Making the Case for Prevention:

Why Washington's Accountable Communities of Health Should Pursue Domain 3D Chronic Disease Prevention Projects

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INTRODUCTION

Under Washington State's Medicaid Transformation demonstration, Accountable Communities of Health (ACHs) are collaborating on the implementation of regional transformation projects to address local health priorities, transform the Medicaid delivery system, improve population health, and reduce health disparities.[1,2] Washington is using Delivery System Reform Incentive Payment (DSRIP) funding to support the transformation projects and reimburse participating providers and partners for achieving milestones and outcomes. Each of the state's nine ACHs must develop a Medicaid transformation project plan articulating how it plans to implement evidence-based strategies within three domains: (1) Health Systems and Community Capacity Building; (2) Care Delivery Redesign; and (3) Prevention and Health Promotion.

This resource makes the case for why states should invest in chronic disease prevention and, using Washington as an example, outlines the rationale for why ACHs should pursue Medicaid transformation projects related to prevention and health promotion. It also describes the financial opportunities for ACHs related to Domain 3D projects and available mechanisms, such as population health metrics, managed care organization (MCO) contracting, and the state's Plan for Improving Population Health (P4IPH), that will support ACHs as they work toward Healthier Washington's value-driven goals.

- **Domain 1:** Health Systems and Community Capacity Building. Must implement strategies across three focus areas: (1) Financial Sustainability through Value-Based Payment (VBP); (2) Workforce; and (3) Systems for Population Health Management.
- **Domain 2:** Care Delivery Redesign. Must implement one required project (Directional Integration of Care and Primary Care Transformation) and one optional project from one of three categories: (1) Project 2B-Community-Based Care Coordination; (2) Project 2C-Transitional Care; or (3) Project 2D-Diversion Interventions.
- **Domain 3:** Prevention and Health Promotion. Must implement one required project (Addressing the Opioid Use Public Health Crisis) and one optional project from one of three categories: (1) Project 3B-Maternal and Child Health; (2) Project 3C-Access to Oral Health Services; and (3) Project 3D-Chronic Disease Prevention and Control.

This document is divided into two sections: (1) the national case for investing in the prevention of chronic disease; and (2) a deep dive in Washington to show the financial benefits of choosing to focus on Domain 3D projects as well as how these projects align well with other components of Healthier Washington. The first section discusses general and disease-specific data on primary and secondary prevention strategies related to diabetes, asthma, obesity and heart disease (particularly those taking place outside of clinical settings), as well as uses the Chronic Care Model. The second section describes the financial opportunities for ACHs that choose Domain 3D projects as well as the mechanisms to support ACHs in working toward Healthier Washington's value-driven goals: (1) population health metrics under the Statewide Common Measure Set; (2) managed care organization (MCO) contracting; and (3) the state's Plan for Improving Population Health (P4IPH).

Nemours Children's Health System was awarded a one-year grant to help three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth's Payment Reform for Population Health initiative, with funding from the Robert Wood Johnson Foundation. While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states – Maryland, Oregon and Washington – as they developed or implemented upstream prevention strategies using Medicaid funds. This brief is one in a series of six "how to" briefs illustrating how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at **https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention**. To learn more about AcademyHealth's Payment Reform for Population Health initiative, visit **www.academyhealth.org/p4ph**.

THE NATIONAL CASE FOR INVESTING IN PREVENTION

The Burden of Chronic Disease

Chronic diseases are the leading cause of poor health, disability and death in the U.S., as well as the greatest contributor to overall health care expenditures.[3] In 2010, 86 percent of all health care spending in the U.S. was linked to people with one or more chronic conditions.[4] Over half of adults in the U.S. have at least one chronic health condition and 26 percent have two or more.[5] These rates are even higher for individuals enrolled in Medicaid. According to the Gallup-Sharecare Well-Being Index, adult Medicaid beneficiaries are significantly more likely than individuals with employer-sponsored insurance (ESI) or those who are uninsured to report suffering from a chronic health condition: 16 percent of Medicaid beneficiaries over age 18 have asthma (compared to six percent with ESI); 15 percent have diabetes (compared to eight percent with ESI); 24 percent have high blood pressure (compared to 20 percent with ESI); and 34 percent are obese (compared to 27 percent with ESI).[6]

National Investment in Prevention

Despite the enormous health and cost burdens posed by preventable chronic health conditions like type 2 diabetes, heart disease and obesity, the U.S. invests very little in prevention when compared to other types of health care expenditures. Of the more than $3 trillion (and rising) spent nationally on health care each year, less than four cents per dollar is dedicated to prevention and public health.[7,8] Numerous reasons exist for why U.S. policymakers may be reluctant to invest in prevention programs, despite the obvious benefits of preventing a disease from developing rather than treating its costly and harmful downstream effects. For example:

- The costs of prevention programs are immediate, but the benefits are often deferred to the future (and sometimes far into the future).
- The target population can be difficult to identify. While it is clear which individuals need treatment because they are sick, it is not always clear which individuals are most at risk of illness or will ultimately avoid illness because of preventive measures.
- Chronic diseases are often caused by multiple and interrelated factors, such as personal behaviors, social circumstances and environmental factors, so pinpointing which factors to address can be challenging.

The Case for Investing in Prevention

1. Reducing the prevalence of chronic diseases lowers health care expenditure

Evidence-based prevention interventions – particularly those aimed at reducing the likelihood of a chronic disease developing or progressing (i.e., primary and secondary prevention programs; see "Three Types of Prevention" sidebar for more information) – have the potential to reduce long-term health expenditures, as individuals with a chronic disease are much costlier to treat than those without the disease. A 2013 Centers for Disease Control and Prevention (CDC) report found that the average health expenditures for adults without multiple chronic conditions was $2,367 in 2009, compared with $8,478 for adults treated for two to three chronic conditions and $16,257 among those treated for four or more chronic conditions.[9] Much of the cost increase is related to an increase in hospitalizations and emergency department (ED) visits. These trends can also be seen in the Medicaid population specifically. In 2009, Medicaid programs spent $13,490 per capita for nonelderly adult Medicaid enrollees with diabetes, compared to about $5,130 for Medicaid enrollees without diabetes.[10] A study by the Milken Institute found that investing in the prevention and treatment of common chronic diseases could decrease treatment costs by $218 billion annually in the U.S., and reduce the economic impact of disease by $1.1 trillion each year.[11]

Three Types of Prevention

Primary prevention: Broadly based interventions that promote healthy environments and behaviors before the onset of symptoms, thereby reducing the likelihood of developing disease.
Secondary prevention (risk management): Measures to quickly detect and intervene when risk factors or early symptoms are identified, thereby minimizing the potential for disease onset or progression.
Tertiary prevention (disease management): Treatment to reduce an existing disease's severity or impact.

2. Specific prevention programs are cost-effective, but not always cost-saving – though still beneficial on multiple fronts

Evidence-based prevention and public health interventions that target chronic diseases can lead to a healthier population with reduced health care utilization, result in less school and workplace absenteeism, increase economic productivity, and improve individuals' quality of life.

However, prevention programs come at a cost, which needs to be considered when deciding which programs to invest in. Some prevention interventions are cost-saving, meaning that they decrease total per person or societal health care costs even after accounting for upfront investments. Other interventions are cost-effective, meaning they do not save money overall, but their benefits are sufficiently large compared to the costs to justify the investment.[12] An often-used threshold for cost-effectiveness in the U.S. is $50,000 or $100,000 per quality-adjusted life year (QALY), a generic measure of disease burden that accounts for both the quality and the quantity of life lived.

Prevention interventions that involve direct medical care or pharmaceuticals to treat existing disease (known as tertiary prevention) are often costlier than primary and secondary prevention measures. Secondary prevention programs that specifically target high-risk populations are more likely to be cost-effective or cost-saving than those that target broader populations. Overall, clinical prevention programs are much more likely to be cost-effective than cost-saving: a 2006 analysis of 25 preventive clinical services found only five were cost saving – though most of the others were cost-effective.[13]

Overall, many prevention programs have simply not been implemented on a large enough scale to conclude whether they would be cost-effective or cost-saving if implemented more broadly. Furthermore, the health, financial and societal impacts of certain prevention programs – particularly community-based and upstream interventions – are much harder to accurately quantify in a traditional assessment or evaluation (and are much more likely to be understated) than the impacts of targeted clinical interventions aimed at treating disease. Non-clinical prevention programs are likely to have more positive societal impacts (especially in the longer-term) than targeted evaluations give them credit for, given that:

- Results are often based on the effect of a prevention measure on a single health condition, but prevention interventions may impact multiple, related health conditions (e.g., measures to reduce obesity may also prevent the onset of type 2 diabetes).
- Prevention initiatives can have ripple effects in sectors outside of health care, such as reducing workers' compensation payments and disability claims, and boosting worker productivity. Reducing the incidence of disease also contributes to a better quality of life. All told, the "social costs of illness" have been estimated to be two to three times the medical costs.
- Savings from prevention continue to accumulate if individuals remain disease-free.

The above items point to other benefits of prevention, which often affect more than one health condition, reduce costs in other sectors, and result in longer-term savings.

3. Financial and Health Impacts of Investing in Primary Prevention Programs

A 2008 Trust for America's Health brief suggested that investing $10 per person per year in community-based disease prevention programs to increase physical activity, improve nutrition and prevent smoking could save the country more than $16 billion annually within five years. Under this scenario, Washington State would see $343 million in annual savings, a return on investment of 5.5 to 1.[14] Below are cost estimates and potential health benefits associated with primary prevention strategies for specific chronic diseases prioritized in Domain 3D projects:

Asthma. Potential primary prevention strategies to reduce the likelihood of developing asthma include: breastfeeding, siting schools away from environmental triggers, addressing potential triggers at schools, and restricting pesticide use near parks and playgrounds. However, few if any studies can quantify the potential effect of primary prevention strategies on preventing the onset or development of childhood asthma, in part because asthma is often the result of complicated interactions between genetic and environmental factors. Studies do, however, show a reduction in ED visits and hospital readmissions associated with programs to control asthma (noted in the next section on secondary prevention).[15]

Obesity Prevention. Primary prevention programs targeting obesity center on the promotion of healthy lifestyle behaviors like maintaining a normal weight, eating a nutritious diet, and partaking in regular physical activity. School-based programs to increase physical activity are one example of an evidence-based primary prevention intervention to reduce the likelihood of individuals becoming obese. Reviews of school-based physical activity programs found that these programs are associated with positive effects on body mass index (BMI)[16] and obesity prevention.[17] A 2015 study by the Washington State Institute for Public Policy found that elementary or middle school programs that added additional physical activity to the school day for students could result in a benefit to cost ratio of approximately $33:1 over time.[18]

A review of the financial return of worksite health promotion programs aimed at improving nutrition or increasing physical activity found positive impacts among the 13 non-randomized studies included in the review (though not in the randomized control trials included in the review, perhaps because most were conducted outside the U.S. and did not adjust for differences in medical costs between countries).[19] Many broad-based strategies also exist to prevent obesity through environmental changes that support physical activity, such as better access to parks, sidewalks, leisure activities and healthy foods. One community-based intervention that created an environment to better support a more active lifestyle (bike paths, extended fitness facility hours, accessible fitness center, cycling clubs, marked running courses and organized athletic events) had an estimated ratio of cost to QALYs gained of $28,548, which is considered cost-effective.[20]

Health Impact in 5 Years

A helpful resource for choosing and assessing community-based primary prevention programs (as well as more general interventions to address the social determinants of health) is the CDC's HI-5 Initiative (i.e., Health Impact in 5 Years), which provides a menu of community-wide approaches aimed at improving population health. All HI-5 interventions have evidence reporting: (1) positive health impacts; (2) results within five years; and (3) cost-effectiveness and/or cost-savings over the lifetime of the population or earlier. The obesity sub-section above notes primary prevention strategies included in the HI-5 menu: school-based programs to increase physical activity and worksite obesity.

Diabetes. While few studies have been able to directly link primary prevention strategies to a reduction in the incidence of prediabetes or diabetes, the Prevention Institute estimates that primary prevention strategies would reduce the rate at which the rates at which people without diabetes develop prediabetes, and people with prediabetes develop diabetes, by 10 percent, saving over $6,000 per person per year (in 2007 dollars) in related health care costs.[21] To a large extent, lifestyle factors such as obesity and sedentary living increase the risk of developing type 2 diabetes, so primary prevention programs focused on healthy eating and active lifestyles will help prevent the development of risk factors for diabetes.

Heart Disease. Primary prevention strategies to reduce the onset and prevalence of heart disease include: decreasing the amount of sodium and trans fat in the food supply; enhancing access to affordable fruits and vegetables; promoting opportunities for safe physical activity; and decreasing exposure to secondhand smoke in public places, work sites and housing. A 2011 *British Medical Journal* article found that any program that produced a modest population-wide reduction in any major cardiovascular risk factor would produce net cost-savings. More specifically, it found that reducing the rate of cardiovascular events in the population of England and Wales by just one percent over 10 years would prevent approximately 25,000 new cases of cardiovascular disease and 3,500 deaths, generating savings of approximately $48 million per year, compared with no additional intervention.[22] If these numbers were applied to the U.S., more than 155,000 new cases of cardiovascular disease would be prevented at a savings of almost $300 million per year.

4. Positive Financial and Health Impacts of Investing in Secondary Prevention Programs

Below are examples of effective secondary prevention programs to prevent the onset or exacerbation of chronic diseases in high-risk individuals, including through the Chronic Care Model. A valuable resource for identifying and implementing evidence-based prevention strategies is the CDC's 6|18 Initiative, which includes a menu of interventions to address six high-burden, preventable health conditions. Each intervention has been shown to both improve health and help control costs in less than five years.[23] Some of the secondary prevention strategies suggested below for asthma (patient self-management education and home visiting by licensed professionals or lay heath workers), diabetes (the National Diabetes Prevention Program), and heart disease (promoting a team-based approach to hypertension control) are 6|18 interventions.

The Chronic Care Model. ACHs implementing a Domain 3D project must use the Chronic Care Model (CCM), a framework for improving chronic disease care at the community, organization, practice and patient levels to improve health, enhance provider satisfaction and save money. CCM encourages the combining of a variety of different strategies to support more productive interactions between patients, providers and systems.[24] Overall, the CCM has been shown to improve health outcomes for individuals with chronic disease, though the effectiveness of the CCM depends on a variety of factors, including how many elements of the model are implemented and which populations are targeted. Overall, several meta-analyses have shown that chronic disease prevention programs that incorporate CCM elements improve both processes of care and clinical outcomes.[25,26,27] The most robust data are around using CCM elements to treat patients with type 2 diabetes, with most studies finding CCM approaches effective in managing diabetes in primary care settings.[28,29]

Evidence on the cost-effectiveness of the CCM is just beginning to emerge. Studies to date have noted that implementing the CCM generally results in short-term costs to provider practices ranging from $6 to $22 per patient in the first year, but can also lead to a reduction in the risk of blindness, end-stage renal disease and coronary heart disease in the longer-term. This increase in QALYs has obvious benefits from a societal perspective; more analysis is needed to determine if the CCM might result in cost-savings long-term.[30]

Asthma. Disease and risk management activities for controlling asthma include intensive indoor environmental control, patient self-management education, and home visiting by licensed professionals or lay heath workers. These programs have been shown to be cost-effective, with many producing a positive return on investment (ROI) – particularly because they are often able to help prevent asthma-related hospitalizations (99 percent of which are preventable)

and emergency department visits (95 percent of which are preventable).[31] For example, an independent evaluation of a pediatric asthma control program in Delaware showed a $500/child per quarter reduction in health care costs compared to the control group. The costs of ED and hospital visits went down and more than offset the increased outpatient costs.[32] A community-based pediatric asthma program providing case management and home visits for children resulted in significant decreases in the number of children with any asthma-related hospitalizations or ED visits, and an ROI of 1.90 (meaning for every dollar invested, $1.90 is saved or returned).[33] Another pediatric asthma reduction program featuring nurse case management and home visits significantly reduced asthma hospitalizations and ED visits and had an ROI of 1.46.[34]

Obesity. More than 10 percent of all health care costs are directly attributable to obesity, while up to 25 percent are related to obesity-related conditions, such as diabetes and coronary heart disease. Per capita spending for individuals with obesity are estimated to be 42 percent higher compared to normal weight individuals, or $1,427 annually.[35,36] Secondary prevention strategies for obesity focus on individuals who are already overweight or at risk for obesity. For example, obesity screening by health care providers — in which clinicians offer or refer patients with a BMI of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions — is recommended by the U.S. Preventive Services Task Force and could yield as much as $44 billion in long-term federal savings.[37]

Studies on the effectiveness of worksite obesity control programs found that programs were consistently associated with reductions in weight, percentage of body fat and BMI.[38,39] One study that assessed the ROI to employers for workplace obesity interventions found that a five percent weight loss among overweight and obese employees would result in an average per person reduction of $90 due to reductions in medical and absenteeism costs.[40]

Diabetes. Structured lifestyle change programs such as the National Diabetes Prevention Program (DPP) – aiming to foster healthier lifestyles and weight loss through improved diet and exercise – have been shown to positively influence health outcomes for individuals with diabetes or at risk of developing diabetes. Intensive interventions with individuals identified as having prediabetes or who have been diagnosed with diabetes show that diabetes can be reduced by 31 to 58 percent over four to six years.[41] A systematic review of combined diet and physical activity promotion programs found that for people at increased risk of type 2 diabetes, the proportion who developed the disease decreased by a median of 11 percentage points.[42] A Washington State Institute for Public Policy review of lifestyle programs to prevent the onset of diabetes (including the Diabetes Prevention Program) found that, on average, lifestyle interventions have significant beneficial effects on diabetes incidence, weight loss, blood glucose levels and certain cardiovascular risk factors.[43] Most lifestyle-focused diabetes prevention programs are identified as cost-effective, with a median cost per quality-adjusted life year of $13,761/QALY (with group-based programs yielding a median $1,819/QALY, and individual-based programs yielding a median $15,846/QALY).[44]

Compelling evidence from the first randomized control trial comparing lifestyle and pharmacologic interventions under the Diabetes Prevention Program to placebo found that weight loss was the predominant predictor of reduced diabetes incidence, with a 16 percent reduction in risk per one kilogram of weight lost.[45] In addition, those who achieved exercise goals, but not weight loss goals, also experienced some reduction in diabetes risk (44 percent). Evaluations of the DPP have also demonstrated its cost-effectiveness.[46]

Heart Disease. Strong evidence exists for the effectiveness of interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for heart disease. A review concluded that team-based care increased the proportion of people with controlled blood pressure and reduced systolic and diastolic blood pressure, especially when pharmacists and nurses were part of the team. Cost estimates from 31 studies of team-based care models to reduce heart disease found that most were cost-effective. [47]

THE BUSINESS CASE FOR WASHINGTON'S ACHs TO IMPLEMENT 3D PROJECTS

In the previous section, strong national evidence is presented to make the case that reducing the prevalence of chronic disease lowers health care expenditures and has numerous benefits, including a healthier population. The previous section also shows the positive financial and health benefits of investing in primary and secondary prevention strategies for four specific chronic diseases – asthma, obesity, diabetes and heart disease. These chronic diseases are prioritized in Washington's Domain 3D projects. The next section uses Washington State as an example to demonstrate a rationale for investing in chronic disease prevention and the financial opportunities for ACHs that choose these projects given the enabling structures in the state.

One of the core aims of Healthier Washington is to transform the health care delivery system to pay for outcomes rather than volume of services, with the state seeking to shift 90 percent of state-financed health services to value-based payment by 2021. The shift toward value and outcomes means health system partners — MCOs, ACHs, social service providers — must target their care delivery approaches to address whole-person needs, focusing more on prevention and less on incident-based treatment. To that end, ACHs will want to consider upstream health promotion and disease prevention interventions that keep populations healthy and engaged in their health care, and ultimately reduce health care expenditures.

While ACHs are not risk-bearing entities like their MCO partners, they have planning and decision-making authority on projects, and are the mechanism by which incentives are dispersed for meeting agreed upon quality improvement and Value Based Purchasing targets under DSRIP. A focus on Domain 3D projects creates an opportunity for ACHs and their partnering MCOs to work toward state-defined population health improvement goals and, in the process, reap financial benefits. The economic rewards of 3D projects can be generated in two ways: (1) ACHs and their project partners will be eligible to earn DSRIP Incentive Payments based on 3D milestone achievements and performance; and (2) savings achieved by MCOs through improved well-being of Medicaid beneficiaries. While funds from the first stream will flow directly to the ACH, the ACH will need to partner directly with the MCOs and come to agreement on how cost savings might be shared between the two entities.

To maximize the financial opportunities, ACHs can tap into existing "enabling" structures within the state that are supporting the vision of Healthier Washington. These levers include: (1) the Statewide Common Measure Set, which is the basis for quality reporting and MCO incentive payments; (2) MCO resources and contracting requirements, which will help define and advance population health improvement goals; and (3) the statewide vision for health promotion and disease prevention, as outlined under the Plan for Improving Population Health (P4IPH). Below is a description of the financial incentives that ACHs can realize through the implementation of Domain 3D projects, along with the enabling mechanisms that will help ACHs achieve positive financial and health outcomes.

Financial Incentives for Investing in 3D Projects

Delivery System Reform Incentive Payments (DSRIP)

ACHs and their participating providers will receive funding under DSRIP for achieving desired project outcomes throughout the course of the demonstration. In Year 1 of DSRIP, pay-for-reporting (P4R) financial incentives are in place for ACHs to meet project milestones related to project planning, implementation and scaling. Starting in Year 3, pay-for-performance (P4P) standards will be phased in, holding ACHs accountable for improvements in health outcomes.

Incentive payment rates are associated with ACH project weights, which are based on key factors including: (1) alignment with the Statewide Common Measure Set; (2) the potential to address population health needs; (3) the potential to generate cost savings; and (4) the evidence base for effectiveness. At eight percent, Project 3D has the largest project weight of Domain 3. 3D projects have the potential to: (1) touch a large percentage of the Medicaid population, especially if they include multiple chronic diseases; and (2) produce positive health and cost outcomes by incorporating evidence-based models, such as one of the CDC 6|18 or HI-5 interventions that improve health and control costs in five years or less, or the Chronic Care Model.

To qualify for incentive payments, ACH performance will be assessed using a gap-to-goal methodology, with a targeted yearly reduction of 10 percent from a baseline measure. Incentive payments will be earned based on performance against reporting and/or performance measures for specific projects. The Medicaid Transformation Project Toolkit[48] includes specific measures tied to each of the project domains, with Domain 3D metrics covering: well-child visits through age six; medication management for individuals with asthma; and comprehensive diabetes screening. Remaining project incentive funds (those not earned by an ACH on a given project) will be redirected to the Reinvestment Pool, which can be earned by any ACH with exceptional performance on yet-to-be-determined statewide quality measures.

This general payment structure provides an incentive for ACHs to effect change both at the systems level and individual level to ensure the maximum project incentive payments are earned and to potentially accrue additional revenue through the Reinvestment Pool. Moreover, the funds flow option – from ACHs to MCOs and other partners— will foster collaboration among project partners to strategize on ways to maximize performance on project metrics, thereby making ACH partners eligible for enhanced earnings.

Cost Savings from Prevention

Under DSRIP, any savings achieved through health promotion and prevention projects (or any of the Medicaid transformation projects) can be repurposed to reward ACH project partners and MCOs, or be reinvested in other regional transformation projects. To that end, health system stakeholders will want to pursue health promotion and disease prevention interventions that work to keep populations healthy and engaged in their health care, and ultimately reduce health care expenditures. While savings achieved from secondary prevention efforts will first accrue to MCOs, ACHs will want to work closely with the partner MCOs to identify and measure associated cost savings from 3D projects, as well as identify financial arrangements that will reward ACHs for helping the MCOs achieve these savings.

Enabling Mechanisms

Measuring Success

The Statewide Common Measure Set, a core element of Healthier Washington, is inextricably linked to both improving health outcomes and transitioning to value-based payment through the evaluation of provider performance.49 The emphasis on quality measurement across regions, payers and sectors is designed to foster a system of accountability and to build the evidence base for health improvement projects, including upstream prevention efforts.

Initially, ACHs will be required to report on progress measures (meeting project milestones), and starting in Year 3 will be required to report on outcomes for their selected projects. Measures for performance reporting align with the Common Measure Set, but also include some project-specific measures as outlined in the Medicaid Transformation Project Toolkit. Incentive payments to the ACHs in Years 2-5 will be adjusted based on level of performance against project metrics, meaning ACHs can expect less funding if targets are not met. Assessment of performance on ACH progress and outcomes will use a methodology that assigns an "Achievement Value" to each project metric:

- Pay-for-Reporting (P4R) progress measures will receive a full score for successful completion and timely reporting;
- P4R outcome measures will receive a full score for timely reporting; and
- Pay-for-Performance (P4P) outcomes measures will be scaled based on a gap-to-goal performance.

As noted above, for each project measure selected, the weighted average of the Achievement Value is applied to the maximum project assessment amount and then distributed to the ACH. Improvement targets for P4P outcome measures will be a 10 percent reduction in the gap-to-goal, although some measures may be assessed on an "improvement over self" approach. The majority of P4R metrics will be provided by the ACH and its partnering provider organizations, and will be submitted to the Health Care Authority on a semi-annual basis. The majority of P4P targets will be provided by the state and compiled on an annual basis.

As incentive payments will be directly tied to performance targets, ACHs and their project partners will want to implement strategies that best drive achievement on gap-to-goal reductions over each evaluation period, as well as have processes in place to evaluate progress over time. For example, ACHs pursuing Domain 3D projects focused on asthma will be evaluated based on the percentage of Medicaid enrollees aged 5-64 with persistent asthma who adhered to an appropriate medication regimen during the treatment period. ACHs and their partners will want to use evidence-based strategies that promote patient engagement in disease self-management and increase medication adherence, which will positively impact performance on the asthma measure.

Leveraging MCO Capacity and Contracting Requirements

As key partners in the Healthier Washington approach, MCOs will collaborate with many of the regionally based ACH projects. MCOs already work to create and coordinate health care for their members across the counties and regions they serve, paying for clinical care and partnering with community-based organizations and agencies on a local and regional basis to address the social factors that influence health and health outcomes. Process and outcome measures for ACH transformation projects align with performance measures in existing MCO contracts, providing an impetus to work collectively toward achieving improvements in population health.

ACHs will want to leverage MCO resources and their experience to develop tailored health disease prevention plans. MCOs have already made significant investments related to chronic disease and prevention, and ACHs can leverage this existing work, as well as build on the partnerships with community-based organizations that MCOs have already developed, to help guide their project development and ongoing monitoring. This is critically important since community-based partners will be well positioned to address the social determinants of health and provide upstream, non-medical supportive services. MCOs can also support ACHs with data-sharing needs, which is vital to make informed decisions around project goals, as well as support in tracking regional and statewide progress on project interventions. With the shared goal of improving population health through health promotion and disease prevention, MCOs and ACHs can work together to identify and implement 3D projects that are most pressing for the region and develop strategies for sustaining transformation projects beyond the waiver period.

Provider incentives offer one potentially mutually beneficial opportunity for alignment. MCOs and ACHs both have the authority to incentivize providers in their networks or regions to meet benchmarks or designated targets, such as increased diabetes screening. Contractually, MCOs must ensure that at least 0.75 percent of their premium is going to providers in the form of incentives to drive quality outcomes and improved patient experience. Additionally, per their contracts, MCOs are subject to a one percent withhold of their premium, and are eligible to earn back the withholds through the achievement of seven performance-based measures, three of which are focused on prevention, including asthma, immunizations and well-child visits. Additional measures and an increasing withhold (capping at three percent in 2021) will be added over the course of the demonstration, driving the need for MCOs and ACHs to work closely on projects to enhance the capacity of ACH project partners to meet performance targets and earn back all the premium withholdings.[50]

Aligning with the Plan for Improving Population Health

Also supporting the focus on chronic disease prevention by ACHs is the Washington State Plan for Improving Population Health (P4IPH). Developed by the Department of Health, the Health Care Authority and other public-private partners, the P4IPH is another key element of Healthier Washington and offers a blueprint for ACHs to drive population health improvement efforts.[51] The P4IPH provides a structured process for improving population health at the state level, while allowing flexibility for the unique needs and resources of local communities.[52] An explicit goal of the P4IPH is to deploy health promotion and disease prevention strategies that address population health needs while leading to systems and policy changes that will incorporate prevention activities into health care delivery and the health care system overall.[53] The Chronic Care Model (Framework) strategies purposefully align with available federal and state funding resources that promote prevention and engage individuals and regions in healthy living, which ACHs can build on to maximize the impact of 3D projects.

The Framework offers another tool for ACHs to orient their community partners, including county health departments, MCOs and other participating providers, toward a common path to population health improvement and reducing health care costs. The P4IPH helps to focus the alignment of population health priorities and available financial resources to ensure that the clinical aspects of disease prevention and policy improvements are continually being addressed, especially through Domain 3D projects. The P4IPH has a guide that ACHs can use to help them better understand population health goals, develop an actionable and sustainable plan for implementing 3D transformation projects, and advance upstream community prevention to support clinical efforts. The guide also has health-specific resources ACHs can use to develop 3D projects related to diabetes, obesity and tobacco cessation.

Achieving Value-Based Payment Goals

The end goal of Healthier Washington is to fully transition to a value-based system of care. As such, DSRIP funding depends in part on achieving statewide VBP adoption targets. While the methodology is still in development, ACH partners are eligible to receive incentives based on provider-level progress in meeting VBP targets, including population-based payment or comprehensive population-based payment. These financial incentives create the opportunity for ACHs to work with project partners to increase the adoption of value-based payment models. Chronic disease prevention and health promotion efforts tie directly to the VBP goals of Healthier Washington since the focus on outcomes creates incentives to invest in prevention to reduce costly readmissions and emergency department visits.

CONCLUSION

Investing in prevention and focusing on outcomes over volume will reduce more costly types of care, while at the same time create financial incentives to reinvest in upstream prevention efforts. ACHs should consider designing and implementing projects that work to prevent chronic disease development and progression in order to reap short- and long-term health and financial benefits.

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