvement, or the potential for self-dealing, etc. While Washington’s new approach is built upon community engagement, the state retains ultimate responsibility for selection and oversight in the procurement and bears legal and financial responsibility.

This new “governance” model builds upon the recent experience with the HealthPathWashington program with King and Snohomish Counties. Washington was one of 15 states to receive a federal grant to plan innovative ways to improve care for some of our state’s most vulnerable people (those who receive services from both Medicare and Medicaid). An extensive stakeholder process informed the resulting demonstration proposal, called “HealthPathWashington: A Medicare and Medicaid Integration Project.” HealthPathWashington includes two distinct pilot strategies to coordinate health, behavioral health, and long-term supports and services:

1. In most counties, dual eligibles can enroll in a “Health Home” in order to receive care coordination across the systems of care as they currently exist; and
2. In King and Snohomish counties, a transformative approach to systems change that integrates Medicare and Medicaid funding and services into a single benefit package administered by health plans and delivered by the health plan’s network.

Since much of the Medicaid funding that would flow to health plans under the latter approach would otherwise flow through county delivery systems, as a condition for the necessary transfer of funds, Washington’s legislature required approval of the terms of the health plan pilots’ implementation by the county legislative body in each area of operation. Rather than a barrier, the requirement was leveraged into a new, collaborative relationship between counties and the state that has allowed planning for an unprecedented level of financial and service integration to proceed. Affected counties having this increased level of influence in and commitment to health plan pilots cleared the way for the CMS-State Memorandum of Understanding that underlies implementation of a capitated model in 2014. The development of this model overcame past resistance to change by focusing energies on common ground—the joint interest in improving health outcomes and being wise stewards of resources—with county representation in setting Medicaid contract standards, review of health plan bids, and a planned role in readiness review and monitoring health plan performance. In addition, the State agreed to mitigate the financial impacts the counties may experience related to decreased caseload and service provision.

Develop a regional health assessment and Regional Health Improvement Plan

ACHs will be expected to complete a region-wide health assessment and planning process. The ACH framework envisions that participating local health jurisdictions will play a strong leadership role and will draw upon and reflect the strengths and insights of other ACH participants. These health assessments identify needs and gaps as well as the strengths and assets available in the community. Ideally, these assessments would also satisfy non-profit community benefit needs assessment and public health jurisdiction accreditation requirements. The State will work with interested parties to help achieve this streamlined approach. The assessments in turn guide development of regional health improvement plans that both align with state priorities and identify community health priorities and key strategies.⁵

Drive accountability for results through voluntary compacts

The Regional Health Improvement Plan as envisioned will focus on outcomes that do not come under the direct control of any one service provider or funder. The parties, therefore, must mutually recognize what actions they agree to take. Working together in this way is often referred to as a “compact,” where each party has voluntarily aligned its actions with the shared goals and is transparent. The ACH is envisioned to function as the primary regional vehicle for developing and coordinating this type of “compact” accountability.

Act as a Forum for harmonizing payment models, performance measures and investments

Using a collective impact approach, ACHs potentially can work with all partners to:

- Strategize how to reduce existing and future administrative burdens and duplication and streamline regional activities.
- Accelerate implementation of new, innovative delivery and payment models that will aid provider groups in achieving better health for the regional population, potentially building partnerships with community service providers and non-health care sectors.
- Review and understand data to address health and community needs, and continuously improve quality as well as inform process for alignment and partnership at the ACH level.

⁵ http://ep50.eventpilotadmin.com/doc/clients/IHI/IHI2011/library/M11_Presentation.pdf, Slide 35

The ACH can also help mobilize and communicate the analysis of the data out to communities and other interested parties that could directly or indirectly impact health.

- Be a forum to identify and develop cross sector investments that may yield created savings or efficiencies for other sectors. If savings are anticipated, the ACH can play a role in negotiating how savings will be distributed and perhaps reinvested. This might include opportunities resulting from cross agreements with ARBEs or innovative funding mechanisms that enable multiple sector investment in projects with anticipated future return on investment.
- ACHs can work to integrate health information exchange (HIE) efforts. In some cases, the ACH may be the organizer of a regional HIE, if necessary. ACHs can be the agent that moves forward HIE adoption as a community standard, especially around shared care planning for high risk individuals.

Health Coordination and Workforce Development

When feasible to effectively support local community resource needs, an ACH could identify and facilitate shared workforce resources to build effective pathways for those community members most at risk, including but not limited to shared intensive case management, care coordination, community health workers, etc. The ACH could also serve as a forum to assure a continuum of crisis outreach, diversion, and involuntary commitment services are in place across the region that improves delivery of the services and reduces duplication or gaps in service.

Host and Facilitator of the Regional Extension Agents

The ACH as planned will host the Transformation Support Regional Extension Service community “spoke” or Transformation Support Regional Extension Agent—a local agent serving as the regional learning and diffusion arm of the Extension Service state hub. This close connection ensures that the practice transformation initiatives of the Extension Service are designed with the needs of ACH partners and communities in mind. The local agents can coordinate community based learning collaboratives to support practice transformation, and reinforce cross regional sharing of best practices.

Use Innovative Data to Address Community Health Needs

The ACH and local health jurisdictions will have better and more accessible data resources and tools. Washington’s strategy for transformation fuses sophisticated GIS-mapping capabilities with a further build-out of data resources and technical assistance as needed to develop a statewide baseline and deepen the local toolbox for population health improvement. These tools offer ACH participants including local public health greater capabilities in targeting potential interventions and investments to support improvement in the most at-risk communities, and measuring progress.

The “Accountability” Element of the ACH

The ACHs will be invited to work with the State to develop performance measures, metrics, and expectations to assure the ACHs are functioning effectively, reducing waste and duplication, and adding value. These will be enforced through:

- ACH/State base contracts setting out agreed core milestones for ACH development, achievement of state priorities, and the region’s priorities informed through the regional improvement planning process.

- A memorandum of understanding will outline mutual expectations for the ACH role in Medicaid procurement and oversight.
- Budget and operations public transparency, including administrative costs (which will be held to a percentage of budget) and investments made in specific initiatives.
- Regional cross sector accountability: The ACHs are envisioned as operating at the community level primarily through the collective impact model described above.

The core set of outcome measures for the ACH will be informed by the 1519⁶/5732⁷ measures and Results Washington.⁸ These measures can also serve as guideposts for the priorities of the ACH. Process measures can examine diverse and active representation on the board, completion of regional needs/asset assessment, implementation of the regional health improvement plan, and mutually reinforcing activities taken on by participating entities. Newly developed AHRQ Clinical Community Measures will also be considered for inclusion. Accountability expectations are expected to vary according to the level of ACH implementation and readiness to meet predetermined targets at a given time.

Development and Capacity Building

Washington will formalize a process to engage with and assist regions in bridging from the current status to a fully developed Accountable Community of Health. The framework and a number of the principles above need to be honed and developed in partnership with key participants. The State will work with interested parties to develop and recommend statutory changes in the upcoming 2014 legislative session and subsequent rule development as needed to support the development and subsequent evolution and oversight of ACHs.

⁶ <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1519&year=2013>

⁷ <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5732&year=2013>

⁸ <http://www.results.wa.gov/>

Accountable Communities of Health

■ Levels of Readiness

Summary

The following chart illustrates the proposed capabilities, relationships and functions that organizations/entities should develop over time in order to fully achieve the vision of Accountable Communities of Health (ACHs). It also recognizes there are some entities that might have the capacity to take on the duties of the ACH with slight changes to their governance structure, geographic reach, and/or membership. It is designed to help Washington and key stakeholders plan for and lay out milestones for readiness, and it is expected to flex and evolve through ongoing community engagement.

The terms “organization” and “provider” are intended to include a broad range of entities and providers that are moving toward greater accountability for health and overall value for the populations they serve. Many types of organizations can have a role in convening, leading, or participating in accountable communities of health—including providers of physical health care, behavioral health services, public health, social services, and education services; and community organizations, faith-based organizations, risk bearing entities, philanthropy, and other private and public sector partners that have a role in individual or population health.

As organizations move from left to right on the table below, the relationships become more formalized and involve more types and numbers of organizations.

Overview of the Proposed Levels

Level 1

A partnership or organization that has begun some community transformation activities around prevention, and may also be pursuing some clinical transformation activities. A designated entity has been assigned as the convener to receive funds and technical assistance from the state to bridge from current status to Level 2 and beyond. This partnership and/or organization will most likely be run on a volunteer basis, or duties may be shared across partnering entities. No formal staffing or structure.

Level 2

An organization that has completed a joint community assets/needs assessment with leadership from/in collaboration with local health jurisdictions, and is jointly planning and executing community based activities based on the assets/needs assessment. It is beginning to use and share data and data analytics to target health improvement activities in the neediest communities. This level also is engaging in activities and data sharing for care coordination or care transitions or similar activities, as well as developing and planning intervention strategies to improve health and lower cost. It will also be developing staffing and organizational structures to meet the needs of the plan. The organization is engaged in Medicaid procurement.

Level 3

Organizations that meet Level 2 and in addition are prepared to jointly plan and coordinate supportive community services with risk bearing entities or other ACH participants. Arrangements may feature shared savings from improving health outcomes and reducing

community service costs for Medicaid clients served, particularly those with physical and behavioral health co-morbidities. Organization will play key advisory role with State on Medicaid procurement process, including an on-going oversight role in providing feedback around service gaps. Able to host the Transformation Support Regional Extension System Agent and will begin to deploy its resources where appropriate.

Level 4

A fully developed accountable community of health model which plays a role in innovative care/delivery models that integrate medical care, behavioral health, community health, public health, social services, schools, oral health, and long term services and supports, and has committed to grow and develop this model of integration among ACH partners and with the state. This includes demonstration of a commitment to share accountability and resources across partners. Has dedicated staff (within ACH or sub-contracted with another entity) able to support and drive priorities forward, analyze and deploy data and resources effectively. Actively engages with the Transformation Support Regional Extension Service and the Extension Agent in deploying their resources. Has ability to participate fully in statewide learning collaboratives.

Organizations and/or partnerships may be at different levels of development on different issues, and the boundaries between the levels may sometimes overlap. It is not necessary for an organization to have achieved level 3 capabilities in all areas to be eligible for anticipated support or technical assistance under the state innovation model implementation. The goal is to use anticipated Innovation Plan supports to move organizations onto the ACH grid, or as far forward in as many areas as possible. For example, an organization may have achieved level 3 capabilities in terms of shared care planning, but may still be working at level 1 or 2 in terms of resource sharing arrangements. The ultimate goal is to increase the number of Washington residents who benefit from a broader community wide focus on the determinants of health, and who receive care and supportive services from organizations that have all of these elements in place, but with a recognition that organizations may move along this continuum at different rates and using different approaches, recognizing the unique attributes of their communities.

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
Governance	<ul style="list-style-type: none"> Informal relationships between health providers (physical, behavioral, oral), public health and community organizations (social services, education, housing, etc.) through basic cross referrals or planning to meet community needs. May come together for a group project of common interest. May 	<ul style="list-style-type: none"> Largely informal partnerships, but may include data sharing or shared service agreements. May be joint financial or in kind contributions to community activities. Risk bearing entities are actively participating in planning. Decision-making and communication structures are in the process of being 	<ul style="list-style-type: none"> Legal entity, public/private arrangement or formal contractual agreements. Includes decision-making, resource allocation, quality improvement initiatives, and data sharing. Risk bearing entities actively engaged and making financial or significant in kind contributions, but in no case have 	<ul style="list-style-type: none"> ACH organization is a public/private partnership, such as quasi-governmental arrangement, 501(c)3 or 4 nonprofit or cooperative. Formal arrangement includes strong engagement with relevant community/local government sectors and formalized relationships with risk bearing entities.

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
	include risk bearing entities.	developed	majority representation, nor do any other organization types.	These arrangements include shared decision-making, agreements on population health goals/strategies in partnership with local public health, shared governance, data sharing and some financial arrangements. Risk bearing entities are included, but in no case have majority representation, nor do any other organization types.
Organizational Structure	<ul style="list-style-type: none"> • Undefined • No formal defined board but possibly a lead convening group. • Group of volunteers possibly formed around an issue • May have jointly applied for a grant together (this happens a lot and are named together as the accountability group) 	<ul style="list-style-type: none"> • Initial, formalized group working on beginning stages of formal operating structures –such as articles of incorporation (if a nonprofit form is chosen) voting, by-laws, collective impact procedures, etc. 	<ul style="list-style-type: none"> • Continued development and refinement of organizational structure. 	<ul style="list-style-type: none"> • Quasi-Governmental arrangement, Non-profit 501 (c) 3, 4 other formal organizational structure, or other public/private arrangement enabling cross sector engagement, commitment and shared governance as appropriate.
Membership	<ul style="list-style-type: none"> • Undefined • Loosely – defined by project or area of interest. 	<ul style="list-style-type: none"> • Base membership, but community outreach is underway to bring in more partners 	<ul style="list-style-type: none"> • Minimum cross-sector representatives in place. (Minimum representation to be determined in innovation planning next steps.) 	<ul style="list-style-type: none"> • Minimum required cross sector representation in place. Additional members as needed to drive agreed agenda. • Flexible to meet community needs, a testament to the functionality of the agreements across the region
Ability to Partner with the State to achieve	<ul style="list-style-type: none"> • Region and state work to build capacity to level two within one year with 	<ul style="list-style-type: none"> • If formal entity exists and it meets minimal to some of the criteria set forth, and has prepared a 	<ul style="list-style-type: none"> • Meet some criteria set forth and can receive ACH grant dollars, but must direct grant dollars 	<ul style="list-style-type: none"> • Meets most of criteria set forth and receives dollars from the grant program. Due to advanced

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
Innovation Plan Objectives	technical assistance	robust plan to develop capacity to meet desired criteria can receive ACH grant dollars. Must move to level three within one year. <ul style="list-style-type: none"> Some demonstrated level of partnering and commitment across shared goals, actions and resources Consumer representation cultivated 	to capacity build out. Must move to level four within one year. <ul style="list-style-type: none"> Consumer representation required and action plan for increased engagement in place 	status, bonus dollars may be tied to achievement of specified outcomes. <ul style="list-style-type: none"> Consumer representation required on formal board structure and consumer committee in place.
Staffing	<ul style="list-style-type: none"> If any, staff is volunteer capacity from representative organizations 	<ul style="list-style-type: none"> Limited staff as needed for dedicated functions 	<ul style="list-style-type: none"> At least part time director, and possibly data analytics capacity, care coordination capacity, other. 	<ul style="list-style-type: none"> Depending on size of organization, at least an effective management structure including a full-time director, and finance, operations and data analytics as needed.
Community Assets and Needs – Joint Assessment and Planning	<ul style="list-style-type: none"> Compares community needs assessments, informally coordinates activities. Limited tracking of community metrics. 	<ul style="list-style-type: none"> May coordinate formal community assets and needs assessment for majority of region (with local public health jurisdictions as lead dependent on local health jurisdiction capacity), facilitates joint planning. Tracks regional metrics. 	<ul style="list-style-type: none"> Coordinates formal community assets and needs assessment roll up for entire region in close coordination with/with leadership from local health jurisdictions, and staffs regional health improvement plan as needed, incorporating state priorities. Tracks regional metrics. 	<ul style="list-style-type: none"> Coordinates formal community assets and needs assessment roll up for entire region in close coordination with/with leadership from local health jurisdictions, and staffs regional health improvement plan as needed, incorporating state priorities. Measures and holds itself accountable for regional progress. The state holds the entity accountable as well to certain metrics.
Care and Service Coordination or Integration	<ul style="list-style-type: none"> Care and service coordination and integration loosely coordinated among participants or not 	<ul style="list-style-type: none"> Greater coordination and planning across providers, service sectors and/or risk 	<ul style="list-style-type: none"> Local practice transformation extension agent actively working to support 	<ul style="list-style-type: none"> Local practice transformation extension agent actively working to support

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
	addressed	bearing entities. May include shared care/resource planning for some patient populations.	development and spread of PCMHs, care teams that extend beyond a single provider organization, and formal models of bi-directional care coordination and care management between primary and behavioral health providers and service sectors. <ul style="list-style-type: none"> Multiple shared resources such as community health workers, intensive care management/care transition assistants may be embedded in ACH or other shared “hub” 	development and spread of PCMHs, care teams that include a broad range of services and populations (including post-acute care, social services, physical, behavioral and oral health) <ul style="list-style-type: none"> Multiple shared resources such as community health workers, intensive care management/care transition assistants may be embedded in ACH or other shared “hub” May include formal relationships with multiple community organizations to identify care coordination barriers and strategies.
Data Analytic Capabilities	<ul style="list-style-type: none"> May have a student intern or volunteer 	<ul style="list-style-type: none"> May be able to purchase some data capacity or is obtained through the joint needs assessment Incorporate and engage data strengths from local public health 	<ul style="list-style-type: none"> Actively building data analytic capability across the region. Is sharing data across participating members, though may not be able to fully activate all tools provided by data partnership. 	<ul style="list-style-type: none"> Expanded level of data reporting to multiple community partners, Community GIS mapping and hot-spotting capabilities in place and actively used to target services and measure progress
Delivery and Community Integration Partnership	<ul style="list-style-type: none"> Informal relationships between health care providers and community providers or organizations – basic referrals 	<ul style="list-style-type: none"> Informal and some formal arrangements with community partners, may include data sharing, participation in common activities or interventions (e.g., coordination of care to reduce high utilizers, community care team focused 	<ul style="list-style-type: none"> Formally partners community organizations with providers/risk bearing entities. (e.g., inclusion of community mental health worker, public health nurse, community care coordinator as part of care team), inclusion of some 	<ul style="list-style-type: none"> Wide range of community organizations, providers and risk bearing entities have entered into formal relationships within a community to coordinate care, collaborate on clinical and population health improvement

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
		on specific chronic disease)	other informal partnerships (coordination/referrals with schools, housing, correctional, transportation, etc.)	activities, etc. (including schools, housing, early learning delivery sites, etc.)
Formalized Relationships with Risk Bearing Entities, Multipayer Participation	<ul style="list-style-type: none"> Risk bearing entities may participate on a voluntary basis. 	<ul style="list-style-type: none"> One or more risk bearing entities actively participate 	<ul style="list-style-type: none"> Most risk bearing entities participate, and contribute financial or in-kind resources 	<ul style="list-style-type: none"> All Medicaid risk bearing entities and one or more commercial risk bearing entities participate. Active cross financing of services, potentially some gain-sharing.
Procurement Partner	<ul style="list-style-type: none"> Informed by state regarding process, participants may be invited to participate/advise. 	<ul style="list-style-type: none"> Organization or members may be providing input to Medicaid procurement 	<ul style="list-style-type: none"> Organization eligible to more fully engage with State on Medicaid procurement process, including procurement development and design, selection and on-going oversight role in providing feedback around service gaps within the region 	<ul style="list-style-type: none"> Same as level 3
HIT/HIE	<ul style="list-style-type: none"> EHRs in place for majority of providers in regions, health information exchange may be limited 			<ul style="list-style-type: none"> EHRs in place for most providers in region, shared care planning and active care management is embraced and achieved through broad interoperability requirements among participants and a fully implemented health information exchange.
Desired Outcomes		<ul style="list-style-type: none"> Successful grant award Completed community health improvement plan 	<ul style="list-style-type: none"> Demonstrated policy change or health improvement because of group efforts. Have baselines 	<ul style="list-style-type: none"> Informed by 1519/5732 and Results Washington; Improved health by region/disparity as measured by <u>BRFSS</u>

Proposed Expectations	Accountable Community of Health Continuum			
	LEVEL 1 Introductory	LEVEL 2 Progressing	LEVEL 3 Intermediate	LEVEL 4 Advanced
			available regarding 1519/5732 measures for region	“Are you in good health” and “Number of days impacted by negative health”, Improvement of County Health Rankings.



■ Appendix F

Washington's Health Mapping Partnership

Washington State has significant capabilities when it comes to data and analytics related to state-provided health and social services

Washington's Accountable Communities of Health serve two linked objectives:

1. Improving health and outcomes, particularly for those with complex health needs, and
2. Supporting regional and local capacity to improve the community features that shape the health and well-being of Washington residents.

The strategies to achieve both of these objectives must be informed and guided by easily accessible and useable data, and success will flow in part from the ability to hone and target initiatives to make the best use of available resources. The Washington Health Mapping Partnership will couple a strengthened statewide database with mapping capabilities and tools that together can be used as a baseline and augmented by partners to measure the health of the population in the Accountable Communities of Health.

Washington State has significant capabilities when it comes to data and analytics related to state-provided health and social services. Washington proposes to leverage these capabilities by:

1. Partnering with world renowned experts at the University of Washington and local public health leaders to develop a new tool box of data, capabilities, and technical assistance in support of the Accountable Communities of Health and local communities, and
2. Continuing to deepen the state's underlying data pool and analytic capacity.

The Institute for Health Metrics and Evaluation (IHME) based at the University of Washington has agreed in principle to partner in this initiative. IHME has worked with the World Bank and other global and national policymakers to develop and deploy new data driven tools and techniques to measure population health status and disease burden, and enable targeted and successful interventions. It has pioneered methods in identifying the specialized needs of local communities by creating new ways of measuring health challenges in small areas. The IHME Geographic Information System (GIS) combines powerful data sources, methodologies, and mapping capabilities. GIS mapping provides new ways of "seeing" and improving health outcomes in targeted areas with poor health and social indicators.

Washington's strategy for transformation fuses these mapping capabilities with a further build-out of data resources to develop a statewide baseline and deepen the local toolbox for population health improvement. Deployed here at home, these resources will strengthen existing data analytics capabilities at the regional level, and provide local public health and community leaders with tailored support in achieving state and local health objectives, recognizing that underlying local analytical resources and capabilities vary across the state. In

some regions, an analytics role is well established within local health jurisdictions that already bring together currently available state data with other relevant data sets at the regional/local level, such as Homeless Management Information System (HMIS) data, jail health data, crisis system data, emergency medical services, housing, etc. In other regions, the Partnership offers not only enhanced mapping tools and augmented data, but can also provide consultation and technical assistance to help build and develop needed capacity and analytics.

A critical first step of the Health Mapping Partnership is an inventory of current data resources and usability features across state agencies, such as:

- Department of Health (DOH),
- Department of Social and Health Services (DSHS),
- The Health Care Authority (HCA),
- The Office of Financial Management (OFM),
- The Office of the Superintendent for Public Instruction (OSPI),
- Commerce,
- Labor and Industries (L&I),
- The Office of the Insurance Commissioner (OIC), and
- The Department of Early Learning (DEL).

The inventory includes potential and current sources of data relevant to health and social indicators.

This inventory is already taking place in some agencies on different data planes—some claims, clinical, population, and other. A more comprehensive inventory will enable the Health Partnership to provide community-responsive data and GIS mapping support that can be used in combination with additional data from the community and agencies.

Another important first step is establishing data sharing agreements across agencies and Accountable Communities of Health. As the data inventory is constructed and the data partnership develops, care will be taken to carefully protect privacy, delineate data disaggregation, and permitted uses.

The Health Mapping Partnership will be kept abreast of other data developments and convene discussions around when it might be appropriate to bridge additional data into the Partnership. Given the rich, population-focused data set, this approach to mapping health outcomes will be a primary mechanism for supporting and measuring the impact of Accountable Communities of Health.



■ Appendix G

Transformation Support Regional Extension Service

Discussion

Achieving the overarching aims of the Innovation Plan and its core innovations around bi-directional integration of physical and behavioral health, reduction of unwarranted overuse and misuse, prevention of chronic disease (particularly for high-risk individuals), and the development of Accountable Communities of Health, requires support beyond enhanced information exchange and payment. Success in transforming health and health care in Washington will depend on the robust delivery of primary care services that are integrated with public health, behavioral health services, community resources, and coordinated care across a supportive medical neighborhood. The creation of a Transformation Support Regional Extension Service in Washington will provide the supports required for practice transformation, increased and efficient workforce capacity, and community collaboration to achieve common goals. Furthermore, an Extension Service could contribute to the culture change necessary to inspire the will, leadership, and sense of urgency and community responsibility to drive transformative change in Washington.

There are many barriers to transforming Washington’s complex health care system, including the lack of an aligned statewide plan and priorities for change, the resulting initiative fatigue, and a sense of competition that manifests proprietary innovations that may run parallel or in conflict with one another. The creation of a state “hub” to support alignment and achieve the State’s goals in partnership with communities would not only provide a common statewide direction, but also may contribute to a culture of collaborative innovation and learning across communities and stakeholders.

Implementing and sustaining necessary changes to support team-based systems that ensure optimal health and health care for the whole person requires an infrastructure that provides on-the-ground support within a regional framework for the necessary redesign within primary care practice settings and between the practice settings and other partners in the community. Such an infrastructure is outlined in Section 5405 of the Affordable Care Act, although no federal funding was allocated. The “Primary Care Extension Program” aims to “provide support and assistance to primary care providers ... about health promotion, chronic disease management, mental and behavioral health services ... by working with ‘Health Extension Agents’... who facilitate and provide assistance to primary care practices by implementing quality improvement or system redesign, necessary to provide high-quality, cost-effective, efficient and safe primary care...”¹ The Washington state Extension Service will provide and/or facilitate support services, training opportunities, and other resources to local communities and primary care providers in those communities that are beyond their ability to offer on their own, but are essential to achieving better health, better care, and lower costs in their communities and the state overall.

As a statewide transformation “hub,” the Transformation Support Regional Extension Service will be well connected to the state and national pulse. It will serve as a convener and

¹ “Patient Protection and Affordable Care Act” (PL 111-148, 23 March 2010)

coordinator of the state’s many transformation efforts and a clearinghouse of tools and resources. At the community level, the “spokes,” or “Transformation Support Regional Extension Agents,” will provide supports required for practice transformation through facilitating and providing assistance for implementing quality improvement or system redesign necessary for high-quality, cost-effective, efficient, and safe person-centered care.

The initial priorities of the Extension Service will be as follows:

- Align, bolster, and distribute resources from the state’s multiple transformation support entities. These may include resources and information around shared decision making, physical-behavioral health integration, delivery of oral health preventive services in primary care settings, chronic illness care, or common statewide performance measures.
- Community-based practice support around health information exchange utilization and data-driven quality improvement.

As proof of concept is established and capacity increases, the Extension Service will expand its scope to address evolving state needs or priorities of individual communities (e.g., grant application training and capacity building; resources and support for community entities that wish to assume risk) as determined by community health needs assessments or otherwise.

1. Align and distribute resources from the state’s multiple transformation support entities. These may include resources and information around shared decision making, physical-behavioral health integration, delivery of oral health preventive services in primary care settings, or common statewide performance measures.

The Extension Service “hub” will engage with primary care organizations across the state via the Accountable Communities of Health (ACHs) as a neutral convener and trusted broker to conduct the outreach necessary to support continual practice improvements needed to achieve the transformation goals in Washington.

- Align efforts of current technical assistance providers, e.g., Qualis Health, Foundation for Health Care Quality, etc.;
- Connect ACHs to one another via virtual learning communities;
- Support development of a “culture of quality” across all primary care organizations and ACHs in Washington state; and
- Serve as a clearinghouse of tools and resources on the use of metrics to achieve better health, better care, and lower costs.

Some programs already exist across the state to provide a heterogeneous set of practice support services. One of the first steps will be to convene these organizations and service providers to develop a consolidated approach to providing these services.

2. Community-based practice support around health information exchange utilization and data-driven quality improvement.

The “spokes” — or “Transformation Support Regional Extension Agents” — of the Extension Service will live within ACHs and assist with the sharing of best practices across communities to meet the prioritized goals set forth by the state in consultation with regions. Initially, the Extension Service is expected to focus its practice support on shared care planning and data-driven quality improvement strategies in primary care.

In addition to initial efforts at the state level and in every community “spoke,” the Extension Service may use its Extension Agents within an ACH to test practice transformation in a more

challenging, but critical area of support, such as team-based clinical improvement and information sharing across physical and behavioral health. Lessons from this early model would be spread as more of the “spokes” take on these challenges.

It is of great importance to limit the initial scope of the Extension Service to health and health care issues of highest priority so as not to overwhelm its capacity and therefore limit its effectiveness. As proof of concept is established and capacity increases, the Extension Service may consider expanding its scope to address evolving needs of the state or priorities of individual communities (e.g., grant application training and capacity building; resources and support for community entities that wish to assume risk) as determined by community health needs assessments or otherwise. Potential priorities for the Extension Service are to:

- Provide technical assistance to implement quality improvement and process changes within primary care settings;
- Support internal quality improvement champions and work groups within each setting;
- Leverage resources from outside groups (e.g., meaningful use of health IT, use of enhanced telemedicine, home monitoring systems, training on incorporating shared decision making into practice workflow, etc.); and
- “Cross-pollinate” ideas and approaches across settings.

Structure and Governance

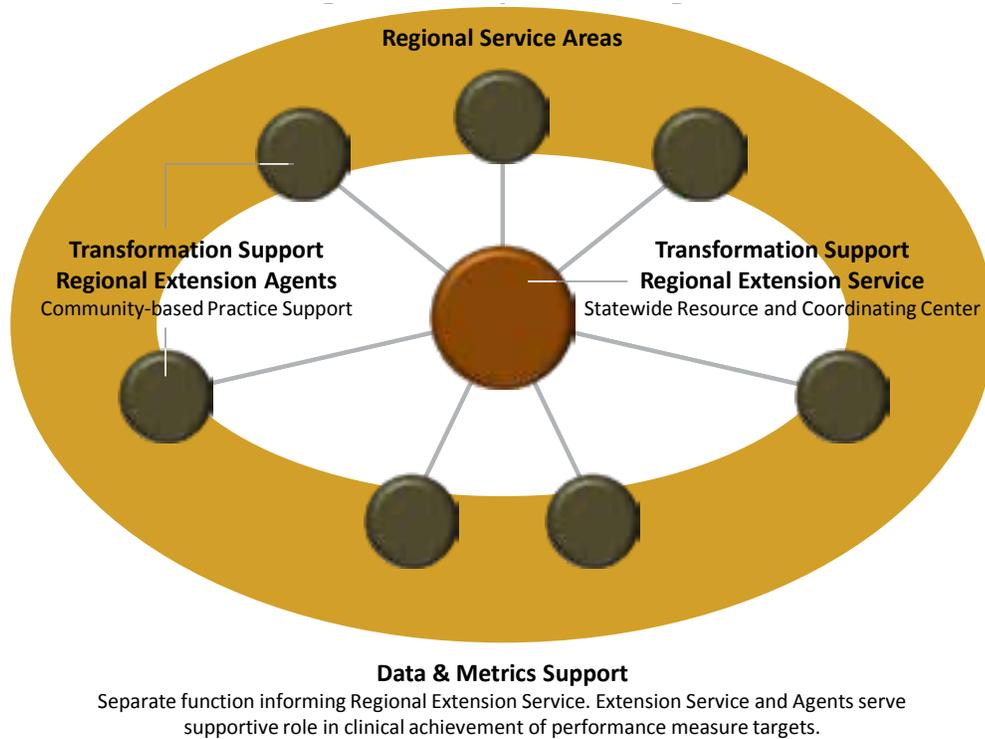
Key to the success of other similar health extension center models across the United States has been including stakeholders at the table during development and governance, including primary care providers, health plans, professional organizations and employers. To be effective, a health extension model must be viewed as a neutral convener and an honest broker. While a development process informed by stakeholder input will occur to form key structure and governance guidelines, best practices from other extension models indicate the following potential actions.

State “hub”—Transformation Support Regional Extension Service

- Creation of a Transformation Support Regional Extension Service at the state level with executive director and operations officer that must be seen as a neutral and trusted party.
- Creation of an Extension Service advisory board comprised of State agencies, health plans, primary care providers, public health, and ACHs, among others. There should be crossover of membership between advisory board and state health cabinet.
- The “hub” would serve as the operational arm and would contract out to experts (e.g., MacColl Center for Health Care Innovation, Qualis Health, University of Washington AIMS Center) for developing and launching this initiative. Create a stable of master contractors—who may currently provide practice support services, but would be coordinated and deployed under the Extension Service—in order to be nimble and ensure rapid transformation support.

Community “spokes”—Transformation Support Regional Extension Agents

- Embed Transformation Support Regional Extension Agents within ACHs. These agents may be representatives from the contracted experts.
- Develop a “training institute” for Extension Agents in order to ensure providers within the regional service areas and the ACHs are receiving aligned information and resources, and connecting with and learning from one another.



A note on performance measurement and the role of the Extension Service:

Primary care providers and organizations need a safe environment that is devoted to problem solving and improving quality of care for patients. It is important to separate the data aggregation and performance measurement and reporting functions outside the Regional Extension Service—potentially through an expanded function of the Alliance and/or state health cabinet concept—and allow the Regional Extension Service and its Extension Agents to serve a supportive role in achieving performance measure targets.

Sustainability

The Extension Service needs to be viewed as a valuable resource that will attract broad support from payers, purchasers, and providers. Washington will propose that the first three to five years of the Extension Service be funded through anticipated Center for Medicare and Medicaid Innovation (CMMI) funding and other grant/philanthropic sources to establish proof of concept, engage necessary stakeholders in a safe environment, and be seen as a valuable resource to payers, purchasers, and providers. Although initial development and start-up costs could be derived from CMMI funding, this support must ultimately come from funding sources within the state. This will lower the burden on primary care practices who must currently work with many different requirements across the major health plans in the state.

While sustainability will be discussed and determined through future program development processes, options for sustainability may include encouraging hospitals to meet a portion of their IRS community benefit requirements through contributions to their community Extension Service; or forming partnerships between State agencies who may already be offering some of these services and private partners, such as health plans, hospitals, local foundations, and provider groups.



■ Appendix H

Accountable Risk Bearing Entities— Medicaid Transformation Toward Whole-Person Care

Background - Regional Alignment

By 2016, the State will enter a new era of Medicaid purchasing with a greater level of accountability and expanded community involvement in serving aligned health and social support needs of the whole person. Under the new proposed structure, all Medicaid procurement will be reorganized into regional service areas that correspond with boundaries defined earlier in the description of Accountable Communities of Health. This approach will ensure that the *local* context is reflected in procurement design, assessment, and subsequent meaningful oversight.

At present, regional service areas are different for many state-funded health, human services, and other state government programs with an impact on determinants of health. As part of the Innovation Plan, regional service areas are being developed to ensure increased coherence and alignment of currently fragmented programs.

Within each regional service area, multiple accountable risk-bearing entities, or “ARBEs,” are expected to compete for physical and/or behavioral health system contracts. Competing organizations may include health maintenance organizations, managed care organizations, behavioral health organizations, accountable care organizations, risk bearing public/private entities, county governmental organizations, or other community-based organizations with a risk-bearing partner or direct capacity to assume full financial risk (for physical and/or behavioral health.)

Medicaid Procurement Principles

Incorporating guidance from our community partners, core principles have been defined for establishing parameters for the Medicaid procurement of physical and behavioral health services under the new ARBE framework.

- Access to effective behavioral health services for adults and children is an essential state responsibility.
- People with behavioral health concerns often do not receive comparable access to, and quality of, physical health care, resulting in increased rates of morbidity and mortality. Any new approach must address this core disparity for individuals with either common or complex behavioral health challenges.
- Medicaid purchasing must support delivery of better integrated, person-centered care that addresses the full spectrum of individuals’ health needs in the context of the communities in which they live and with assurance of care continuity as their health needs change.
- Behavioral health needs and interventions are inextricably linked to other local systems, such as law enforcement and other first responders, courts, and jails. These community

connections will be amplified through new levels of accountability supported by community governance and oversight.

- Benefit design must be comprehensive with adequate preventive care, crisis intervention and support services that ensure a prevention and recovery-focused approach.
- Evidence-based care interventions and continuous quality improvement will be enforced through contract specifications and performance measures that ensure meaningful integration at the patient care level with broadly distributed accountability for results.
- Active purchasing and oversight of Medicaid managed care contracts (and, to some degree, remaining fee-for-service arrangements) are shared state and community responsibilities, without which individuals with behavioral health needs will suffer.
- A deliberate and flexible system change plan with identified benchmarks and periodic readiness reviews will promote system stability, ensure continuity of treatment for patients, and protect essential behavioral health system infrastructure and capacity.
- Community and organizational readiness will be key determinants of implementation timing; a phased approach will, therefore, be desirable.

ARBE – New Payment and Delivery System Models

Through the procurement process, new Medicaid delivery system models are anticipated, in which:

- ARBEs demonstrate their ability to hold risk, maintain necessary reserves, and fulfill the same consumer protection expectations of existing Medicaid contractors, including network adequacy requirements.¹
- ARBEs use innovative reimbursement methods that incentivize integration of physical and behavioral health care at the delivery system level, with near universal adoption of such reimbursement methods by 2017. ARBEs also commit to effectively partner with local providers to continue, adopt, and expand transformative care models through mutually agreed value-based payment methods such as sub-capitation for a defined set of services.²
- Competition among multiple ARBEs in each regional service area creates the potential for specialized ARBEs with expertise to target services to people with common and/or complex behavioral health challenges and physical comorbidities. Such arrangements may also support existing bi-directional service integration models through opportunities to expand their service area footprint over time.
- ARBEs demonstrate a plan and commitment to achieving better health, lower cost, and improved outcomes in their regional service area, with intent to share savings among community partners.
- ARBE risk-adjusted compensation will be tied to specific, publicly reported outcomes on a common set of metrics, fully incorporating the measures developed in response to HB 1519/SB 5732.³ Consistent with these outcome measures, Washington is considering Medicaid

¹Network adequacy standards will be reviewed to incorporate qualitative elements, including capacity to provide coordinated/integrated care to people with physical and behavioral co-morbidities.

²The streamlining of funding through a sub-capitation arrangement for mental health that also incurs full risk for patients is considered a key reason for the success of models such as the Kitsap Mental Health bidirectional model of integrated care.

³The outcomes include: improvements in client health status; increases in client participation in meaningful activities; reductions in client involvement with the criminal justice system; reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons; increases in stable housing; improvements in client satisfaction with quality of

financing options that encourage investment in Accountable Communities of Health to drive mutually agreed regional health improvement priorities and reduce overall health care costs.

ARBE - Contractual Linkages to Accountable Communities of Health

To accomplish the goals of procurement and make progress toward integration of physical and behavioral health care delivery systems while also considering regional self-determination in health improvement, ARBE contracts are likely to include specific requirements for working with regional ACHs. These include:

- Binding priority setting with regional stakeholders as a result of shared governance in the regional ACH.
- Expectations for sharing of core community assets/resources to drive greater seamlessness and efficiencies. Examples of core community assets include intensive care management services and shared care planning support.
- Performance expectations and incentives for: cost savings and reinvestment, bi-directional integration of physical and behavioral health services, system improvements, and regional improvements in health and social support coordination.

Policy Questions

Considering the extensive input from stakeholders throughout the Innovation Plan development, further key policy and operational questions will need to be addressed with key partners (state and local government, health care delivery, community-based organizations, consumers) during planning for the two Medicaid procurement pathways:

1. Fully integrated physical and behavioral health delivery systems in “early innovator” regions and
2. Separate physical and behavioral health delivery systems in remaining regions.

Questions cover risk-bearing parameters, scope of service alignment, seamless coordination – for people with common or complex co-morbidities, continuity of care assurance, regional variation, regulatory/financing flexibility, enrollee assignment, and procurement expectations. In some cases they reflect consideration of essential linkages between ARBEs and ACHs to ensure that opportunities for regional priorities are elevated.

■ ***Exactly what risk is borne (or not) by which entities—fully integrated ARBEs, separate physical- and behavioral health-focused ARBEs, Accountable Communities of Health?***

- What are the required/demonstrated elements that confirm an ARBE’s readiness to take on integrated service risk—for common and complex physical and behavioral health issues?
- How can the state best work with counties in the ACHs to ensure that current effective health care and community support services are preserved and not unnecessarily disrupted under different models?
- What do pharmaceutical formularies cover in different ARBEs; specifically, mental health and substance abuse drugs?

- ***If a community was willing to collaborate toward the design of a single, fully integrated ARBE with the intent of serving a full regional service area, would the state consider contracting with a sole entity and what are the implications of such an approach?***
 - Could individual counties or groups of counties within a region elect to be “early innovators?”
 - What unique considerations apply in regions transitioning toward a fully integrated delivery model, when contracts with separate physical and behavioral health ARBEs have already been put in place?
- ***Regardless of the purchasing model, (i.e., fully integrated or separate physical and behavioral health ARBEs) how can seamless service delivery be assured?***
 - How are substance abuse services accessed by individuals with common vs. complex health co-morbidities?
 - Which mental health services are included in each model?
 - Where does accountability for crisis and institutional services fall?
 - Can data be shared to support common care plans, and how?
 - How can accountability for the “whole person” be achieved under multiple purchasing models?
 - How are current access-to-care standards for mental health services impacted?
- ***How do separate physical health and behavioral health ARBEs coordinate to address the needs of people with multiple cross-cutting co-morbidities—i.e., complex enrollees?***
 - How does the current approach to health home services change or support the new model?
 - Which ARBE is responsible for coordination of services?
 - Will either or both be financially accountable for coordination of services?
- ***Are “like” ARBEs responsible for exactly the same functions and outcomes, or can they differ by region as regional ACHs evolve?***
 - In an “early innovator” region, must an ARBE cover the entire service area or could it demonstrate full integration of services in a subset of counties in the region? If so, under what circumstances?
 - How should the functionality of an ACH be assessed and should it be a factor in determining readiness for fully integrated models in the “early innovator” regions? (*Potential* levels of ACH development are described in Appendix C.)
 - What process will regions and counties use to formally declare their interest in pursuing “early innovator” status for purposes of a fully integrated Medicaid procurement?
- ***How can practice innovation towards bi-directional care integration at the individual clinical level still be supported where an entire region is not yet ready to be an “early innovator” on a broader scale?***
 - Is there opportunity for “alternative” regions defined to support practice driven innovation with opportunity to scale-up as success becomes evident?
 - How can ARBEs accommodate the sustainability and spread of current integrated care delivery models (i.e., those models described in Section 4 that target bi-directional physical and behavioral health care resources for a defined population)?
- ***How do Medicaid clients choose, or get “assigned” to different ARBE models?***

■ ***How could additional federal flexibility in Medicaid financing be used to support integrated health care and essential community supports, for example:***

- Critical/priority non-health services such as supported housing and employment and ACH-related financing.
- Flexible financing options with risk-sharing and/or gain-sharing elements across health care settings and social support services.
- Application of new value-based payment methodologies in federally-designated clinic settings.
- Potential targeted population demonstrations at a regional level.
- Global budgeting.

■ ***How will the different ARBE model pathways be evaluated (and aligned with incentives) in terms of common elements for:***

- Integration and coordination of physical, behavioral, and social service needs.
- Administrative streamlining and operational sustainability.
- Quality metrics.
- Patient outcomes.
- Costs.
- Support for scalability and spread of bi-directional delivery models.



■ **Appendix I**

Governor Request Legislation

State of Washington

House Bill 2572

HOUSE BILL 2572

State of Washington

63rd Legislature

2014 Regular Session

By Representative Cody; by request of Governor Inslee

Read first time 01/21/14. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to improving the effectiveness of health care
2 purchasing and transforming the health care delivery system by
3 advancing value-based purchasing, promoting community health, and
4 providing greater integration of chronic illness care and needed social
5 supports; amending RCW 41.05.650, 41.05.660, and 43.70.533; adding new
6 sections to chapter 41.05 RCW; adding new sections to chapter 43.41
7 RCW; adding a new section to chapter 48.43 RCW; adding a new section to
8 chapter 74.09 RCW; and creating a new section.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

10 NEW SECTION. **Sec. 1.** The legislature declares that collaboration
11 among state purchased health care programs, private health carriers,
12 third-party purchasers, and health care providers to identify
13 appropriate strategies that will increase the quality and effectiveness
14 of health care delivered in Washington state is in the best interest of
15 the public. The legislature therefore exempts from state antitrust
16 laws, and intends to provide immunity from federal antitrust laws
17 through the state action doctrine, those activities convened and
18 supervised by the director of the health care authority or the
19 director's designee pursuant to this act or by the director of the

1 office of financial management pursuant to sections 8 and 9 of this act
2 that might otherwise be constrained by such laws. The legislature does
3 not intend and does not authorize any person or entity to engage in
4 activities or to conspire to engage in activities that would constitute
5 per se violations of state and federal antitrust laws including, but
6 not limited to, agreements among competing health care providers or
7 health carriers as to the price or specific level of reimbursement for
8 health care services.

9 NEW SECTION. **Sec. 2.** (1) The state of Washington has an
10 unprecedented opportunity to implement a five-year state health care
11 innovation plan developed through the center for medicare and medicaid
12 innovation state innovation model program. The innovation plan
13 describes Washington state's strategy to transform its health care
14 delivery system through multipayer payment reform and other state-led
15 initiatives, including exploration of health innovation funding
16 options.

17 (2) The state health care innovation plan establishes the following
18 primary drivers of health transformation, each with individual key
19 actions that are necessary to achieve the objective:

20 (a) Improve health overall by building healthy communities and
21 people through prevention and early mitigation of disease throughout
22 the lifespan;

23 (b) Improve chronic illness care through better integration and
24 strengthening of linkages between the health care delivery system and
25 community, particularly for individuals with physical and behavioral
26 comorbidities; and

27 (c) Through strategic leadership and collaborative partnership,
28 Washington will advance value-based purchasing across the community,
29 and lead by example in transforming how it purchases health care
30 services.

31 (3) Implementation of the plan must address barriers in Washington
32 which impede the progress of health care delivery system
33 transformation, including:

34 (a) Costly and inefficient systems resulting in fragmentation,
35 inefficient delivery and payment models, and silos within the public
36 and private sectors;

1 (b) A health care market influenced by diverse, misaligned payment
2 methods, priorities, and performance measures;

3 (c) A lack of comparable information regarding the price and
4 quality of health care;

5 (d) Significant gaps in coordination between primary care and
6 specialty practices; ambulatory, hospital settings, long-term services
7 and supports; and primary care and behavioral health;

8 (e) Health care delivery and data systems that have not
9 consistently addressed the impacts of the social determinants of health
10 or embraced population health strategies such as nutrition, early
11 childhood interventions, education, and housing.

12 NEW SECTION. **Sec. 3.** (1) The authority is responsible for
13 coordinating, planning, implementation, and administration of
14 interagency efforts and local collaborations of public and private
15 organizations to implement the state health care innovation plan.

16 (2) By January 1, 2015, and January 1st of each year through
17 January 1, 2019, the authority shall coordinate and issue a report to
18 the legislature summarizing the status of the progress made and actions
19 taken towards implementing the innovation plan, including the reporting
20 provisions in sections 11 and 12 of this act and agency recommendations
21 for legislation necessary to implement the innovation plan.

22 (3) The authority may adopt policies, procedures, standards, and
23 rules, as necessary to implement and enforce sections 2 through 4, 10,
24 12, and 13 of this act and RCW 41.05.650 and 41.05.660.

25 NEW SECTION. **Sec. 4.** (1) The authority shall develop
26 certification criteria for the establishment of accountable
27 collaboratives for health, in close collaboration with state and local
28 partners. The authority shall certify each accountable collaborative
29 for health, as a regional organization responsible for aligning
30 community actions and initiatives within the region for the purpose of
31 achieving healthy communities and populations, improving health care
32 quality, and lowering costs. Each accountable collaborative for health
33 shall align their mutual activities to achieve local public health
34 services improvement and assessment goals consistent with RCW 43.70.520
35 and health improvement innovations consistent with the state health

1 care innovation plan. The authority shall provide for a phased
2 implementation approach to address variations in regional, community,
3 and local organizational readiness.

4 (2) By September 1, 2014, after consultation with counties and
5 other interested entities, no more than nine regional boundaries for
6 accountable collaboratives for health must be established, consistent
7 with medicaid procurement established by the authority and the
8 department of social and health services under chapters 71.24, 70.96A,
9 and 74.09 RCW. The boundaries for each region must be contiguous and
10 distinct based on county borders, with population sufficient to support
11 risk-based contracting for medicaid services.

12 (3) Entities seeking certification may be nonprofit or
13 quasi-governmental in orientation and must incorporate membership from
14 across the health care delivery system, public health, social supports
15 and services, and consumers with no single entity or organizational
16 cohort serving in majority capacity.

17 (4) To qualify as an accountable collaborative for health, an
18 organization must demonstrate ongoing capacity to:

19 (a) Convene key stakeholders to link, align, and achieve regional
20 and state health care innovation plan goals;

21 (b) Lead health improvement activities within the region with other
22 local systems, including primary care and specialty practices;
23 ambulatory, hospital, long-term services and supports; behavioral
24 health; and social service and public health agencies, to improve
25 health outcomes and the overall health of the community, improve health
26 care quality, and lower costs;

27 (c) Develop a partnership with the state and local jurisdictions to
28 provide shared leadership and involvement in developing medicaid
29 procurement criteria and conducting performance evaluation related to
30 the health care services provided within the region;

31 (d) Act as a regional host for the health regional extension
32 program under RCW 43.70.533;

33 (e) Act in alignment with statewide health care initiatives,
34 including the statewide all payer health care claims database under
35 sections 8 and 9 of this act and the statewide health performance and
36 quality measures under section 10 of this act;

37 (f) Incorporate the following collective impact principles to
38 successfully act as a catalyst for change:

1 (i) All accountable collaborative for health participants have a
2 shared vision for change including a common understanding and joint
3 approach to solving problems through agreed upon actions;

4 (ii) Data collection and results measurements are consistent across
5 the community and participants to ensure efforts remain aligned and
6 participants hold each other accountable;

7 (iii) Participant activities are coordinated with the activities of
8 others through a plan of action;

9 (iv) Maintain consistent and open communication across participants
10 to build trust, assure mutual objectives, and create common motivation;

11 (v) Create, manage, and coordinate the collective work of multiple
12 organizations each with staff and a specific set of skills to provide
13 the resources to implement initiatives and coordinate participating
14 organizations and agencies.

15 **Sec. 5.** RCW 41.05.650 and 2009 c 299 s 1 are each amended to read
16 as follows:

17 (1) The community health care collaborative grant program is
18 established to (~~to further the efforts~~) support the design, development,
19 and sustainability of community-based (~~coalitions to increase access~~
20 ~~to appropriate, affordable health care for Washington residents,~~
21 ~~particularly employed low income persons and children in school who are~~
22 ~~uninsured and underinsured, through local programs addressing one or~~
23 ~~more of the following: (a) Access to medical treatment; (b) the~~
24 ~~efficient use of health care resources; and (c) quality of care))
25 accountable collaboratives for health.~~

26 (2) (~~Consistent with funds appropriated for community health care~~
27 ~~collaborative grants specifically for this purpose, two-year)) Subject
28 to available funds:~~

29 (a) Community health care collaborative grants may be awarded
30 pursuant to RCW 41.05.660 by the (~~administrator~~) director of the
31 health care authority.

32 (~~(3)~~) (b) The health care authority shall provide administrative
33 support and technical assistance for the program. (~~Administrative~~
34 ~~support activities~~) This may include health care authority
35 facilitation of statewide discussions regarding best practices and
36 standardized performance measures among grantees, or subcontracting for
37 such discussions.

1 ~~((4))~~ (3) Eligibility for community health care collaborative
2 grants related to the design and development of an accountable
3 collaborative for health shall be limited to nonprofit or quasi-
4 governmental organizations ~~((established to serve a defined geographic~~
5 ~~region or organizations with public agency status under the~~
6 ~~jurisdiction of a local, county, or tribal government. To be eligible,~~
7 ~~such entities must have a formal collaborative governance structure and~~
8 ~~decision making process that includes representation by the following~~
9 ~~health care providers: Hospitals, public health, behavioral health,~~
10 ~~community health centers, rural health clinics, and private~~
11 ~~practitioners that serve low income persons in the region, unless there~~
12 ~~are no such providers within the region, or providers decline or refuse~~
13 ~~to participate or place unreasonable conditions on their~~
14 ~~participation)).~~ The ~~((nature and))~~ format of the application, and the
15 application procedure, shall be determined by the ~~((administrator))~~
16 director of the health care authority. At a minimum, each application
17 shall: (a) Identify the geographic region served by the organization;
18 (b) show how the structure and operation of the organization reflects
19 the interests of, and is accountable to, this region and ~~((members~~
20 ~~providing care within this region))~~ the state; (c) indicate the size of
21 the grant being requested, and how the money will be spent; ~~((and))~~ (d)
22 include sufficient information for an evaluation of the application
23 based on the criteria established ~~((in))~~ under RCW 41.05.660; and (e)
24 identify any other needs or expectations the organization has of the
25 state in order to be successful.

26 **Sec. 6.** RCW 41.05.660 and 2009 c 299 s 2 are each amended to read
27 as follows:

28 (1) ~~((The))~~ No more than one community health care collaborative
29 grant~~((s))~~ shall be awarded ~~((on a competitive basis based on a~~
30 ~~determination of which applicant organization will best serve the~~
31 ~~purposes of the grant program established in RCW 41.05.650. In making~~
32 ~~this determination, priority for funding shall be given to the~~
33 ~~applicants that demonstrate:~~

34 ~~(a) The initiatives to be supported by the community health care~~
35 ~~collaborative grant are likely to address, in a measurable fashion,~~
36 ~~documented health care access and quality improvement goals aligned~~

1 ~~with state health policy priorities and needs within the region to be~~
2 ~~served;~~

3 ~~(b) The applicant organization must document))~~ at a time within
4 each region established under section 4 of this act. In deciding
5 whether and to which organization to award a grant, the health care
6 authority shall consider, but is not limited to, the following factors:

7 (a) Whether and to what extent the organization will be able to
8 further the purposes of sections 2 through 13 of this act, help achieve
9 for all Washington residents better health, better care, and lower
10 costs, and serve as a sustainable foundation for an accountable
11 collaborative for health under section 4 of this act;

12 (b) Whether and to what extent the decisions of the organization
13 will be based on public input and the formal, active collaboration
14 among key community partners ((that includes)) including but not
15 limited to, local governments, school districts, early learning
16 regional coalitions, large and small businesses, labor organizations,
17 nonprofit health and human service organizations, tribal governments,
18 carriers, ((private)) health care providers, and public health
19 agencies ((, and community public health and safety networks, as defined
20 in RCW 70.190.010));

21 (c) Whether and to what extent the applicant organization will
22 match the community health care collaborative grant with funds from
23 other sources.

24 (2) The health care authority may ((award grants solely to))
25 prioritize grant awards for those organizations providing at least
26 ((two dollars)) one dollar in matching funds for each community health
27 care collaborative grant dollar awarded((+)

28 ~~(d) The community health care collaborative grant will enhance the~~
29 ~~long term capacity of the applicant organization and its members to~~
30 ~~serve the region's documented health care access needs, including the~~
31 ~~sustainability of the programs to be supported by the community health~~
32 ~~care collaborative grant;~~

33 ~~(e) The initiatives to be supported by the community health care~~
34 ~~collaborative grant reflect creative, innovative approaches which~~
35 ~~complement and enhance existing efforts to address the needs of the~~
36 ~~uninsured and underinsured and, if successful, could be replicated in~~
37 ~~other areas of the state; and~~

1 ~~(f) The programs to be supported by the community health care~~
2 ~~collaborative grant make efficient and cost-effective use of available~~
3 ~~funds through administrative simplification and improvements in the~~
4 ~~structure and operation of the health care delivery system.~~

5 ~~(2) The administrator of the health care authority shall endeavor~~
6 ~~to disburse community health care collaborative grant funds throughout~~
7 ~~the state, supporting collaborative initiatives of differing sizes and~~
8 ~~scales, serving at risk populations).~~

9 (3) Grants shall be disbursed ~~((over a two-year cycle, provided the~~
10 ~~grant recipient consistently provides timely reports that demonstrate~~
11 ~~the program)) in a way that assures the organization or agency is~~
12 ~~satisfactorily meeting the purposes of the grant and the objectives~~
13 ~~identified in ((the organization's)) its application. ((The~~
14 ~~requirements for the performance reports shall be determined by the~~
15 ~~health care authority administrator.)) Before any grant funds are~~
16 ~~disbursed to an organization or agency, the health care authority and~~
17 ~~the organization shall agree on performance requirements and the~~
18 ~~consequence if the organization meets or fails to meet those~~
19 ~~requirements. The performance ((measures)) requirements shall be~~
20 ~~aligned with the ((community health care collaborative grant program~~
21 ~~goals and, where possible, shall be consistent with statewide policy~~
22 ~~trends and outcome measures required by other public and private grant~~
23 ~~funders)) purposes of sections 2 through 13 of this act.~~

24 **Sec. 7.** RCW 43.70.533 and 2011 c 316 s 3 are each amended to read
25 as follows:

26 (1) ~~((The department shall conduct a program of training and~~
27 ~~technical assistance regarding care of people with chronic conditions~~
28 ~~for providers of primary care. The program shall emphasize evidence-~~
29 ~~based high quality preventive and chronic disease care and shall~~
30 ~~collaborate with the health care authority to promote the adoption of~~
31 ~~primary care health homes established under chapter 316, Laws of 2011.~~
32 ~~The department may designate one or more chronic conditions to be the~~
33 ~~subject of the program.~~

34 ~~(2) The training and technical assistance program shall include the~~
35 ~~following elements:~~

36 ~~(a)) Subject to available funds, the department shall establish a~~
37 ~~health regional extension program. The department shall establish a~~

1 program hub with agencies that conduct state purchased health care and
2 other appropriate entities. The program must provide training and
3 technical assistance to primary care, behavioral health, and other
4 providers. The program must emphasize comprehensive, evidence-based,
5 high-quality preventive, chronic disease and behavioral health care.

6 (2) The health regional extension program hub shall coordinate
7 training, technical assistance, and distribution of tools and resources
8 through local regional extensions that promote the following elements:

9 (a) Physical and behavioral health integration;

10 (b) Clinical information systems ((and)) with sharing and
11 organization of patient data;

12 ~~((b))~~ (c) Clinical decision support to promote evidence-based
13 care;

14 ~~((c) Clinical delivery system design;))~~

15 (d) Support for patients managing their own conditions; ((and))

16 (e) Identification and use of community resources that are
17 available in the community for patients and their families, including
18 community health workers; and

19 (f) Practice transformation including, but not limited to,
20 team-based care, shared decision making, use of population level health
21 data and management, and quality improvement linked to common statewide
22 performance measures.

23 ~~(3) ((In selecting primary care providers to participate in the~~
24 ~~program, the department shall consider the number and type of patients~~
25 ~~with chronic conditions the provider serves, and the provider's~~
26 ~~participation in the medicaid program, the basic health plan, and~~
27 ~~health plans offered through the public employees' benefits board.~~

28 ~~(4))~~ For the purposes of this section, "health home" and "primary
29 care provider" have the same meaning as in RCW 74.09.010.

30 (4) The department will continue to collaborate with the health
31 care authority to promote the adoption of primary care health homes
32 established under chapter 316, Laws of 2011.

33 NEW SECTION. Sec. 8. A new section is added to chapter 43.41 RCW
34 to read as follows:

35 (1) The office of financial management shall establish a statewide
36 all payer health care claims database as provided in this section and

1 section 9 of this act. The statewide all payer health care claims
2 database must support transparent public reporting of health care
3 information to facilitate:

4 (a) A comprehensive view of the variation in the cost and quality
5 of health care services;

6 (b) Advanced web-enabled analytic capabilities to provide health
7 quality and cost transparency and access for consumers, health care
8 providers and purchasers, insurers, and researchers;

9 (c) Integrated cost, quality, and outcome information available for
10 public purposes to improve health, cost, and efficiency.

11 (2) The statewide database shall comply with all federal and state
12 privacy requirements. The office shall ensure that data received from
13 reporting entities is securely collected, compiled, and stored in
14 compliance with state and federal law. Federally protected
15 confidential patient-protected data or data protected by the health
16 information portability and accountability act provided by an entity to
17 the statewide database is confidential and exempt from public
18 inspection and copying under chapter 42.56 RCW. The statewide
19 database, including the data compilation and the unified data
20 management platform database is exempt from public disclosure,
21 inspection, copying, and review as a public record.

22 (3) Paid claims data related to health care coverage and services
23 funded, in whole or in part, by state or federal moneys appropriated in
24 the state omnibus budget or nonappropriated funds otherwise used for
25 this purpose must be included in the statewide database pursuant to the
26 data terms and rules adopted by the office and provide documentation of
27 compliance to the office.

28 (4) Local government and private employers are encouraged to
29 actively support the inclusion of their employee claims data in the
30 statewide all payer health care claims database. Claims data related
31 to health care coverage and services funded through self-insured
32 employers or trusts are exempt from participating. However, to the
33 extent they wish to participate, their third-party administrators must
34 provide claims data pursuant to this section and section 11 of this
35 act.

36 (5) The statewide database must be available as a resource for
37 public agencies and private entities, including insurers, employers,

1 providers, and purchasers of health care, to continuously review health
2 utilization, expenditures, and performance.

3 (6) The office may adopt policies, procedures, standards,
4 timelines, and rules, as necessary to implement and enforce this
5 section and section 9 of this act including, but not limited to,
6 definition of claims data submission and data files for all covered
7 medical services; pharmacy claims and dental claims; member eligibility
8 and enrollment data; and provider data with necessary identifiers. To
9 the extent fees are levied, the fees must be comparable across data
10 requesters and users.

11 NEW SECTION. **Sec. 9.** A new section is added to chapter 43.41 RCW
12 to read as follows:

13 (1) The director shall select a lead organization and enter into an
14 agreement with the selected organization to coordinate and manage the
15 statewide all payer health care claims database. The organization is
16 responsible for the collection of claims data from public and private
17 payers for reporting performance on cost and quality using the
18 statewide health performance and quality measures developed under
19 section 10 of this act. Efforts must be designed to provide
20 transparency that:

21 (a) Assists patients and providers to make informed choices about
22 care;

23 (b) Enables providers and communities to improve by benchmarking
24 their performance against that of others and by focusing on best
25 practices;

26 (c) Enables purchasers to identify value, build expectations into
27 their purchasing strategy and reward improvements over time;

28 (d) Promotes competition based on quality and cost.

29 (2) The director may appoint an interagency steering committee to
30 provide oversight, direction, and assistance to the lead organization
31 of the statewide database. The committee may advise the lead
32 organization on the composition of the lead organization's advisory
33 committees for the statewide database under subsection (3)(b) of this
34 section.

35 (3) The lead organization of the statewide database shall:

36 (a) Be responsible for internal governance, management, funding,
37 and operations of a statewide all payer health care claims database in

1 a manner that improves transparency, and the quality, value, and
2 efficiency of health care in Washington state; provides data to
3 stakeholders for measurement and analysis of the status and progress on
4 performance goals and objectives; and supports continuous improvement
5 and elimination of unwarranted variation. Data collection mechanisms
6 must be chosen with consideration for the time and cost involved in
7 collection and the benefits to be achieved from measurement;

8 (b) Appoint advisory committees including, but not limited to: A
9 data policy development committee on the statewide database that
10 maximizes the commitment and participation of key provider, payer,
11 health maintenance organization, purchaser, and consumer organizations;
12 and a data release review committee to establish a data release process
13 consistent with state and federal privacy requirements, including the
14 health insurance portability and accountability act privacy
15 requirements and to provide advice and counsel regarding formal data
16 release requests. The lead organization shall end the data policy
17 development committees when it deems appropriate with the approval of
18 the director;

19 (c) Ensure protection of collected data. All data with
20 patient-specific information will be stored and used in a manner that
21 protects patient privacy. Data and reports derived from requested data
22 may be used in conjunction with other data sets to achieve the purposes
23 of sections 2 through 13 of this act, consistent with state and federal
24 law, including the health insurance portability and accountability act
25 privacy rules;

26 (d) Develop a plan for the financial sustainability of the
27 statewide database and charge reasonable fees for reports and data
28 files, as needed to fund the statewide database.

29 NEW SECTION. **Sec. 10.** The authority shall develop standard
30 statewide measures of health performance and select a lead organization
31 to complete the following tasks:

32 (1) By January 1, 2015, develop an initial statewide health
33 performance and quality measures set that includes dimensions of
34 prevention, effective management of chronic disease, and use of the
35 lowest-cost, highest-quality care for acute conditions. The measure
36 set must:

37 (a) Be of manageable size;

1 (b) Give preference to nationally endorsed measures;
2 (c) Be based on readily available claims and clinical data;
3 (d) Focus on the overall performance of the system, including
4 outcomes and total cost;

5 (e) Be aligned with the governor's performance management system
6 measures and common measure requirements specific to medicaid delivery
7 systems under RCW 70.320.020 and 43.20A.895;

8 (f) Be used by the state health benefit exchange and state
9 purchased health care;

10 (g) Consider the needs of different stakeholders and the
11 populations served;

12 (h) Be usable by multiple payers, providers, and purchasers, as
13 well as communities where applicable, as part of health improvement,
14 care improvement, provider payment systems, benefit design, and
15 administrative simplification for providers.

16 (2) The lead organization shall establish a process to periodically
17 evaluate the measures set and make additions or changes to the measures
18 set as needed.

19 (3) The lead organization must use the statewide health performance
20 and quality measure set and statewide all payer health care claims
21 database to provide health care data reports with transparent access to
22 reliable and comparable information about variation in quality and
23 price. Wherever possible, measures will be stratified by demography,
24 income, language, health status, and geography to identify both
25 disparities in care and successful efforts to reduce disparities.
26 Analyses must be conducted and shared to:

27 (a) Identify and recognize providers and health systems delivering
28 efficient, high-quality care, and enable purchasers and consumers to
29 direct business to these systems;

30 (b) Identify unnecessary variation in care and other opportunities
31 to improve quality of care and reduce cost.

32 NEW SECTION. **Sec. 11.** A new section is added to chapter 48.43 RCW
33 to read as follows:

34 (1) Health insurance issuers shall submit claims data to the
35 statewide all payer health care claims database, in compliance with the
36 timeline and criteria established under sections 8 and 9 of this act.

1 (2) Health insurance issuers shall annually submit a status report
2 to the commissioner regarding compliance with the provisions of
3 subsection (1) of this section. The commissioner shall provide a
4 summary of this information to the health care authority for inclusion
5 in the interagency report to the legislature under section 3 of this
6 act.

7 (3) The commissioner may adopt rules necessary to implement and
8 enforce this section and may impose penalties pursuant to RCW 48.05.185
9 for noncompliance with this section.

10 NEW SECTION. **Sec. 12.** (1) State purchased health care, in
11 coordination with other private and public purchasers, shall develop
12 common and aligned procurement methodologies, best practices to assure
13 implementation of contractual provisions, common payer and delivery
14 system organization expectations, and aligned utilization of the
15 statewide measure set under section 10 of this act.

16 (2) State purchased health care initiatives and purchasing
17 strategies must be consistent with the provisions of sections 2 through
18 13 of this act.

19 (3) State purchased health care must submit paid claims data to the
20 statewide all payer health care claims database, in compliance with the
21 timeline, criteria, and rules established under sections 8 and 9 of
22 this act. State purchased health care contracts for the purchase or
23 administration of health care services must require compliance with the
24 reporting requirements in this subsection. The authority shall request
25 state purchased health care agencies to provide a status report
26 regarding compliance with the provisions of this subsection. The
27 authority shall include a summary of the information, in the annual
28 report to the legislature under section 3 of this act.

29 NEW SECTION. **Sec. 13.** A new section is added to chapter 74.09 RCW
30 to read as follows:

31 (1) Consistent with the implementation of the state health care
32 innovation plan as provided in sections 2 through 13 of this act and
33 the provisions of RCW 70.320.020, the health care authority and the
34 department of social and health services shall restructure medicaid
35 procurement of health care services and agreements with managed care
36 systems on a phased basis to better support integrated physical health,

1 mental health, and substance use treatment. The authority and
2 department shall develop and utilize innovative mechanisms to spread
3 and sustain integrated clinical models of physical and behavioral
4 health care including: Practice transformation support and resources;
5 workforce capacity and flexibility; shared clinical information
6 sharing, tools, resources, and training; and outcome-based payments to
7 providers.

8 (2) The authority and department shall facilitate and utilize the
9 accountable collaboratives for health and primary health regional
10 extension services infrastructure established in sections 4 and 7 of
11 this act and RCW 43.70.533 to support integration of services and
12 transformation to a provider payment system based on cost, quality, and
13 effectiveness. This must include the agencies engaging in a
14 partnership with established accountable collaboratives for health to
15 provide shared leadership and involvement in developing medicaid
16 procurement criteria and local oversight of performance.

17 (3) The authority and department shall incorporate the following
18 principles into future medicaid procurement efforts aimed at
19 integrating the delivery of physical and behavioral health services:

20 (a) Equitable access to effective behavioral health services for
21 adults and children is an essential state priority;

22 (b) People with complex behavioral health conditions often do not
23 receive comparable access to, and quality of, physical health care,
24 resulting in increased rates of morbidity and mortality. Any new
25 approach must address this core disparity for individuals with either
26 common or complex behavioral health challenges;

27 (c) Medicaid purchasing must support delivery of better integrated,
28 person-centered care that addresses the full spectrum of individuals'
29 health needs in the context of the communities in which they live and
30 with assurance of care continuity as their health needs change;

31 (d) Behavioral health services and interventions are linked to
32 local systems such as law enforcement and other first responders,
33 courts, and jails. These community connections must be amplified
34 through new levels of accountability supported by community governance
35 and oversight;

36 (e) Medicaid benefit design must include adequate preventive care,
37 crisis intervention, and support services that ensure recovery-focused
38 approach;

1 (f) Evidence-based care interventions and continuous quality
2 improvement must be enforced through contract specifications and
3 performance measures, including the statewide measure set under section
4 10 of this act, that ensure meaningful integration at the patient care
5 level with broadly distributed accountability for results;

6 (g) Active purchasing and oversight of medicaid managed care
7 contracts is a shared state and community responsibility, without which
8 individuals with behavioral health needs will suffer;

9 (h) A deliberate and flexible system change plan with identified
10 benchmarks and periodic readiness reviews will promote system
11 stability, ensure continuity of treatment for patients, and protect
12 essential behavioral health system infrastructure and capacity;

13 (i) Community and organizational readiness are key determinants of
14 implementation timing; a phased approach is therefore desirable.

15 NEW SECTION. **Sec. 14.** Sections 2 through 4, 10, and 12 of this
16 act are each added to chapter 41.05 RCW.

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■ **Appendix J**

Return on Investment Literature Review

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1. Move the Market – State as First Mover, and In General through Public/Private Action Plan and Aligned Purchaser Action

i. High cost/high variation procedures and interventions

Intervention Name	Intervention Description and Source	Intervention Result
Addressing unwarranted variation in preference sensitive services	<p>Multifaceted approaches described, all of which are featured in the Innovation Plan:</p> <ul style="list-style-type: none"> • Use of evidence (Bree, Alliance, FHCQ) • Increasing Transparency (APCD, Alliance, Bree) • Shared Decision-making 	<p>Patients who are fully informed of their care options are on average 20% less likely to choose an invasive treatment option, with no adverse effects on health outcomes or satisfaction with their care.</p> <p>For a good recent summary of all these interventions, see “All over the Map: Elective Procedure rates in California vary widely” California Healthcare Foundation. www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/V/PDF%20VariationResearchSummary.pdf</p> <p>In 2010, Washington state issued a strategic health planning brief noting both high levels of variation in Washington, and limitations of analytic/transparency capabilities in the state. See, Washington State Office of Financial Management: Strategic Health Planning: A Progress Report 2010: www.ofm.wa.gov/healthcare/planning/report2010.pdf</p>
Introducing Decision Aids at Group Health linked to Sharply Lower Hip and Knee Surgery Rates and Costs	<p>The purpose of this observational study was to examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint replacement surgery and costs in a large health system in Washington State.</p> <p>Arterburn D, Wellman R, Westbrook E, et al. <i>Health Affairs</i>. 2012 Sept 4;(9):2094-104</p>	<p>Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs.</p> <p>Consistent with prior randomized trials, introduction of decision aids was associated with 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements, and 12–21 percent lower costs over six months.</p> <p>These findings support the concept that patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients’ and physicians’ preferences, may reduce rates of elective surgery and lower costs.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Enhanced Support For Shared Decision-Making Reduced Costs Of Care For Patients With Preference-Sensitive Conditions</p>	<p>The study compared the effects on patients of receiving a usual level of support in making a medical treatment decision with the effects of receiving enhanced support, which included more contact with trained health coaches through telephone, mail, e-mail, and the Internet.</p> <p>Veroff D, Marr A, Wennberg DE. With Preference-Sensitive Conditions, Enhanced Support For Shared Decision Making Reduced Costs Of Care For Patients. <i>Health Affairs</i>, 32, no.2 (2013):285-293</p>	<p>Intervention reduced utilization and downstream costs. Patients who received enhanced support had 5.3 percent lower overall medical costs than patients who received the usual level of support. The enhanced-support group had 12.5 percent fewer hospital admissions than the usual-support group, and 9.9 percent fewer preference-sensitive surgeries, including 20.9 percent fewer preference-sensitive heart surgeries. These findings indicate that support for shared decision making can generate savings.</p> <p>Total medical costs were \$23.27 per person per month lower in the enhanced-support group—a difference of 5.3 percent compared to costs for people in the usual-support group (p < 0:05).The enhanced-support group had lower per member per month costs than the usual-support group in all six of the condition subsets except knee pain. The only condition subset in which the differences between costs for usual and enhanced support were significant was the heart condition subset. In that case, the enhanced support group had 8.7 percent lower costs than the usual-support group (p ¼ 0:01).</p> <p>The difference of \$23.27 per person per month between the enhanced-support group and the usual-support group was primarily due to reduced inpatient costs (\$16.53 per person per month) and hospital outpatient expenditures (\$4.42 per person per month).</p>

Intervention Name	Intervention Description and Source	Intervention Result
Savings if Bree total knee replacement (TKR) and total hip replacement (THR) warranty is implemented	Analysis by Bree Collaborative staff	<p>Intervention reduces avoidable readmissions, payment for readmissions</p> <p>Analysis of the 2011 CHARS dataset suggests that state-wide implementation of the total knee and total hip replacement (TKR/THR) surgery warranty as recommended by the Bree Collaborative could reduce hospital reimbursement by as much as \$1.5 million per year. These reductions in reimbursement would result from an estimated 153 readmissions following TKR/THR for conditions covered in the warranty and therefore ineligible for additional payment.</p> <p>Assumptions</p> <ul style="list-style-type: none"> • 80% of TKRs/THRs are performed on patients with a diagnosis of osteoarthritis • Patients only had one complication per readmission (every complication was assumed to be a different readmission) • Average cost of a readmission for a complication following TKR/THR is \$9,600¹ <p>CHARS Findings Used for Calculation</p> <ul style="list-style-type: none"> • 165 TKR patients and 141 THR patients were readmitted due to complications included in the warranty • 58.5% of TKR patients and 67.0% of THR patients were readmitted to the same hospital that performed the index surgery <p>Calculation</p> <p>Estimated savings = (# of TKR/THR patients readmitted due to warranty complications)*(% of TKRs/THRs due to osteoarthritis)*(% Readmitted to Same Hospital)*(Estimated Cost of Readmission)</p> <p>Estimated reduction in reimbursement for TKRs = \$740,768</p> <p>Estimated reduction in reimbursement for THRs = \$724,228</p> <p>Total reduction in reimbursement = \$1,464,996</p>

¹ According to the Centers for Medicare & Medicaid Services, the estimated average cost of a Medicare readmission is \$9,600.

Intervention Name	Intervention Description and Source	Intervention Result
The Foundation for Health Care Quality's Clinical Outcomes Assessment Program (COAP): Appropriate use of Percutaneous Cardiac Intervention (PCI)	Measuring appropriateness of PCI using national guidelines & public reporting www.coap.org	Intervention of COAP – better adherence to clinical guidelines, reduces rate of PCIs, and downstream costs Rates of PCIs (on COAP website) – www.qualityhealth.org Bree report on PCIs - http://www.hca.wa.gov/bree/Pages/index.aspx
C-Section Evidence Review	Evidence Review Childbirth Connection Transform.childbirthconnection.org/wp-content/uploads/2013/02/Cesarian-Report.pdf	Reduction of unnecessary C-Section- downstream health and costs avoided for moms and babies. Caesarian delivery is associated with maternal death, cardiac arrest, urgent hysterectomy, blood clot, anesthetic complications, major infection, wound infection, hematoma, increased length of stay by .6 to 2 days, moderate to large excess number of readmissions, problems with physical recovery Future birth effects- impaired fertility, placenta previa, abruption, hysterectomy, large excess number of intensive care admission on next delivery, moderate number of hospital readmits on next delivery. Large excess number of babies with hospital stays of more than 7 days. Babies experience higher neonatal mortality, respiratory distress, pulmonary hypertension, not breastfeeding. C-section increases the likelihood of childhood asthma, type I diabetes, allergic rhinitis, obesity.

Intervention Name	Intervention Description and Source	Intervention Result
Decreasing early term deliveries/ inductions	<p>Various, cited in National Business Group on Health Fact Sheet, March 2012</p> <p>http://www.businessgrouphealth.org/pub/f314bc30-2354-d714-519a-fb0c2d3d08cf</p>	<p>The number of preterm births and induction of labor preterm continue to rise, even though increasing evidence shows that babies born preterm or late preterm are less healthy and incur higher costs than infants born at full term. Approximately 900 late preterm births occur every day in the U.S., equivalent to one in every three births. Preterm birth costs total \$26 billion annually or \$51,500 for every infant born prematurely. Nearly half of these costs, or almost \$13 billion, fall to employers and other private insurers.</p> <p>Mothers of preterm babies spend 10.2 days more on short-term disability during the first six months after delivery than mothers of full-term babies, costing employers an average of \$1,513 in lost productivity per premature baby.</p> <p>The average hospital cost of preterm infants is \$26,054 versus \$2,061 for infants born at full-term.</p> <p>Total first-year costs after the initial hospitalization were, on average, three times higher for late preterm infants (\$12,247) than for full-term infants (\$4,069).</p> <p>Induction of labor is consistently more costly than spontaneous labor.</p> <p>Higher rates of C-section delivery are found with elective induction of labor, and C-sections are substantially more expensive than vaginal deliveries (\$10,958 vs. \$7,737).</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Cost of having a baby in the united states</p>	<p>Study highlights additional costs of two targets for Bree and shared decision making: Elective induction and C Section.</p> <p>Truven Health Analytics Market scan study, Transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-A-Baby-Executive-Summary.pdf</p>	<p>The MarketScan databases provide a unique opportunity to understand recent, 2010, average payments for maternal and newborn care by Commercial Insurers and Medicaid. Key findings are as follows:</p> <ul style="list-style-type: none"> • Average total payments for maternal and newborn care with cesarean births were about 50% higher than average payments with vaginal births for both Commercial payers (\$27,866 vs. \$18,329) and Medicaid (\$13,590 vs. \$9,131). • Commercial payers paid an extra \$1,464 to clinicians and \$7,518 to facilities for cesarean versus vaginal births. • Average total payments for maternal-newborn care by Commercial payers were about 100% higher than average Medicaid payments for both vaginal births (\$18,239 vs. \$9,131) and cesarean births (\$27,866 vs. \$13,590). • Across the prenatal, childbirth hospitalization, and postpartum phases of care, average inpatient maternal-newborn payments predominated (from 70% to 86% of all payments) for both types of payers and both types of birth. • Across the prenatal, childbirth hospitalization, and postpartum phases of care, average maternal payments to maternity care providers were concentrated in the hospitalization phase (from 70% to 84% of all maternity care provider payments, depending on type of payer and type of birth). • Facility fees (from 59% to 66% on average) and professional service fees (from 20% to 25%) predominated over anesthesiology, laboratory, radiology, and pharmacy fees for both types of payers and both types of birth. • For both Commercial and Medicaid payers, average total for maternal care payments were about twice as great as average total newborn care payments with vaginal births, and between 40% and 50% higher with cesarean births. • Across five selected states, average Commercial insurer payments for all maternal care ranged from \$10,318 (Louisiana) to \$16,888 (Massachusetts) with vaginal births and from \$13,943 (Louisiana) to \$21,307 (California) with cesarean births. • Average payments for babies with stays in neonatal intensive care unit nurseries far exceeded average payments for all newborns (from 3.7- to 5.6-fold) for both types of payers and both types of birth. • From 2004 to 2010, average Commercial insurer payments for all maternal care increased by 49% for vaginal births and 41% for cesarean births. • From 2004 to 2010, average out-of-pocket payments for all maternal care covered by Commercial insurers increased nearly fourfold for both vaginal (from \$463 to \$1,686) and cesarean (from \$523 to \$1,948) births.

Intervention Name	Intervention Description and Source	Intervention Result
Elective Induction and shared decision making	National Business Group on Health Fact Sheet www.businessgrouphealth.org/pub/f314bc30-2354-d714-519a-fb0cd3d08cf	Induction of labor is consistently more expensive than spontaneous labor. Higher rates of C-section are found with elective induction, and C-section are substantially more expensive than vaginal deliveries (\$10,958 versus \$7,737) NBGH recommends a number of interventions, including use of decision aids and selecting best in class providers. Note: OB OAPs and other programs promoted in innovation plan also aimed at adoption of clinical guidelines
Opioid Use, and Dosing Guideline	Franklin, G et al. Bending the Prescription Opioid Dosing and Mortality Curves, Impact of the Washington State Opioid Dosing Guideline. <i>Am J Int Med</i> 2012 April (55)4	Upcoming focus of Bree will focus on reducing overuse of opioids, extending benefits of Washington L&I program. L&I program has seen substantial decline (27%) in schedule II opioid use, and number of opioid related deaths have declined.
End of Life Care/Advanced Planning	End-of-life care in the intensive care unit: can we simultaneously increase quality and reduce costs? <u>Curtis JR, Engelberg RA, Bensink ME, Ramsey SD.</u> <i>Am J Respir Crit Care Med.</i> 2012 Oct 1;186(7):587-92. doi: 10.1164/rccm.201206-1020CP. Epub 2012 Aug 2. Division of Pulmonary and Critical Care, Harborview Medical Center, University of Washington, Seattle, WA 98104, USA. jrc@u.washington.edu.	More than 25% of healthcare costs are spent in the last year of life, and approximately 20% of deaths occur in the intensive care unit (ICU). Two recent studies suggest that important opportunities may exist to improve quality and reduce costs through two mechanisms: advance care planning for patients with life-limiting illness and use of time-limited trials of ICU care for critically ill patients. The goal of these approaches is to ensure patients receive the intensity of care that they would choose at the end of life, given the opportunity to make an informed decision. Although these mechanisms hold promise for increasing quality and reducing costs, there are few clearly described, effective methods to implement these mechanisms in routine clinical practice. “We believe basic science in communication and decision making, implementation research, and demonstration projects are critically important if we are to translate these approaches into practice and, in so doing, provide high-quality and patient-centered care while limiting rising healthcare costs.”

Intervention Name	Intervention Description and Source	Intervention Result
ii. Value Based Payment, delivery system and benefit design		
Mass Alternative Quality Contract (AQC)	<p>AQC combines a risk adjusted annual global budget for BC members with p4p bonuses for clinicians who meet clinical targets. Providers paid FFS and then retroactively adjust at end of year. Upside and downside risk.</p> <p>Song, Z, Safran, DG, Landon BE et al, (2012) The Alternative Quality Contract. <i>Health Affairs</i>, 31(8), 1885-1894.</p>	<p>Discusses impact of global payment model that will be promoted under State Innovation Plan.</p> <p>“After 2 years, medical spending was 3.3% lower than the control group, and quality was consistently high among participating physicians.”</p>
Harvard study – spillover effects of AQC in Mass	<p>Spillover effects of BCBS alternative quality contract for commercial population on Medicare beneficiaries.</p> <p>McWilliams L, Chernew M et al, Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO contract. <i>Journal of the American Medical Association</i>, 2013: 310 (8) 829-836.</p> <p>Jama.jamanetwork.com/article.aspx?articleid=1733718</p>	<p>Doctors who were part of the AQC but were not being paid through a global budget for their Medicare spending still cut Medicare spending by 3.4%. (Providers are changing their processes of care).</p>

Intervention Name	Intervention Description and Source	Intervention Result				
Maine Health Management Coalition - estimated savings from cost reduction initiatives	Washington's Innovation Plan includes many of the same targets.	How Much Could Be Saved?		Reduction in Annual PMPM		
		Maine Health Management Coalition		1-2 Years	3-5 Years	
		Cost Reduction Initiative				
		Reduce Admissions and Readmissions for Chronic Illness				
		Increased Payments for Medical Homes (\$3 PMPM)			-0.8%	-0.8%
		20% Reduction in Chronic Disease Admissions			3.8%	3.8%
		50% Adjustment to Prices to Cover Hospital Fixed Costs			-1.9%	
		25% Adjustment to Prices to Cover Hospital Fixed Costs				-1.0%
		Net Savings			1.1%	2.1%
		Reduce Variation in Price and Utilization for Outpatient Services				
		Reduce Utilization of Top 10 Outpatient Services to Median County			1.1%	1.1%
		Reduce Utilization of Additional Outpatient Services				1.1%
		Total Savings			1.1%	2.2%
		Reduce Costs/Prices for Inpatient Care (Phased In)			0.8%	1.6%
		Reduce Administrative Costs (Phased In)			0.5%	1.0%
		Improve Wellness and Community Health				
		Reduce Risk Factors by 2% (Phased In)			1.0%	4.8%
		Reduce Cost-Shifting				
		Reduce MainCare utilization rates, increase MainCare payments			0.5%	1.0%
		Total Annual Savings			5.5%	13.7%

Intervention Name	Intervention Description and Source	Intervention Result
Centers of Occupational Health and Education (COHE)	<p>COHEs - Financial incentives to providers encourage adoption of best practices, coupled with organizational support and care management activities, aimed at reducing work disability for patients treated within the Washington State workers' compensation system.</p> <p>Wickizer TM. Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Healthcare: A Population-based Intervention Study. <i>Med Care</i>. 2011 Dec;49(12):1105-11.</p>	<p>Innovation Plan recommends spread of COHE model beyond L&I</p> <p>Results: COHE patients were less likely to be off work and on disability at 1 year post claim receipt (OR= 0.79, P=0.003). The average COHE patients experienced a reduction in disability days of 19.7% (P= 0.005) and a reduction in total disability and medical costs of \$510 per claim (P < 0.01). For patients with back sprain, the reduction in disability days was 29.5% (P = 0.003). Patients treated by providers who more often adopted occupational health best practices had, on average, 57% fewer disability days (P= 0.001) compared with patients treated by providers who infrequently adopted best practices.</p> <p>For all cases, disability cost decreased from \$1147 per claim in the baseline period to \$880 in the follow-up period. The corresponding decrease in disability cost for back sprain cases was larger, from \$1576 to \$1034. COHE medical cost per claim decreased by approximately 7%, but this decrease was not statistically significant (P = 0.13). However, the post intervention COHE medical costs included added provider incentive payments (approximately \$57 per claim). Had these added payments not been included, the decrease in medical costs would have been larger.</p> <p>"We combined medical and disability costs to derive an estimate of total costs and then examined the change in total costs associated with the COHE. Total costs for all cases (n = 105,606) decreased by approximately \$510 per claim (P < 0.01)."</p>
Intensive Outpatient Care Program (IOCP)	<p>Originally aimed at Boeing employees, pre-Medicare retirees, being spread to other populations including PEB UMP. Patients assigned to care team that includes an RN case manager and at least one IOCP dedicated physician.</p> <p>Robert Wood Johnson summary, www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwif404563</p>	<p>Per capita spending for participants dropped 20% relative to a control group, patients' functional status scores, depression scores, experience of care scores and absenteeism all improved. The drop in spending was primarily due to reduction in ED and inpatient hospital stays. The reductions more than offset the additional fees paid to the physicians and any increases in office visits, pharmacy and lab services.</p> <p>Similar case control study of program for local 54 HEREIUWF workers showed that total net spending was 12.3% lower.</p> <p>Similar program for CalPERs reports initial findings, one patient example: participant went from spending \$2,947/month to \$640/month during the first four months after enrollment.</p>

Intervention Name	Intervention Description and Source	Intervention Result
CalPERS population based payment pilot with BS CA	BS CA paid to provider systems in Sacramento a pre-determined amount to provide care to 41,500 CalPERS employees and dependents. Shared Savings model www.rwif.org/content/dam/farm/reports/issue_briefs/2013/rwif404563	Innovation plan would promote this type of payment reform model By end of year 1, the pilot exceeded all expectations, saving more than \$20 million in costs. Over the first 3 years, CalPERS has seen \$32 million in aggregate savings. Partners in addition saw a meaningful reduction in utilization, including a 15% drop in inpatient days, and a 13% reduction in surgeries. By providing shared savings opportunities, the provider focus shifted to population health improvement, targeting patients with chronic illnesses and medically complex conditions and reducing unnecessary care. Program is being expanded within CalPERS.
Maine State Employee Health Commission	Maine General Health System moved to payment reform model with up and downside risk.	Expected to generate \$1 million in savings for Maine State Employees' system. Same citation as above.
Hill Air Force Base PCMH	Aimed at transforming care at all primary care practices through the DOD in the base area in Utah. Team based PCMH model.	Improved blood sugar control for 77% of diabetic population, at or above 98% control for asthma. Project savings estimated at \$300k per year just by improving diabetes care. Network care costs down by 4.5% over two fiscal years. Same citation as above.
CalPERS Priority Care program	High intensity primary care services to members with chronic health conditions in Humboldt/Del Norte IPA.	Program will be formally evaluated in 2013, but preliminary findings encouraging. Similar program for CalPERS reports initial findings, one patient example: participant went from spending \$2,947/month to \$640/month during the first four months after enrollment. Same citation as above.
Payment Bundles - Acute Care Episode Project at Baptist Health Texas	Hospitals required to propose bundles of physician and hospital services related to 28 cardiac and nine orthopedic services. Medicare also offered to share in cost savings with physician partners.	Payment Bundles As of May 2011, the implementation of bundled payments save more than \$2,000 per case for a total of \$4.3 million since the program began in 2009. Same citation as above.
Payment Bundles Medicare heart bypass center project	Medicare participating heart bypass center demonstration.	Participating hospitals offered a single price for all inpatient services related to heart bypass. From 1990-93, the total cost per case decreased in three out of four hospitals as physicians changed their practices to reduce LOS and overall costs. Over the first 27 months of the demonstration, the project saved more than \$17 million at four participating hospitals. Same citation as above.

Intervention Name	Intervention Description and Source	Intervention Result
Reference Pricing	<p>CalPERs Orthopedics Reference Pricing – affects total spend for joint replacement by having significant impact on pricing.</p> <p>www.calpers.wa.gov/elp-docs/about/committee-meetings/agendas/pension/201306/item-7-attach-1.pdf</p> <p>Health Affairs, Increases in Consumer cost sharing redirect patient volumes and reduce Hospital Prices, August 2013 32:81 392-1397</p>	<p>Savings for hip and knee replacements - 19.6% with no attendant decrease in quality in 2011, 18.6% in 2012, for a cumulative savings for CalPERs of \$5.5 million.</p> <p>2011: \$2.8 million – 15.4% due to market share growth at VBPD hospitals, 84.6% due to reduction in prices (at both VBPD and non-VBPD hospitals).</p> <p>2012: \$2.7 million – 12.9% due to market share growth at VBPD hospitals, 87.1% due to reduction in prices (both VBPD and non-VBPD hospitals).</p> <p>Enrollee cost sharing per case reduced in non-VBPD facilities, but statistically flat in VBPD facilities. Hospital pricing changes larger than expected, suggesting that hospitals perceive CalPERs initiative as bellwether of larger trends in private purchasing.</p>
Narrowed/tiered network	<p>Blues Increasingly Turn to Tiered Networks To Compete in Transparent 2014 Market Blues (http://aishealth.com/archive/nblu0413-02)</p>	<p>Blue Benefit Administrators of Massachusetts, a subsidiary of Blue Cross and Blue Shield of Massachusetts, recently introduced Select Blue Network for self-funded cities and towns in the state, as well as other self-funded customers. The Massachusetts Blues said March 13 its new option could save employer groups up to 10% in costs by using a “select PPO network of cost-effective, high-quality hospitals, physicians” and other providers. Select Blue’s 54 hospitals and 13,000-plus physicians “meet quality and efficiency guidelines and are low- to moderate cost,” the company says.</p> <p>Highmark Blue Shield said March 21 it will offer a new tiered PPO benefit to groups in nine counties in north-central Pennsylvania starting July 1. Community Blue Premier Flex could save employers up to 20% on premium costs, depending on the group’s current utilization, by offering a benefit design that gives incentives to members to use lower-cost providers without compromising quality, the company says.</p>

Intervention Name	Intervention Description and Source	Intervention Result
Reference Pricing Safeway Imaging and Lab Tests (including colonoscopy)	Safeway established a benefit limit of \$1500 for colonoscopy except in cases of emergency or complications, covering the facility fee but not the physician clinical fee. Project extended across the country in 2010. Robinson J, MacPherson, Payers test reference pricing and centers of excellence to steer patients to low price and high quality providers. <i>Health Affairs</i> , September 2012, vol. 31 no 9 2028,2036.	Price limit reduced to \$1250, and extended to routine lab tests.
Safeway Overall, multifaceted	Safeway focused on behavior change and critical measures – weight, smoking, cholesterol, BP, premiums reduced by \$1560/year if employee and spouse get passing grades on 4 metrics. Reference pricing (now being expanded to 1500 procedures). Smokers pay more, but quitters get rebate.	Safeway has held its costs relatively constant since 2006 based on a per capita index. Program extended to 75% of union population. Safeway Health, projects company with 10,000 employees could save \$45 million/year by the fifth year into this type of market based plan. Cited in RWJ summary, above.

2. Integrated Physical and Behavioral Health

Collaborative Primary Care: Preliminary Findings for Depression and Anxiety	Meta-Analysis of costs/benefits of collaborative care model for integration of mental health services into primary care Washington State Institute for Public Policy (inventory/meta-analysis) October 2013	<p>Collaborative care for depression: Benefit to cost ratio: \$8.73, total benefits minus costs \$6,093.</p> <p>Collaborative Care for Depression with a co-morbid physical condition: Benefit to cost ratio, \$7.21, total benefits minus costs, \$5,167.</p> <p>Collaborative primary care benefits exceed costs 100% of the time.</p>
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Intervention Name	Intervention Description and Source	Intervention Result
<p>Bending the Medicaid Healthcare Cost Curve through financially sustainable medical-behavioral integration</p>	<p>Paper presents recommendation to provide more behavioral health care services to Medicaid beneficiaries through integrated medical-behavioral healthcare programs, and presents value data for doing so.</p> <p>Milliman Research Report July 2012 http://publications.milliman.com/publications/health-published/pdfs/bending-medicaid-cost-curve.pdf</p>	<p>Cites “huge opportunity”. “State Medicaid programs that are successful with integrated care initiatives will likely change their healthcare trends and improve the health of their covered populations.”</p> <p>Estimated savings for patients with chronic medical and co-morbid behavioral health disorders range from \$50million to \$150million for every 100,000 covered Medicaid lives, based on Milliman prevalence models. Current estimates from the integrated program innovations for the targeted potential of reduced healthcare costs resulting from an effective integrated medical-behavioral program are 10% of this exacerbated cost level, on average, for these co-morbid lives. With the current Medicaid covered population (US, 2012) of 60 million lives, this translates to potential healthcare cost reductions of \$3billion to \$9 billion annually across the United States.</p>

Intervention Name	Intervention Description and Source	Intervention Result
Mental disorders and medical comorbidity synthesis project	<p>A literature review and analysis was conducted using standardized approaches for systematic reviews of the peer-reviewed literature conducted by Druss and Walker.</p> <p>http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/su_basets/rwjf69438_1</p>	<p>Findings:</p> <ul style="list-style-type: none"> • Comorbidity between medical and mental conditions is the rule rather than the exception. • One of the most important drivers of the high numbers of individuals with comorbid mental and medical conditions is the high prevalence of mental disorders and chronic conditions in the United States. • In addition to the high prevalence of these conditions, there is also evidence that having each type of disorder is a risk factor for developing the other. • Exposure to early trauma and chronic stress may be a risk factor for both mental and medical disorders • Four modifiable health risk behaviors—tobacco use, excessive alcohol and illicit drug consumption, lack of physical activity, and poor nutrition—are responsible for much of the high rates of comorbidity, burden of illness, and early death related to chronic diseases • Many of the most common treatments for diseases may actually worsen the comorbid mental or medical problems Many chronic medical conditions require patients to maintain a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions • When mental and medical conditions co-occur, the combination is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs • Mental disorders are associated with a twofold to fourfold elevated risk of premature mortality • There are analogous problems of under recognition and under treatment of medical problems for persons with mental conditions • Comorbid mental and medical conditions are associated with substantial individual and societal costs. For example, the average total monthly expenditure for a person with a chronic disease and depression is \$560 dollars more than for a person without depression; the discrepancy for people with and without comorbid anxiety is \$710. • Collaborative care approaches have been found to be highly cost-effective from a societal perspective. Cost-effectiveness indicates a good value for society, but does not necessarily mean that cost-effective programs will save money or result in a “cost-offset”. However, more recent clinical trials have suggested that cost savings may be achievable over the long term, particularly among the costliest and most complex patients, such as those with comorbid diabetes and depression.

Intervention Name	Intervention Description and Source	Intervention Result
Budget Impact and Sustainability of Medical Care Management for Persons With Serious Mental Illnesses	<p>The authors assessed the 2-year outcomes, costs, and financial sustainability of a medical care management intervention for community mental health settings.</p> <p>Am J Psychiatry Druss et al.; AiA:1–8</p> <p>http://www.integration.samhsa.gov/pbhci-learning-community/Budget_Impact_and_Sustainability_of_Medical_Care_Management_for_Persons_with_SMI.pdf</p>	<p>Sustained improvements were observed in the intervention group in quality of primary care preventive services, quality of cardiometabolic care, and mental health-related quality of life. From a health system perspective, by year 2, the mean per-patient total costs for the intervention group were \$932 (95% CI=-1,973 to 102) less than for the usual care group, with a 92.3% probability that the program was associated with lower costs than usual care. From the community mental health center perspective, the program would break even (i.e., revenues would cover setup costs) if 58% or more of clients had Medicaid or another form of insurance. Given that only 40.5% of clients in this study had Medicaid, the program was not sustainable after grant funding ended.</p>
The Health and Recovery Peer (HARP) Program: a peer-led intervention to improve medical self-management for persons with serious mental illness	<p>The study team developed and pilot-tested the Health and Recovery Program (HARP), an adaptation of the Chronic Disease Self-Management Program (CDSMP) for mental health consumers.</p> <p>Schizophrenia Res. 2010 May;118(1-3):264-70. doi: 10.1016/j.schres.2010.01.026. Epub 2010 Feb 25.</p> <p>http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2856811/</p>	<p>At six month follow-up, participants in the HARP program had a significantly greater improvement in patient activation than those in usual care (7.7% relative improvement vs. 5.7% decline, p=0.03 for group *time interaction), and in rates of having one or more primary care visit (68.4% vs. 51.9% with one or more visit, p=0.046 for group *time interaction). Intervention advantages were observed for physical health related quality of life (HRQOL), physical activity, medication adherence, and, and though not statistically significant, had similar effect sizes as those seen for the CDSMP in general medical populations. Improvements in HRQOL were largest among medically and socially vulnerable subpopulations.</p> <p>This peer-led, medical self-management program was feasible and showed promise for improving a range of health outcomes among mental health consumers with chronic medical comorbidities. The HARP intervention may provide a vehicle for the mental health peer workforce to actively engage in efforts to reduce morbidity and mortality among mental health consumers.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Disability Caseload Trends and Mental Illness: Incentives under Healthcare Reform to Invest in Mental Health Treatment for Non-Disabled Adults</p>	<p>Washington State Department of Social and Health Services. November 2011 RDA Report 3.36 http://www.dshs.wa.gov/pdf/ms/rda/research/3/36.pdf</p>	<p>This paper documents the role of mental illness in driving disability caseload growth and healthcare costs in Washington’s Medicaid population. Recommends Collaborative Care Model (MHIP) for consideration.</p> <p>Also documents that low income parents with mental health needs have longer stays on family cash assistance, greater likelihood of involvement in child abuse and neglect investigations, and to have children in foster care. Persons with disabilities living in community residential settings or receiving in-home assistance have a relatively higher prevalence of mental health needs, placing them at increased risk of more costly institutional care. Frail elders with mental illness are more likely than other groups to have difficulties continuing to live at home as they age.</p> <p>An approach aimed at creating plan and provider capabilities to improve population health status and reduce disability risk in the Medicaid expansion population is recommended.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Intermountain Healthcare (Utah) Mental Health Integration (MHI) Programⁱ</p>	<p>A comprehensive, team-based mental health approach available to all patients.</p> <p>PCPs and their staff are integrated with MH professionals, community resources, care management, the patient, and his/her family.</p> <p>Patients complete a comprehensive assessment tool; an algorithm then stratifies patients into categories. Available resources are matched to the patient's need.</p> <p>As of 2010, implemented in 69 of Intermountain's 130 primary care clinics.</p> <p>Quasi-experimental, retrospective cohort study measured MHI's impact on cost and quality.</p> <p>Martin, Lindsay and Peter Brown. "90-Day Project Final Summary Report: Integrating Primary Care and Behavioral Health Care." Institute for Healthcare Improvement. October 2008.</p> <p>Reiss-Brennan, Brenda, et al. "Cost and quality impact of Intermountain's mental health integration program." <i>Journal of Healthcare Management</i> 55.2 (2010): 97.</p>	<ul style="list-style-type: none"> • MHI patients in the 12 months after initial diagnosis of depression were 54% less likely to have an ER visit and had fewer claims for total primary care and psychiatry. • The rate of growth in treatment costs between the 12-month pre-mental health diagnosis period and the 12-month post-diagnosis period was \$405 less for MHI patients than for the usual care cohort (\$640 for MHI, compared to \$1,045 for usual care).

Intervention Name	Intervention Description and Source	Intervention Result
<p>Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) Research Trials</p>	<p>Primary care-based collaborative care model for late-life depression in 18 primary care clinics across the US.</p> <p>Unützer J, et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." <i>Am J Manag Care</i> 14 (2008): 95-100.</p> <p>Unützer J, et al. "Collaborative care management of late-life depression in the primary care setting." <i>JAMA: the journal of the American Medical Association</i> 288.22 (2002): 2836-2845.</p> <p>Unützer J, et al. "From establishing an evidence-based practice to implementation in real-world settings: IMPACT as a case study." <i>Psychiatric Clinics of North America</i> 28.4 (2005): 1079-1092.</p> <p>Edwards BC, Garcia SP, Smith AD. "Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives." Health Management Associates (2007).</p>	<p>Over a four year period, IMPACT patients had lower average net costs for their medical care (\$3,363 less) than patients receiving usual care (total healthcare costs were \$29,422 compared to \$32,785 for usual care patients).</p> <p>Intervention patients had lower healthcare costs in every cost category: outpatient and inpatient mental health, outpatient and inpatient medical and surgical, pharmacy, and other outpatient costs.</p> <p>Corresponds to an ROI of \$6.50 per dollar spent at the Kaiser Permanente Southern California site, total health care costs decreased 14% per year during the IMPACT study and an additional 9% for one year post study.</p>

Intervention Name	Intervention Description and Source	Intervention Result
SMI Innovations Project in Pennsylvania	<p>Two-year pilot to better integrate care for Medicaid enrollees with serious mental illness that began in July 2009 in Southeast and Southwest Pennsylvania.</p> <p>Each pilot was a collaboration between physical health managed care organizations, behavioral health managed care organizations, and county behavioral health offices.</p> <p>Southeast Pennsylvania Pilot included use of navigators to coordinate care, integrated member health profiles, and case rounds with staff from both plans and the navigator.</p> <p>It also included use of plan care managers to engage members, nurse case managers to help coordinate care, and multidisciplinary case conferences.</p> <p>Kim J et al. "SIM Innovations Project in Pennsylvania: Final Evaluation Report." Mathematica Policy Research. 1 October 2012.</p>	<p>Southeast PA Pilot: The rate of ED visits was an estimated 9% lower across all counties than would have occurred in the absence of the program (changes in mental health hospitalizations and readmissions not significant).</p> <p>Southwest PA Pilot: Mental health hospitalization and all-cause 30-day readmission rates for the study population were an estimated 12% and 10% lower, respectively, compared with projected trends without the intervention (changes in ED visits not significant).</p>
A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral, and Evaluation (PCARE)	<p>The authors tested a population-based medical care management intervention designed to improve primary medical care in community mental health settings.</p>	<p>At a 12-month follow-up evaluation, the intervention group received an average of 58.7% of recommended preventive services compared with a rate of 21.8% in the usual care group. They also received a significantly higher proportion of evidence-based services; The intervention group showed significant improvement on the SF-36 mental component summary and a non-significant improvement on the SF- 36 physical component summary. Medical care management was associated with significant improvements in the quality and outcomes of primary care.</p> <p>Cost offsets were not studied.</p> <p>http://www.integration.samhsa.gov/clinical-practice/pcare.pdf</p>

Intervention Name	Intervention Description and Source	Intervention Result
Colorado Access Integration Model	<p>Colorado Access is a non-profit managed care plan with contracts as regional Medicaid HMO and MH carve-out.</p> <p>Care coordination model in which care managers who are registered nurses in the managed care organization work with medical and behavioral health providers to coordinate care and develop a care plan. Care managers also provide outreach and treatment support calls to patients.</p> <p>Centralized care management in the plan, with telephonic, onsite in primary care, or in-community care contacts based on risk stratification.</p> <p>Thomas M. Colorado Access. Presentation at Robert Wood Johnson Foundation Depression in Primary Care Annual Meeting. February 2006.</p>	<p>Patients in the program had fewer office visits, ED visits, hospital admits, and hospital days.</p> <p>Overall savings of \$170 PMPM (\$2040/year), and an overall decrease in health spending for high-risk/high-cost patients of 12.9%.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Kaiser Permanente Sacramento Integrated Care Model</p>	<p>Patients with substance use conditions entering the outpatient Chemical Dependency Recovery Program were randomly assigned to receive treatment through an integrated model, in which primary health care was included within the addiction treatment program, or an independent treatment-as-usual model, in which primary care and substance abuse treatment were provided separately.</p> <p>3 physicians with specialty training in substance abuse, 1 medical assistant and 2 nurses were made available for primary care for patients in Integrated Care Group. Care was provided during the 8-week Program, with 10 months of aftercare available.</p> <p>Randomized controlled trial conducted between April 1997 and December 1998.</p> <p>Weisner C, et al. "Integrating primary medical care with addiction treatment." <i>JAMA: the journal of the American Medical Association</i> 286.14 (2001): 1715-1723.</p> <p>Parthasarathy, S, et al. "Utilization and cost impact of integrating substance abuse treatment and primary care." <i>Medical Care</i> 41.3 (2003): 357-367.</p>	<p>Integrated services patients had higher addiction treatment (\$384.39 vs \$337.99, $P = .02$) and total treatment (\$428.87 vs \$382.81, $P = .03$) costs per member-month than independent services patients.</p> <p>However, average medical costs (excluding addiction treatment) decreased from \$313.50 to \$200.08 ($P = .04$) among the full integrated services sample, whereas there was no significant reduction in the independent services sample.</p> <p>Among patients with substance abuse related medical conditions, Integrated Care patients had significant decreases in hospitalization rates ($P = 0.04$), inpatient days ($P = 0.05$) and ER use ($P = 0.02$). Total medical costs per member-month declined from \$431.12 to \$200.03 ($P = 0.02$).</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Aetna's Depression in Primary Care program</p>	<p>Aetna reimburses PCPs for administering a Patient Health Questionnaire, or PHQ-9, to patients, and providing follow-up consultations for patients who are put on antidepressants or referred to psychiatrists or psychologists.</p> <p>Un H. "Integrating behavioral health in primary care." Presentation to Carter Center Medical Home Summit. July 2009.</p> <p>Butler M, et al. "Integration of mental health/substance abuse and primary care." (2008).</p>	<p>A decrease in medical costs of \$175-\$222 PMPM (most of this in inpatient care) and an increase in pharmacy costs of \$21-\$40 PMPM (\$8-\$11 in antidepressants). The net savings was about \$136-\$201 PMPM.</p> <p>However, these figures were limited to a small subset of Aetna enrollees who had very high risk of medical care and were already in an active case management program; they also had higher risks of depression.</p>
<p>Puentes (California) Integrated Medical Care</p>	<p>Primary care clinic co-located with an outpatient methadone clinic, targeted to individuals with history of injection drug use and the homeless population.</p> <p>Includes traditional medical care, hepatitis C treatment, psychology and psychiatry services and a pain clinic.</p> <p>Integrated treatment team composed of professionals with distinct areas of expertise who work together to treat the whole patient (fostered by single, shared office space and formal case conferences).</p> <p>Kwan L, et al. "Puentes clinic: an integrated model for the primary care of vulnerable populations." The Permanente Journal 12.1 (2008): 10.</p>	<p>ER and urgent care visits decreased from 3.8 visits in the 18 months prior to the clinic opening to .8 visits in the first 18 months of clinic opening</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Tennessee Cherokee Health System Behavioral Health and Primary Care Clinical Model</p>	<p>Embedded Behavioral Health Consultant on the Primary Care Team</p> <p>Real time behavioral and psychiatric consultation available to PCP</p> <p>Shared decision-making among the team members.</p> <p>Khatri P. "Bring it Together: Blending Behavioral Health into Primary Care." Advancing Care Together Learning Collaborative Webinar. 24 October 2012.</p>	<p>28% decrease in medical utilization for Medicaid patients</p> <p>20% decrease in medical utilization for commercially-insured patients</p> <p>27% decrease in psychiatry visits</p> <p>34% decrease in psychotherapy sessions</p>
<p>VA Integrated Care Clinic</p>	<p>A medical clinic was established to manage routine medical problems of patients with serious mental illness at a VA mental health clinic (a co-location model)</p> <p>Nurse practitioner provided the bulk of medical services; a care manager provided patient education and referrals to mental health and medical specialists.</p> <p>Druss BG., et al. "Integrated medical care for patients with serious psychiatric illness: a randomized trial." <i>Archives of general Psychiatry</i> 58.9 (2001): 861.</p>	<p>Program cost-neutral from a VA perspective (primary care costs offset by reduction in inpatient costs)</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Hypothetical “effective, evidence-based collaborative care program”</p>	<p>Study took into account cost estimated from Minnesota’s DIAMOND Program, a collaborative care program in 80 clinics and supported by 6 commercial payers.</p> <p>Unützer J, Schoenbaum, M, Druss B. “The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.” Center for Medicare & Medicaid Services. May 2013.</p> <p>See also, Butler M et al, “Integration of mental health/substance abuse and primary care”, AHRQ Publication No 09-E003 (2008).</p> <p>Edwards et al, “Integrating Publicly Funding Physical and Behavioral Health Services: A Description of Selected Initiatives, Health Management Associations (2007).</p> <p>Jung K et al, “SMI innovations project in Pennsylvania: Final Evaluation Report”.</p> <p>Mauer BJ, Jarvis D. “The Business Case for Bidirectional Integrated Care, MCPP Healthcare Consulting (2010).</p>	<p>Net savings estimated at \$5200 over 4 years (\$1,300/year).</p> <p>Estimates that implementing a collaborative care for the 20% of Medicaid members with diagnosed depression could save the Medicaid program \$15 billion/year.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Melek, Norris D: Chronic Conditions and comorbid psychological disorders. Milliman Research Reports, 2008</p>	<p>Actuarial analysis, documenting very large ROI from integrating physical and behavioral health</p> <p>Cited in: Busting the Silos: How Integrated Mental Health, Substance Use and Primary Care Services can Save Money and Lives, April 2011.</p> <p>http://publications.milliman.com/research/health-rr/pdfs/chronic-conditions-and-comorbid-RR07-01-08.pdf</p>	<p>If a 10% reduction can be made in the excess healthcare costs of patients with co-morbid psych disorders via an effective integrated medical-behavioral healthcare program, \$5.4 million healthcare savings could be achieved for each group of 100,000 insured members...the cost of doing nothing may exceed \$300 billion per year in the United States”.</p>
<p>Kaiser N. CA. substance abuse</p>	<p>Cost Studies at Northern California Kaiser Permanente, Presentation to County Alcohol and Drug Program administrators, January 28,2010, cited in Jarvis, Busting the Silos: How Integrated Mental Health, Substance Use and Primary Care Services can Save Money and Lives, April 2011.</p>	<p>Patients who received substance use treatment had a 35% reduction in ER cost, and a 26% reduction in total medical cost, compared with a matched control group.</p>
<p>Evidence Based Treatment of Alcohol, Drug and Mental Health Disorders: Potential Benefits, Costs and Fiscal Impacts for Washington State Washington State Institute for Public Policy, 2006.</p>	<p>Data Analysis</p>	<p>Evidence based treatment works, and can achieve roughly a 15-22% reduction in the incidence or severity of these disorders – at least in the short term.</p> <p>Evidence based treatment can result in about \$3.77 in benefits per dollar of treatment cost.</p> <p>Reasonably aggressive implementation could generate \$1.5 billion in net benefits for people in Washington.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>HMA projected savings Attributable to Health system Transformation through CCOs (CMMI analysis for Oregon SIM)</p>	<p>A key strategy in Oregon includes the integration of mental and health physical health.</p> <p>Target population, all current and future Oregon Health Plan enrollees.</p>	<p>“While at least one study of integration savings projected results as high as 20% to 40%, this model uses a lower figure of 10% to 20% given the extent of other savings already applied in Oregon. The model assumes both the integration of physical health with certain mental health settings, as well as the addition of mental health into appropriate physical health settings.”</p> <p>Savings estimate: (Average enrolled Medicaid) 7/13-6/15- \$285 million (low) ; \$704 million (high) 7/15-6/17 – \$678million(low); \$1.78 billion (high) 7/17-6/19 - \$1.04 billion (low); \$2.01 billion (high)</p>
<p>Unützer et al, The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes May 2013</p>	<p>Recent meta-analysis and evidence summary of the intervention supported through the innovation plan, including all necessary elements suggested for success.</p> <p>www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf</p>	<p>“Using the data on ROI described above, we estimate that implementation of collaborative care for the 20 percent Medicaid members with diagnosed depression could save the Medicaid program approximately \$15 billion per year. This corresponds to savings in excess of 2% of total annual Medicaid spending.”</p> <p>Long term 4 year cost analyses from the IMPACT study found that patients receiving the collaborative care intervention had substantially lower cost than those receiving usual care. An initial investment of \$522 during year 1 resulted in a net cost savings of \$3,363 over years 1-4. This corresponds to an ROI of \$6.50 per dollar spent, with aver annual savings of \$841.</p> <p>Savings were in every category of health costs examined, including medical collaborative care programs for patients with serious mental illness.</p>
<p>Cost effectiveness of psychological services: a summary review of the literature Dr. Sam Knapp</p>	<p>Survey of cost offset studies</p> <p>http://www.duq.edu/Documents/psychology/Cost%20effectiveness%20of%20Psychological%20Services%20copy(3).pdf</p>	<p>19 Studies Amassed in this paper</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes May 2013</p>	<p>Impact on employment and workforce participation</p> <p>www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf</p>	<p>Systematic implementation of collaborative care programs for depression in primary care can reduce many of the negative economic effects of depression, resulting in improved personal income, employment, and other workplace outcomes. These findings suggest net savings to the Medicaid program by successfully returning adults to the workplace.</p>

3. Savings Attributed to “Cross Cutting” Strategies

<p>Practice transformation support through Primary Health Regional Extension System</p> <p>Phillips et al. The Primary Care Extension Program: A Catalyst for Change</p>	<p>EHR identification of practice improvement priorities</p> <p>The extension program concept builds upon the USDA’s highly effective Cooperative Extension, which has resulted in significant, positive effects on increased agricultural production and profits. In 2009, the Hawaii Department of Agriculture reported a 32 percent return on investment for its Cooperative Extension program. Leaders in health care have pushed for nearly a decade for a similar resource in health care.</p>	<p>Additionally, significant ROI has been found in programs that facilitate primary care practice improvement. For example:</p> <ul style="list-style-type: none"> ▪ Primary care practices are 2.76 times more likely to adopt evidence-based guidelines through practice facilitation. ▪ A 2005 study of practice facilitation in Canada found net savings of \$3,687 per physician and \$63,911 per outreach facilitator. ▪ The same study estimated a 40 percent return on intervention investment and delivery of appropriate preventive care. ▪ A review of 27 randomized trials found that practice coaching improved chronic and preventive care and increased willingness to implement changes, and that the effect was improved with increased intensity and duration of coaching.
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Intervention Name	Intervention Description and Source	Intervention Result
<p>Workforce</p> <p>Included, because innovation plan workforce strategy places heavy emphasis on significant expansion of use of CHWs for Medicaid patients</p>	<p>Substantially increase use of community health workers</p> <p>www.chef.org/Portals/Summit/ChwEffectivenessAndRoleInHcReform.pdf</p> <p>see also white paper, www.chef.org/portals/0/CHW/FinalChwWhitePaper.pdf</p> <p>www.ncsl.org/pring/health/chwbrief.pdf</p>	<p>Community Health Workers effect on cost and use</p> <p>A growing body of evidence suggests that CHWs reduce healthcare costs for people with chronic illness. A Baltimore program that matched community diabetes patients achieved significant drops in ER visits and hospitalization (38% and 30% respectively) This translated into a 27% reduction in Medicaid costs for the patient group. The program achieved savings of \$80,000 to \$90,000 per year per community health worker.</p> <p>A program in Denver Health found health worker interventions decreased urgent care and inpatient and outpatient behavioral health visits. Overall, the program reduced costs by more than \$14,000 per month or \$2.28 for every \$1.00 invested.</p> <p>Significant reduction in number of claims and payments for Medicaid clients in New Mexico.</p> <p>24% annual reduction in annual Medicaid spending per participant (Arkansas, 2011)</p> <p>Reduction in ER use resulting in an ROI from 3:1 to 15:1 (Texas 2010)</p> <p>5:1 returns with CHWs coordinating care and self-management for employees with high healthcare costs (NJ and Georgia, 2011)</p>
<p>Thomson Reuters White Paper</p> <p>Save \$36 Billion in US Healthcare Spending through Transparency 2012</p>	<p>Price transparency</p> <p>http://www.hreonline.com/pdfs/06022012Extra_ThomsonReutersStudy.pdf</p>	<p>Significant savings opportunity in every market of the country based on similar observed variation in prices. Thompson Reuters models the savings of reducing prices for the targeted services that were above the median to the median price after removing high cost outliers. This reduction in price would reduce overall medical spending by 3.5%. Applied nationally to those under 65 with ESI, the savings potential is \$36 billion. More conservative models yield significant savings. Assumed An employer with 20,000 with a healthcare cost trend of 6.1 percent, and that 10% YR1, 25-50% YR2 and YR3 moved to median price providers, this employer would see savings of \$715k in YR1 and \$6.8 million by YR3.</p>
4. Primary and Secondary Prevention and Disease Mitigation & Community Action		
<p>Northern Kaiser Permanente Depression and Substance Abuse Screening, Jan 28,2010</p>	<p>Behavioral Health Screening</p>	<p>A ranking (based on clinically preventable burden and cost effectiveness) of 25 preventive services found that alcohol screening and intervention rated at the same level as colorectal cancer screening. Depression screening/intervention rated at the same level as osteoporosis screening and cholesterol screening/treatment.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>ROI: Evidence-Based Options to Improve Statewide Outcomes —April 2012 Update—WSIPP</p>	<p>Meta-analysis of ROI for improving statewide outcomes, including health Included, because ACH strategy and community prevention innovation plan includes focus On more effectively linking populations to cost effective services for prevention and mitigation of poor health outcomes.</p>	<p>Please see evidence tables for many high ROI programs that will be enabled through ACH structure www.wsipp.wa.gov/rptfiles/12-04-1201.pdf</p>
<p>Implementation of the Diabetes Prevention Program (DPP)</p>	<p>Through Governor’s Executive Order DPP will be implemented to the PEB population, SHCIP would like to recommend to be covered more broadly. http://diabetes.doh.wa.gov/DI554205PAR-DLI%20White%20Paper%203-FINAL%20CRC%20APPROVED-DIGITAL.pdf/view</p>	<p>The Diabetes Prevention Program study showed a reduction in the risk of developing type II diabetes of 58% in people at high risk for diabetes, through a lifestyle program that helped participants lose 5-7% of their body weight.</p>
<p>Investing in comprehensive tobacco cessation program</p>	<p>Through Governor's wellness Executive Order and other initiatives in communities, smoke free housing and work places, smoking cessation. http://makesmokinghistory.org/uploads/MassHealth%20ROI%20-%20PLOS%20One%20article.pdf</p>	<p>Methods: A cost-benefit analysis approach was used to estimate the program’s return on investment. Administrative data were used to compute annual cost per participant. Data from the 2002–2008 Medical Expenditure Panel Survey and from the Behavioral Risk Factor Surveillance Surveys were used to estimate the costs of hospital inpatient admissions by Medicaid smokers. These were combined with earlier estimates of the rate of reduction in cardiovascular hospital admissions attributable to the tobacco cessation program to calculate the return on investment. Findings: Administrative data indicated that program costs including pharmacotherapy, counseling and outreach costs about \$183 per program participant (2010 \$). We estimated inpatient savings per participant of \$571 (range \$549 to \$583). Every \$1 in program costs was associated with \$3.12 (range \$3.00 to \$3.25) in medical savings, for a \$2.12 (range \$2.00 to \$2.25) return on investment to the Medicaid program for every dollar spent.</p>

Intervention Name	Intervention Description and Source	Intervention Result
<p>Implementation of the “Authoritative standard for developmental screenings.”</p>	<p>DOH, DEL and OSPI recommend the implementation of “authoritative standard for developmental screenings” otherwise known as Bright Futures.</p> <p>http://www.wsipp.wa.gov/pub.asp?docid=13-01-3401r</p> <p>Bauer, J. (2013). <i>Bright Futures Guidelines and Washington State Medical Assistance Programs</i> (Document No. 13-01-3401r). Olympia: Washington State Institute for Public Policy.</p> <ul style="list-style-type: none"> • WSIPP study was inconclusive about direct and indirect costs <p>http://www.ncbi.nlm.nih.gov/pubmed/22550686</p>	<p>This study shows the burdens on families and the system for those with disabilities</p> <p>According to the studies Stabile and Allin review, negative effects on future well-being appear to be much greater, on average, for children with mental health problems than for those with physical disabilities. Stabile and Allin calculate that the direct costs to families, indirect costs through reduced family labor supply, direct costs to disabled children as they age into the labor force, and the costs of safety net programs for children with disabilities average \$30,500 a year per family with a disabled child. They note that the cost estimates on which they base their calculation vary widely depending on the methodology, jurisdiction, and data used. Because their calculations do not include all costs, notably medical costs covered through health insurance, they represent a lower bound. On that basis, Stabile and Allin argue that many expensive interventions to prevent and reduce childhood disability might well be justified by a cost-benefit calculation.</p>

Intervention Name	Intervention Description and Source	Intervention Result
Healthcare cost savings for persons with severe alcohol problems – evaluation of “housing first”	Included because ACH strategy will enable spread of similar programs in Washington state through shared savings for Medicaid populations.	<p>Context Chronically homeless individuals with severe alcohol problems often have multiple medical and psychiatric problems and use costly health and criminal justice services at high rates.</p> <p>Objective To evaluate association of a “Housing First” intervention for chronically homeless individuals with severe alcohol problems with health care use and costs.</p> <p>Design, Setting, and Participants Quasi-experimental design comparing 95 housed participants (with drinking permitted) with 39 wait-list control participants enrolled between November 2005 and March 2007 in Seattle, Washington.</p> <p>Main Outcome Measures Use and cost of services (jail bookings, days incarcerated, shelter and sobering center use, hospital-based medical services, publicly funded alcohol and drug detoxification and treatment, emergency medical services, and Medicaid-funded services) for Housing First participants relative to wait-list controls.</p> <p>Results Housing First participants had total costs of \$8 175 922 in the year prior to the study, or median costs of \$4066 per person per month (interquartile range [IQR], \$2067-\$8264). Median monthly costs decreased to \$1492 (IQR, \$337-\$5709) and \$958 (IQR, \$98-\$3200) after 6 and 12 months in housing, respectively. Poisson generalized estimating equation regressions using propensity score adjustments showed total cost rate reduction of 53% for housed participants relative to wait-list controls (rate ratio, 0.47; 95% confidence interval, 0.25-0.88) over the first 6 months. Total cost offsets for Housing First participants relative to controls averaged \$2449 per person per month after accounting for housing program costs.</p> <p>Conclusions In this population of chronically homeless individuals with high service use and costs, a Housing First program was associated with a relative decrease in costs after 6 months.</p>
Strategic Home visiting programs such as SafeCare, Triple P Parenting Program and Nurse-Family Partnerships applied	To prevent ACEs these programs should be implemented. Through universal screening the appropriate follow up would occur to place the appropriate home visiting program with the based on the needs of the family.	<p>http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf: Page 5 of WSIPP Evidence Based Options to Improve Statewide Outcomes report reviewed a number of programs and developed a system to show effectiveness and cost-benefit. Below are a series of home visiting strategies that showed to be the most successful. As noted in the column to the left, these strategies would not be applied universally, but would be applied based on need.</p> <p>http://www.wsipp.wa.gov/rptfiles/3900.SafeCare.pdf</p> <p>http://www.wsipp.wa.gov/rptfiles/3900.TripleP.pdf</p> <p>http://www.wsipp.wa.gov/rptfiles/3900.NFP.pdf</p>

Intervention Name	Intervention Description and Source	Intervention Result
Asthma home visit programs	<p>Community Health Workers are able to go into homes and assess for environmental triggers that cause Asthma.</p> <p>http://here.doh.wa.gov/materials/asthma-home-visits/13_AsthmaROI_E13L.pdf (number of studies listed in this brochure, including AHRQ's Asthma ROI calculator.</p>	<p>Within the brochure, it captures: home visits ROI ranged from \$5.30 to 14 in costs averted from every dollar spent.</p>

Intervention Name	Intervention Description and Source	Intervention Result
Investment in prevention programs using ROI based TFAH per capita investment in prevention from TFAH report	<p>Community Transformation Grants will implement effective programs targeting physical activity, healthy eating and tobacco use.</p> <p>http://healthyamericans.org/reports/prevention08/Prevention08.pdf (see page 35 for Washington table)</p>	<p>The Trust for America’s Health suggested that if we invest 10\$ per person/per year on prevention activities it will save: Total Annual Intervention Costs (at \$10 per person): \$62,060,000</p> <p>Washington Return on Investment of \$10 Per Person</p> <p>1-2 Years 5 Years 10-20 Years</p> <p>Total State Savings \$120,400,000 \$405,800,000 \$445,500,000</p> <p>State Net Savings</p> <p>(Net savings = Total savings \$58,400,000 \$343,700,000 \$383,500,000 minus intervention costs)</p> <p>ROI for State 0.94:1 5.54:1 6.18:1</p> <p><i>* In 2004 dollars</i></p> <p>Indicative Estimates of State-level Savings by Payer: Proportion of Net Savings for an Investment of \$10 Per Person</p> <p>1-2 Years 5 Years 10-20 Years</p> <p>Medicare Net Savings \$15,700,000 \$92,800,000 \$103,500,000 (proportion of net savings)</p> <p>Medicaid Net Savings (federal share) \$2,830,000 \$16,600,000 \$18,500,000 (proportion of net savings)</p> <p>Medicaid Net Savings (state share) \$2,830,000 \$16,600,000 \$18,500,000 (proportion of net savings)</p> <p>Private Payer and Out of Pocket Net \$36,900,000 \$217,500,000 \$242,700,000 Savings (proportion of net savings)</p> <p><i>* In 2004 dollars</i></p> <p><i>* Source: TFAH calculations from preliminary Urban Institute estimates, based on national parameters applied</i></p>

¹ Martin, Lindsay and Peter Brown. "90-Day Project Final Summary Report: Integrating Primary Care and Behavioral Health Care." Institute for Healthcare Improvement. October 2008.



■ Appendix K

Financial Analysis of Washington State Health Care Innovation Plan

Prepared by Mercer
For the Washington State Health Care Authority
December 9, 2013



**FINANCIAL ANALYSIS OF WASHINGTON
STATE HEALTH CARE INNOVATION PLAN
WASHINGTON STATE HEALTH CARE
AUTHORITY
DECEMBER 9, 2013**

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1

Introduction

Mercer Health & Benefits (“Mercer”) was engaged to assist the Washington State Health Care Authority (“HCA”) with a financial evaluation of their proposed State Health Care Innovation Plan (“SHCIP”). The purpose of this document is to describe the approach deployed in our analysis including the data, assumptions, basis for assumptions, and methodologies we employ as well as to present a summary of our findings.

The populations addressed by our work include State Medicaid Beneficiaries, members of the Public Employee Benefit program (PEB), commercially insured state residents, and Medicare beneficiaries. For each population we address

- the population’s projected total medical and other services costs absent the SHCIP
- anticipated cost savings resulting from specified outcomes anticipated as a result of the SHCIP interventions

Estimates of the cost necessary to implement the plan are considered in total (not specific to population segments) and compared to total estimated savings across all population segments in order to provide estimates of potential return on investment over the first three years of the project period. Implementation costs were developed by the HCA, and represent only the initial funds required to implement the SHCIP. We have not considered on-going costs related to the administration and maintenance of the plan.

We also provide an appendix containing references to published studies, prior experience studies, and other sources of information relied upon in developing the estimates presented in this report.

2

Analytic Approach

The SHCIP envisions many far reaching and crosscutting changes to the ways in which the State organizes and purchases health care and how providers are reimbursed under State-purchased health benefit programs. By acting as a first-mover, it is further anticipated that many interventions first deployed by the State will subsequently be adopted by other purchasers and payors or indirectly affect care delivery for all participants in Washington's health care system – and thus result in additional savings from commercial and Medicare programs. Because of the lack of detailed tactics proposed in the SHCIP, we are unable to assign specific savings to individual components of the plan. Rather, we have considered the plan as a whole to be the required supporting infrastructure needed in order to achieve the specific objectives described. A subset of the expected outcomes described by the plan which are quantifiable, have direct impact on medical expenditures, and are amenable to actuarial methods are addressed in our analysis. While this approach explicitly does not attempt to quantify all the potential financial outcomes resulting from the plan's implementation, it does serve to provide a robust demonstration of the plan's ability to generate a positive return on investment.

Although the project time horizon is composed of a 5- five year period, our analysis is performed entirely in 2015 dollars. Our intent is to avoid the compounding influence of trend which may serve to distort impacts over time. In other words, our savings estimates are made relative to a “zero-trend” environment. As this environment is unlikely absent significant intervention, our opinion is that the approach will result in conservatively low estimates of savings from the plan. In addition, we have limited our analysis to annual estimates of savings for the first three years of implementation.

Unlike many actuarial projects, these estimates are a combination of meta-analysis of other studies and implementations, reliance on actuarial experience and judgment, high level estimation methods, and an understanding of the Washington health insurance markets developed over many years. We have not used or created detailed models, simulations, or micro-simulations for this work – as the interventions described are broad themes not suited to such analyses. As such, it is the development of an actuarial opinion – and in developing that opinion we attempted to capture both the potential savings from the interventions envisioned, and the difficulties in capturing those savings. We attempted to develop real-world, and somewhat conservative estimates of the return on investment for the plan. There are several reasons conservatism should be employed in this analysis, including execution risk; competing initiatives at federal, state, local, and provider levels; perceived level of industry and political support; and difficulties associated with shepherding multiple, significant and fundamental changes concurrently.

3

Direct Impacts on Health Care Costs

As discussed above, our financial analysis focuses on certain specific objectives of the plan that can reasonably be expected to have direct and meaningful impact on the cost of health care in Washington State. The range of outcomes included in our analysis is summarized below.

Ultimate Savings Estimates (3+ Years Out)								
	Medicaid		PEB		Commercial		Medicare	
	Range	Point Estimate	Range	Point Estimate	Range	Point Estimate	Range	Point Estimate
Chronic								
Physical/Behavioral Health Integration	1%–5%	2.5%	0%–2%	0.5%	0%–2%	0.1%	0%–1%	0%
Other Chronic Management	0%–3%	1%	0%–4%	1%	0%–4%	0.2%	0%–4%	0.1%
Acute								
Transparency/ Payment Reform	0%–4%	0.45%	0%–4%	0.9%	0%–4%	0.18%	0%–4%	0.09%
Preventive								
Obesity Reduction/ Other Prevention	0%–2%	0.37%	0%–2%	0.25%	0%–2%	0.05%	0%–2%	0.03%
Maternity								
Reduction in Elective C-Sections (37 – 39 weeks)	0%–0.05%	0%	0%–0.1%	0.03%	0%–0.1%	0.01%	0%	0%

Ranges for Medicaid and PEB savings were developed from relevant studies of experience from similar interventions in other geographies. Commercial and Medicare ranges represent the potential for “spill-over” effects resulting from the State acting as a first mover in the marketplace. In general, we anticipate that 10% to 20% of the expected impact on Medicaid/PEBB could be achieved by Commercial and Medicare programs once the market changes envisioned by the SHCIP are fully implemented and operational.

4

Supporting Infrastructure from the SHCIP Assumed as a Prerequisite for Savings

Because of the nature of fundamental structural changes envisioned by the SHCIP, we do not attempt to quantify savings from individual components of the plan. Our focus is instead on specific outcomes anticipated through the successful implementation of the plan.

In order to achieve the savings we estimate in direct health care costs, we assume the SHCIP will be successfully implemented in a manner consistent with its description in the plan. For example, concepts such as Value Based Contracting, Value Based Benefits, Accountable Communities of Health, Bi-directional integration of medical and behavioral health services, etc. are viewed as required infrastructure for achieving real savings in acute and chronic illness, and in preventing costs related to obesity, excess maternity costs, etc.

While the plan as a whole is considered a prerequisite to our estimates, there are particular components which are critical in nature. These are summarized below.

- Value Based Contracting: We tacitly assume the amount of State-purchased health care funded through value based reimbursement methods will meet or exceed the targets set forth in the SHCIP. We further expect that any such contracts will include aggressive cost and quality targets, which, if met will provide reasonable assurance that the stated specific objectives will be met. In particular
 - Shared savings arrangements are robust enough in nature to ensure realized gains by the payor, and include some provision for provider down-side risk in case performance objectives are not met
 - Any direct patient management expenditures are structured in a way to ensure value for money, and are of a magnitude that can reasonably be expected to provide positive return on investment assuming appropriate performance of the services
- Value Based Benefits: Where applicable (for example, PEB), we assume the structure of benefit programs will include strong incentives for the use of lower cost and higher quality/value providers and services. These may include, but are not limited to
 - Payroll contribution and benefit structures encouraging the use of narrowed networks consisting of demonstratively higher value providers
 - The use of referenced based pricing (calibrated for savings) for appropriate discrete services with high unit price variation
 - High quality decision support aids and programs for patients with diagnoses related to preference sensitive procedures

- **Accountable Risk Bearing Entities (ARBES):** Achieving the level of savings included in our estimates (particularly for Medicaid) will require the HCA is successful in identifying and contracting with one or more ARBEs in each geography that is willing and able to accept the risk and accountability described in the SHCIP. We anticipate these organizations will either successfully deliver the outcomes prescribed by the plan, or be financially responsible for the implications of falling short of performance targets.
- **Accountable Communities of Health (ACHs):** Achieving the level of savings included in our estimates (particularly for Medicaid) will require organized, well-functioning ACHs in each geography. The SHCIP envisions these organizations as an important enabler of care delivery at the local level. We also assume (and encourage) the development of the evaluation and measurement metrics early in the process – both for the intended purpose of measuring results – but also to help discover and prioritize the most promising interventions and to provide the transparency which will tend to drive the market to more efficient positions.
- **Transparency:** In our view, one of the most important dimensions of this work lies in the ability to understand and communicate regarding it. High quality data supporting clearly articulated measurements against meaningful benchmarks will allow for the calculation of return on investment for SHCIP. More importantly, success in this area creates implicit incentives for efficiency, cost savings, and broad improvement in the health of Washington residents.

5

Potential Sources of Savings not Addressed

As discussed earlier in the document, we have not attempted to address every potential source of savings that may result from the successful implementation of the SHCIP. In particular, we made no effort to quantify savings from programs outside the realm of health care. The authors of the SHCIP anticipate other potential benefits, which while we acknowledge their potential, we did not attempt to quantify collateral benefits such as:

- Reduced State administrative expense through the restructuring, and reorganizing of the agencies tasked with administering the Medicaid and PEB programs
- A variety of reductions in social service expenditures resulting from more effective integration of physical and behavioral health treatment
 - Juvenile and adult detention
 - Housing aid
- Decreased leave and disability costs and increased productivity from Public and Private employees resulting from improved health status

6

Summary of Results

Baseline enrollment and PMPM cost data was provided by the HCA, and are discussed in detail in the Financial Analysis section of the HCA's report. Mercer reviewed these estimates for reasonableness, but has not independently verified their accuracy.

- Medicaid: PMPM values based on FY2010 data, assuming maintenance of 0% cost trends through FY2015. Enrollment figures include state estimates of the impact of Medicaid expansion in 2014
- PEB: Enrollment and PMPM values based on internal HCA projections of the FY14/FY15 biennium
- Commercial: PMPM values based on 2012 Medical Expenditure Panel Survey (MEPS) trended to 2015 at 5% per year. Enrollment based on OIC estimates for 2012, with adjustment for enrollees of the State Exchange
- Medicare: Enrollment and PMPM values based on HCA analysis of data from the Kaiser Family Foundation, and general CMS trends (from CMS' Research Statistics Data and Systems)

After reviewing the SHCIP, comparing and contrasting its features with other similar projects, assuming success – but applying conservative assumptions as described above, and synthesizing this information at the level it currently exists, we project savings and return on investment shown in the table on the following page.

	Medicaid	PEB	Commercial	Medicare	Total
Baseline Data	FY2015	FY2015	CY2015	CY2015	
Size of Population	1,445,944	357,070	2,803,245	1,182,150	5,788,409
Annual Cost of Care (all funding sources)	\$7,680 M	\$2,089 M	\$17,407 M	\$13,410 M	\$40,585 M
PMPM	\$443	\$488	\$517	\$945	\$584
Estimated Savings Percentages					
Year 1	0.6%	0.4%	0.0%	0.0%	
Year 2	1.4%	0.9%	0.1%	0.1%	
Year 3+	4.3%	2.7%	0.5%	0.2%	
Annual Savings					
Year 1	\$50 M	\$8 M	\$5 M	\$1 M	\$64 M
Year 2	\$110 M	\$19 M	\$23 M	\$7 M	\$160 M
Year 3+	\$332 M	\$56 M	\$93 M	\$29 M	\$510 M
			Grand Total Savings		\$734 M
			Estimated Investment		\$51 M
			Return on Investment (\$)		\$683 M
			Gross Return on Investment		14.4 : 1
			Net Return on Investment		13.4 : 1

Even with conservative assumptions, we project a significant return on investment from this effort. It is clear that a sizable gap exists between current care organization and delivery and today’s definitions of “best practice”, and recouping even a fraction of the potential savings system-wide more than offsets the investment costs envisioned in this report. We encourage the HCA to continue refining the approach, adding structure and detail to the interventions, and putting these into an overarching and flexible implementation plan.

7

Important Notices

Mercer has prepared this report exclusively for the HCA; subject to this limitation, the HCA may direct that this report be provided to other interested parties in connection with the review and evaluation of the HCA's SHCIP. Mercer is not responsible for use of this report by any other party.

The only purpose of this report is to present Mercer's actuarial opinion of potential savings from the specific outcomes of the SHCIP discussed in the section of this report titled "Direct Impacts on Health Care Costs".

This report may not be used for any other purpose. Mercer is not responsible for the consequences of any unauthorized use. Its content may not be modified, incorporated into or used in other material, sold or otherwise provided, in whole or in part, to any other person or entity, without Mercer's permission.

All parts of this report, including any documents incorporated by reference, are integral to understanding and explaining its contents, no part may be taken out of context, used or relied upon without reference to the report as a whole.

To prepare this report Mercer has used and relied on baseline cost and enrollment data as summarized in the "Summary Results" section of the report. This information was provided by the HCA and we relied on it to provide an accurate description of the programs considered by this report. Although Mercer has reviewed the data in accordance with Actuarial Standards of Practice No. 23, Mercer has not verified or audited any of the data or information provided. The savings estimates used in our calculation of return on investment assume the successful implementation of the SHCIP as described in the innovation plan, and that the specific goals and objectives of the plan are realized as described within the timeframe of our analysis. We make no representation as to the likelihood of a successful implementation; however we have used conservative estimates in part to account for implementation risk. The merits of the plan and potential for its successful implementation and sustainability should be judged based solely on the contents of the HCA's SHCIP documents.

The "investment" included in our return on investment estimate includes only the HCA estimate of the amount of direct investment required to implement the plan. We have made no attempt to quantify other expenses that may arise from the operation of the plan.

Because modeling all aspects of a situation is not possible or practical, we may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events

in an efficient and cost-effective manner. We may also exclude factors or data that, if used, in our judgment, would not have significantly affected our results. Use of such simplifying techniques does not, in our judgment, affect the reasonableness of the estimates.

Different assumptions or scenarios within the range of possibilities may also be reasonable and results based on those assumptions would be different. As a result of the uncertainty inherent in a forward looking projection over a very long period of time, no one projection is uniquely “correct” and many alternative projections of the future could also be regarded as reasonable. Two different actuaries could, quite reasonably, arrive at different results based on the same data and different views of the future. A “sensitivity analysis” shows the degree to which results would be different if you substitute alternative assumptions within the range of possibilities for those utilized in this report. We have not been engaged to perform such a sensitivity analysis and thus the results of such an analysis are not included in this report.

This report was prepared in accordance with generally accepted actuarial principles and procedures. Based on the information provided to us, we believe that the actuarial assumptions are reasonable for the purposes described in this report.

8

Sources and Citations

See Appendix I to the HCA report for a matrix detailing case studies and references considered in developing this report.



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**Washington State
Health Care Innovation Plan**

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