SECTION II: PROJECT-LEVEL: Reproductive and Maternal and Child Health

Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

	Menu of Transformation Projects
Domain 2: Care Delivery Redesign	
☐	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
☐	2B: Community-Based Care Coordination
☐	2C: Transitional Care
☐	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
☐	3A: Addressing the Opioid Use Public Health Crisis (required)
X	3B: Reproductive and Maternal and Child Health
☐	3C: Access to Oral Health Services
☐	3D: Chronic Disease Prevention and Control

Project Description and Justification

Abstract

Healthy families are the center of a healthy community. By helping young men and women, mothers, and children access a specific array of reproductive, maternal, and child health prevention and early intervention services, CPAA intends to reduce the adverse childhood experiences (ACEs) burden in our region with positive, long-lasting effects on the health and wellbeing of our residents and communities. Specifically, with this project, and related interventions, we plan to (1) reduce ACEs passed down to the next generation in our region by coordinating and expanding home visiting programs; (2) expand primary care and reproductive care through One Key Question, pregnancy intention screening, training on trauma-informed practices, and highly effective contraceptive methods, including long-acting reversible contraception; and (3) expand implementation of Bright Futures guidelines or EMHI into clinical models, as well as to work with MCOs, pediatricians/family practitioners, and children's stakeholder groups to improve well-child visits.

Justification for Selecting Project and How It Addresses Regional Priorities

Preventing and mitigating the impact of Adverse Childhood Experiences (ACEs) has been a top regional priority for CPAA since its inception. ACEs are traumatic events experienced during childhood that can have long lasting effects on the child and through adulthood, including significant adverse health outcomes. Many of these adverse experiences tend to be generational, i.e., there is a much greater risk of ACEs when families are raising children in adverse community environments, where socio-economic status tends to be low, where built environments are unhealthy, and where there are few community and family resources.

In general, CPAA's population is more vulnerable than the statewide population. The region has slightly higher unemployment, especially in Grays Harbor and Pacific counties, more children in poverty (all counties but Thurston), lower median household income (all counties), and higher rates of persons

receiving food stamps (all counties but Thurston). Additionally, the region has higher rates of children participating in Aid to Families programs (all counties but Thurston) and higher rates of students eligible for free and reduced price lunches (all counties but Thurston) [1]

When CPAA began the work to identify shared regional health priorities in 2014, reducing ACEs and mitigating the impact of ACEs on individuals and communities emerged as one of the five key health improvement areas. This focus on ACEs corresponds with CPAA's overall focus on prevention and early intervention strategies as a key building block in our region's vision of better health for our residents and a healthier community.

CPAA's focus on ACEs as a key health improvement area comes from a review of the relevant science and specific health data for our region. According to the Health, Safety & Resilience report provided by Healthy Generations, six out of the seven counties in the CPAA region have more than 25% of adults with an ACE score of three or more[2]. This is significant because these adults have a higher likelihood that they have a higher disease burden of COPD, cancer, asthma, cardiovascular, and liver diseases. It also means they are at higher risk for smoking, drinking, illicit drug use, and risk for HIV. This population also is more likely to have poor mental health outcomes and have experienced disabilities, divorce, incarceration, homelessness, family violence, and unemployment. Additionally, the report suggests, "at 6+ ACEs, adults are 9 times more likely to experience life dissatisfaction and 4.6 times more likely to suffer from chronic diseases and engage in risk behaviors such as smoking[3]". This corresponds to a significantly elevated risk of adverse health outcomes for our population.

In recognition of the importance of addressing ACEs and the long-term impact on the health of our region, CPAA established an ACEs Work Group prior to the Medicaid Transformation Project. This work group identified the following priority strategies to reduce and mitigate the effects of ACEs: improve referrals and access to RMCH home visiting programs; expand the Kinship Care program to provide better supports to adults, who are not the biological parents and are caring for children within their family; and develop trauma-informed communities by coordinating a region-wide Neurological, Epigenetics, ACEs, and Resiliency (the NEAR Sciences) Speakers Bureau to help different facets of a community understand the impact the NEAR sciences can have on people's health, wellbeing, and development. The ACEs work group reviewed multiple data sources and anecdotal evidence to determine these priority strategies. For instance, Thurston County's Nurse Family Partnership program serves more than 150 women annually according to Gretchen Thaller, the Maternal Child Health Coordinator/Nurse Family Partnership Supervisor. She reports that women will often see multiple providers in the community before learning about the NFP program and will be far into their pregnancy when an earlier referral could have potentially had a better impact on the health outcomes of the child and mother. This anecdotal evidence suggests many women are not being served in the community when there are 33.2% of all births in Thurston County are to women with no prior pregnancy.[4] Unfortunately, this anecdote describes the situation in the other counties in the region equally well.

The Reproductive and Maternal & Child Health project represents an important opportunity for our region to build on this foundational work to address ACEs in our community by scaling existing work and better connecting community-based services and clinical providers that care for children and families.

[1] RHNI Data Summary, RWJF County Health Rankings, 2017

[2] Health, Safety & Resilience (2015); Foundations for Health Equity; Statewide Summary Fall 2014/2015

[3] Anda, R., Brown, D. (2010) Adverse Childhood Experiences and Population Health in Washington; The Face of Chronic Public Health Disaster; Retrieved from ACE Interface.com; 2014

[4] Community Health Assessment Tool, 5 years combined 2011-2015.

With the help of Providence CORE (CORE), our strategic data analytics partner, we analyzed a broad range of data for the region. The following data further emphasizes the need to continue our focus on maternal and child health strategies.

Reproductive and Maternal Health Data[5]:

- Higher teen pregnancy rate overall (33 per 1,000 compared to 26 statewide)
- Higher teen pregnancy, ages 15-17 (16 per 1,000 compared to 12)
- Significantly higher teen pregnancy, ages 18-19 (62 per 1,000 compared to 47 statewide)
- Counties with higher teen pregnancy rates include Cowlitz, Lewis, and Mason.
- Overall, CPAA's population utilizes effective contraception at similar rates to the state; however, there is large variation within the counties (e.g., the percentage of women receiving long-active reversible contraception postpartum ranges from 6% in Mason to over 20% in Cowlitz).
- For overall use of long-acting reproductive contraception (LARC), Pacific County has the lowest rates of LARC utilization.

Child Health Data[6]:

For Immunization measures, CPAA's performance lags slightly behind statewide, with substantial county level variation:

- Childhood immunization rates for the general population (by age 2) range from 7% in Mason to 12% in Cowlitz, compared to 12% statewide. Adolescent immunization rates range from 7% in Pacific to 15% in Thurston, compared to 15% statewide.

CPAA reviewed these findings with the Reproductive and Maternal & Child Health (RMCH) Work Group, which includes reproductive, maternal, and child health experts from a wide range of agencies and community sectors. After the Medicaid Transformation Toolkit was published and finalized, the work group reviewed Transformation Project 3B and saw that the metrics and interventions went beyond expanding home-visiting programs. The work group determined that all interventions had a positive impact on reducing and mitigating ACEs and expanded the continuum of work related to ACEs reduction. Therefore, the work group decided that all Project strategies would be explored.

Selected Interventions

CPAA will employ all of the evidence-based approaches included in the Medicaid Transformation Toolkit in this project area. Our project partners have pointed out that in order to affect the project-related metrics and achieve the desired health system transformation that will result in improved outcomes for the maternal and child population in the region, one standalone strategy is insufficient. Rather, we will need to deploy a host of synergistic strategies. This includes the following approaches:

- Recommendations to Improve Preconception Health[7]
- Home visiting for pregnant mothers and families
- Bright futures or EMHI

This also includes harnessing synergies with other Transformation project areas, for instance, by

[5] Washington Department of Health, (2015) Data provided by HCA in RHNI "Starter Set" files
[6] Healthier Washington Dashboard (2016)
[7] Johnson, K., Posner S., Briermann J., et al, (2006) Recommendations to Improve Preconception Health and Health Care – United States Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm

coordinating target populations and sub-regions to the greatest extent possible *across* project areas, and making shared investments in shared, supportive infrastructure (health information systems, workforce training, etc.). The strategies above are very much dependent on strong linkages between efforts to improve primary prevention in clinical practice through the bi-directional care project focus on improved primary care and efforts to improve coordination of care and social services to increase access and referrals to prevention-based home-visiting programs.

How Project Will Support Sustainable Health System Transformation for the Target Population

Helping providers move towards value-based payment will support sustainable health system transformation for the target population. The Transformation is a unique opportunity for partners to work with MCOs to bill Medicaid for services that help keep clients out of the emergency department, increase well child visit rates, and reduce the financial burden a patient may place on the entire health system.

Beyond sustaining the project interventions through payment reform, CPAA sees the Reproductive and Maternal/Child Health project as the primary opportunity for upstream health impact within the entire Transformation. The project will result in informed and educated providers, specifically on trauma informed practices, effective referral mechanisms to social service agencies for patients, and a coordinated system of access to home visiting. Therefore, we foresee a significant number of impacts for the target population/s that will compound over time. We know from data that parents, especially parents in our target population/s, have more detrimental health impacts from toxic stress, which is why this project area's two-generation approach to care is vital to its success: supported parents are more resilient and, in turn, have healthier children. Our region has a higher rate of unintended pregnancies in Mason, Grays Harbor, Lewis, Cowlitz, and Thurston County counties than the state average[8]. Research shows if we can help a woman prevent unintended pregnancy until a time when she feels her life circumstances and well-being better support it, then she, and her partner and future children, will need fewer health and social services over their lifetimes[9].

How CPAA Will Ensure Project Coordinates With and Does Not Duplicate Existing Efforts

CHOICE Regional Health Network, CPAA's administrative support organization, has worked closely with the community for over 20 years and is familiar with both the social and health care needs and existing services provided in the region. CPAA can readily build on this knowledge and these established partnerships. Moreover, CPAA's governance and advisory structure bring to the table a wide-range of service providers and stakeholders, enabling us to hear real-time concerns about health issues, and allowing us to identify potential overlaps or duplicative efforts.

In an effort to gather project ideas and gauge the interest of providers and community partners to work with CPAA under the Medicaid Transformation Project, CPAA conducted a Request for Qualifications (RFQ). The response to the RFQ has been very positive and a number of project ideas have emerged (see Appendix xxx for details). In reviewing responses received to date, there is much overlap between different project areas. CPAA will harness these synergies by not only coordinating project interventions, target populations, and sub-regions across projects to the greatest extent possible, but also by assessing and comparing existing efforts and resources. As one of the first implementation planning steps, a current state analysis will be undertaken or updated for each project area. This provides the opportunity

8 Unintended Pregnancies (2013) Department of Health. Retrieved from: https://www.doh.wa.gov/Portals/1/Documents/1500/MCH-UP2016-DU.pdf

9 Bailey, M. J. (2013). Fifty Years of Family Planning: New Evidence on the Long-Run Effects of Increasing Access to Contraception. Brookings Papers on Economic Activity, 2013, 341–409. http://doi.org/10.1353/eca.2013.0001

to look holistically across all project areas to avoid duplication of existing efforts and maximally leverage existing assets. This approach of building on existing capacities and strengthening existing infrastructure and care systems to the greatest extent possible is central to CPAA's overall approach. It reflects the alliance's deep roots in the *collective impact* framework.

In performing the current state analysis for the RMCH project area, CPAA will build on an environmental scan that the CPAA ACEs Work Group began prior to the Transformation. This landscape analysis identified existing maternal and child health home visiting programs in all seven counties of our region and barriers/challenges to expanding these programs. For instance, hiring nurses in rural communities is a challenge and is a barrier to implementing NFP in communities that are in the most western part of our region. To overcome that challenge, we are exploring if another home visiting program can be expanded in those regions such as Parents As Teachers or to create a regional NFP contract to make the best use of our communities' resources. In that environmental scan, we also gathered information on referral pathways into home visiting programs to understand how clients obtain access to certain programs. This will help us determine improvement strategies for referrals.

Anticipated Project Scope

Anticipated Target Population

The Medicaid target populations for Reproductive and Maternal/Child Health are women of reproductive age, women who are having babies each year, and children in the CPAA region. There are 29,210 women of reproductive age[10] in the region, over 3,700 babies are born each year[11], and more than 78,000 children are receiving Medicaid[12]. Based on the review of the data and the work group members' extensive experience in the field, the following sub-populations were identified as particularly in need of RMCH interventions to create more stability in their lives:

Table 3B - 1

Target Populations to Further Explore	
High risk obstetric patients	Homeless or at risk for homelessness
Patients with Substance Use Disorder Diagnosis[13]	Patients with SMI Diagnosis
Families in Kinship Care[14]	

We will refine the specific target population(s) for this project during implementation planning. This will include an assessment of target populations identified in *other* project areas in an effort to align project interventions across our entire project portfolio to the greatest extent possible and achieve maximum synergies and impact. This will also include an analysis of sub-populations and sub-regions across project areas. The data for our region suggests focusing our RMCH interventions in particular in Cowlitz, Lewis, Mason, and Pacific, counties that experience some of the greatest disparities. There may also be pockets of disparities in Thurston County. We will identify these pockets in the implementation-planning phase.

Involvement of Partnering Providers

CPAA has established a work group comprised of key providers and other stakeholders from throughout

[10] RHNI (2015), Washington State Health Care Authority, Phase 3 Retrieved November 8, 2017
[11] HCA First Step DB (2015) Retrieved November 8, 2017
[12] Healthier Washington Dashboard (2015) Retrieved November 8, 2017
[13] RDA Measure Decomposition data file, CY 2015.
[14] https://www.dshs.wa.gov/altsa/home-and-community-services-kinship-care/kinship-care

the region to plan and develop the RMCH project. In establishing the work group, CPAA was able to draw upon a large and diverse group of clinical and social service providers from within the region that had previously engaged in the CPAA's ACEs Work Group.

In addition, CPAA has conducted two efforts to identify partnering providers: 1) a Request for Qualifications (RFQ) was issued in August 2017 to identify and engage partnering providers; and 2) an analysis was conducted by CORE to identify the key providers collectively serving 90% of Medicaid clients in the region. Please refer to Appendix ? and ?.

The RFQ responses for the RMCH project area show nine organizations proposed projects, with many of the projects covering more than one project area. Note that while the proposals represent preliminary ideas for consideration during the planning year, CPAA has made no commitments to support any particular proposal at this time. During project implementation planning, the project ideas of our partners will be analyzed in greater depth, augmented with other strategies necessary to achieve our project goals, and combined into a comprehensive, well-aligned set of project initiatives. Thus, our partners will make contributions to a synergistic portfolio of project initiatives, rather than pursue separate, stand-alone projects. The RFQ remains open through implementation planning, and we anticipate additional potential partners will continue to step forward with project ideas.

The analysis of the largest Medicaid providers in the CPAA region by CORE is being used to systematically approach and engage key Medicaid providers that serve large numbers of Medicaid beneficiaries but have not yet responded to the RFQ. As CPAA finalizes the selection of specific target populations, we will further refine this analytical tool to identify those key Medicaid providers that serve our prioritized project target populations, especially those in prioritized sub-regions (e.g., Cowlitz, Lewis, Mason, Pacific, and pocket areas of Thurston counties).

CPAA is keenly aware that we need to engage the right providers in order to meet our region's transformation goals. Clearly, this includes the main Medicaid providers in our region; however, this also includes key social services providers that will have an impact on the metrics and success of reproductive, maternal and child health improvements. While our initial analyses and outreach focused on medical and behavioral health providers, we are now reaching out to other provider types, such as children's services, family planning providers, DSHS community service offices, local public health, Tribal and Indian Health providers, and other community-based organizations. It is important that we focus on whole-person care to address maternal and child health needs to truly make transformational, sustainable change. During the project-planning phase, CPAA will expand this outreach to partnering providers to include these and other service agencies, and we will make explicit connections to other Transformation project areas, such as community-based care coordination, behavioral health care integration, and the opioid response project.

Level of Impact

Our region has the opportunity to impact up to 29,210 women of reproductive age[15], over 3,700 babies born each year[16], and more than 78,000 children receiving Medicaid[17] in the CPAA region. As evidenced by the data above, our region has significant unmet reproductive, maternal, and child health needs. In order to improve the health status of our young families, the project's overall scope will have to be region-wide. This region-wide impact will be supported through synergies derived from coordinating this project with other projects in our overall Transformation project portfolio across all seven counties

[15] RHNI (2015), Washington State Health Care Authority, Phase 3 Retrieved November 8, 2017
[16] HCA First Step DB (2015) Retrieved November 8, 2017
[17] Healthier Washington Dashboard (2015) Retrieved November 8, 2017

participating in CPAA. For example, improving immunization rates across the region and number of well-child visits will be part of the work of the bi-directional care project.

Nevertheless, to achieve the greatest impact for the region, our data analysis points us toward certain target populations and geographic focus areas in the RMCH project area to amplify impact. During project implementation planning, we will further refine our analysis of relevant data. We anticipate that the comprehensive current state analysis will lead us to identify specific geographic sub-regions that are particularly underserved, as well as sub-populations that required more focused interventions. Again, aligning this project with other Transformation project areas, in particular community-based care coordination, behavioral health care integration, and opioid response, will likely point us to synergistic sub-populations.

How CPAA Will Ensure Health Equity is Addressed in the Project Design

As per the discussion above, our data analysis points us toward certain target populations and geographic focus areas in the reproductive, maternal, and child health project. In their review of the data, the RMCH Work Group explicitly considered health equity as a guiding principle, in keeping with the CPAA's broader values. A key aspect of a health equity approach with this project is addressing trauma-informed care, a best-practice for addressing ACEs in clinical settings. This work group advocated for trauma-informed/sensitive trainings for clinical and social service providers to become a component of CPAA's entire project portfolio integrated into every care improvement strategy. CPAA will raise regionwide awareness about the impact of trauma on health and wellness and how to appropriately manage a person's health when they have experienced trauma in their past or present.

CPAA is engaging consumers in our region to help with the identification and selection of target population/s for this and other project areas. In late October, CPAA began to vet the work of the work group through a conversation with consumers from throughout the seven-county region coming together within the CPAA Consumer Advisory Committee. This will continue in the coming weeks and months as we work with this committee more closely and seek to engage consumers in the project implementation planning through surveys and community meetings.

We are consulting with our Tribal partners, some of whom have been involved in our work groups, to ensure that health equity is thoroughly considered in our project planning and implementation. For instance, we recently met with the health director of the Nisqually Indian Tribe to learn about the Tribe's greatest health needs. As a result of these ongoing consultations, the list of priority target populations and interventions may change, reflecting more fully health equity considerations.

Finally, in keeping with CPAA's commitment to adopt a health equity lens in our planning and implementation of our project portfolio, we are equipping our project partners with information and practical tools to ensure health equity considerations are at the forefront of our regional health improvement. For instance, we have used a monthly shared learning sessions at CPAA Council meetings to conduct health equity trainings, and we are developing a decision-making aid that our council, board, and work groups will use to formally integrate health equity consideration into their decision-making. (Training slides can be found in Appendix TK.)

Project's Lasting Impacts and Benefit to the Region's Overall Medicaid Population

The investments in this project area will generate lasting impacts in a number of ways:

1. **Workforce:** We anticipate making targeted investments in the workforce of our region as part of this project. This will include training partnering provider personnel in evidence-based strategies, such as One Key Question, LARC training, trauma informed practices, Nurse Family

Partnership (NFP), Parents as Teachers (PAT), Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI), and Bright Futures. Once partnering providers have been trained, the expertise gained and the capacity built through these trainings will be available indefinitely as a resource to our partnering providers and region.

2. **Changes at the Practice Level:** We anticipate that our partnering providers will make structural changes in their business practices, staffing configurations, and workflows to conform to the evidence-based models and strategies associated with the chosen interventions. Once these changes have been made, they will be "hard-coded" into the service delivery infrastructure (processes and procedures) and provide lasting benefits beyond the Transformation project period. For instance, through this project, we anticipate that the use of Bright Futures model in pediatric and family practice settings will be considered the "gold standard" of how best to serve children, which will have lasting impacts.
3. **Health System Infrastructure:** This project includes targeted investments in the ability of our partnering providers to communicate with each other and exchange relevant patient information. The exact nature of these investments will be determined during implementation planning and will, in part, depend on investments the state is going to make in Health Information Exchange systems. Regardless, once these infrastructure investments have been made, they will provide benefits into perpetuity for our region to improve reproductive, maternal, and child health care specifically and care coordination in general.
4. **Partnerships:** Through this project, partnering providers will learn what community resources and services are available in the region to which they can turn and refer patients in need of social supports and other wrap-around services. For example, pediatric practices in our region will be more aware of and incentivized to refer to home visiting programs throughout the region and will be able to rely on them as trusted partners in supporting their work. Once awareness about available community resources has been raised and interagency relationships have been established, these essential community-clinical linkages will be permanent and provide lasting benefits.
5. **VBP:** In part, the permanence of the transformation of partnering providers' infrastructures, systems, and behaviors depends on sustainable payment mechanisms that carry this change into the future beyond the Medicaid Transformation Project. The state's commitment to changing its healthcare purchasing from fee-for-service to value-base care will be a major supporting strategy for sustaining the CPAA's investments in a transformed healthcare delivery system through the investment areas outlined above. CPAA will continue to work with MCOs and providers to support Reproductive and Maternal Child health metrics.

While our investments in this project area will be targeted at specific target populations as a subset of Medicaid beneficiaries, the workforce trained, the workflows established, the infrastructure built, the partner relations established, the financing mechanisms put into place, and the overall synergies harnessed, are not exclusive to these prioritized populations. Rather, they will benefit all populations, including the entire Medicaid population.

Implementation Approach and Timing (Supplemental Workbook Tabs)

See 3B Implementation Approach tab in ACH Project Plan Supplemental Data Workbook for a brief description of how CPAA will accomplish each set of project milestones in State 1, Stage 2, and Stage 3.

Partnering Providers

How CPAA Has Included Partnering Providers That Collectively Serve a Significant Portion of the Medicaid Population

CPAA is well positioned to bring major partnering providers in the region together to create collective impact. A principal asset in this engagement process are the well-established provider relationships CHOICE has cultivated over the last two decades; a number of key Medicaid providers are members of CHOICE, including two of the region's three Federally Qualified Health Centers (Valley View Health Center and Sea Mar) and all of the region's hospitals in five of the seven counties covered by CPAA, including our largest tertiary hospital, Providence St. Peter Hospital. From the beginning, CPAA has included a broad range of providers in its work across our seven-county region, including providers that collectively serve a significant portion of the Medicaid population.

CPAA convened a RMCH Work Group and has been meeting at least monthly to collect information and design the project intervention. The work group includes representatives from partners from every county in the region. Members have played an active role in project design and on the development of this application and are fully engaged in the RMCH project. The following key Medicaid partners in our region have participated consistently in the planning for the RMCH project.

Table 3B - 2

RMCH Planning Partners		
Amerigroup	Behavioral Health Resources	Centralia College
Chehalis Tribe	Child and Adolescent Clinic	Community Care Action Council
Community Health Plan of WA	Coordinated Care	CR-ESD 113
Department of Early Learning	Grays Harbor Public Health	Lewis County Public Health
Lower Columbia CAPP	Mason General Hospital	Molina Health Care
NAMI SW WA	Northwest Venture Philanthropy	Planned Parenthood
Providence Health & Services	Sea Mar CHC	Skokomish Tribe
Summit Pacific Medical Center	Thurston County Public Health	Valley View Health Center
Wahkiakum Public Health		

To ensure that a significant portion of the Medicaid population will be served in this Transformation, CPAA partnered with CORE to analyze provider claims data provided by HCA to develop a landscape analysis of the major Medicaid providers and payers as well as public health departments in the region. This list has been cross-referenced with RFQ responses received from partners to ensure a significant portion of Medicaid recipients can be reached through the partners engaged in each project. For providers, this includes dental, primary care, FQHCs, hospitals, and major health systems. The purpose of this tool is to better understand who the major stakeholders are in the CPAA region, who is already engaged in Transformation projects, and who we still need to contact to engage. To populate this tool, we used Provider data supplied by HCA and included providers who collectively served approximately 90% of Medicaid beneficiaries in 2016. By analyzing the provider landscape, CPAA can engage and connect stakeholders with the goal of creating new partnerships and coordinating intervention efforts. The CPAA is well positioned to facilitate new partnerships between providers, track individual provider

initiatives, and create new tools to monitor existing project efforts.

Process for Ensuring Partnering Providers Commit to Serving the Medicaid Population

As previously mentioned, CPAA conducted a Request for Qualifications (RFQ) prompting providers to describe the target population and estimated number of Medicaid lives served. This preliminary information is a first step to understanding what Medicaid populations providers intend to serve, which in turn helps to inform our conversation about choosing specific target populations.

In order to secure formal commitments for participation from implementation partners, CPAA will define the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); and payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its project work group to clarify the scope of work of prospective partnering providers. CPAA will utilize its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than discreet, stand-alone projects. We are confident that partnering providers will be able to make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio.

In DY 2, we will secure formal commitments from our partnering providers to implement the evidence-based approaches outlined in the project toolkit that will include a commitment to serve specific Medicaid populations. CPAA will monitor this commitment by tracking progress on project implementation and outcomes for performance metrics. Additionally, CPAA will ensure providers interested in participating in the Transformation that have a lower than average Medicaid population commit to increasing their access to the Medicaid population.

Process for Engaging Partnering Providers That are Critical to the Project's Success, and Ensuring That a Broad Spectrum of Care and Related Social Services are Represented

CPAA engages key partnering providers in the Transformation in various ways. A number of key implementation partners serve on our project work groups. Work groups consist of individuals from partnering organizations, including large and small, urban and rural clinical providers that encompass behavioral health and primary care, social services, community-based organizations, MCOs, and public health departments.

We are systematically reaching out to key Medicaid providers that have neither participated in the project planning so far, nor responded to the RFQ to ensure that they are aware of this project and engage in the project planning and implementation going forward. A principal asset in this engagement process is the well-established provider relationships that CHOICE Regional Health Network (which supports the CPAA administratively) has cultivated over the last two decades. A number of key Medicaid providers are members of CHOICE, including two of the region's three Federally Qualified Health Centers (Valley View Health Center and Sea Mar) and all of the region's hospitals in five of the seven counties covered by CPAA, including our largest tertiary hospital, Providence St. Peter Hospital.

In instances where engagement from missing key Medicaid partners should prove challenging, we will ask our Provider Champions from the Clinical Advisory Committee, Dr. Beth Harvey, Dr. Phyllis Cavens, and Dr. Jennifer Polley – clinicians that have agreed to assume a leadership role in liaising with our provider community – to reach out to their peers at these key Medicaid provider organizations to begin the engagement process. Additionally, we will reach out to our public health department directors to identify community partners not yet engaged. We will then follow up with in-person visits to explain the project and answer any questions for the targeted key providers.

In our outreach to missing social service providers, we can again draw on the CHOICE membership network, which includes five of the seven local health jurisdictions in the CPAA region (public health and social/human services departments at the county level). We can also build upon our extensive network of partners in the region that have come together under the ACEs Work Group that CHOICE led prior to the Medicaid Transformation. Given the well-established relationships that we have been able to forge with these critical partners to date, we anticipate that we will be able to engage any missing social service partners successfully. In sum, we are confident that this systematic, personalized and multi-pronged approach that builds on well-established partnerships in our region will result in the successful engagement of key Medicaid providers in our region as well as a broad range of social service agencies that are essential for effective improvements of reproductive, maternal, and child health in our region.

How CPAA is Leveraging MCO's Expertise in Project Implementation, and Ensuring There is No Duplication

MCOs have been active participants in the all work groups, the Clinical Advisory Committee, and the CPAA Council and Board of Directors. MCO representatives have contributed to the identification of regional health priorities, have provided input into the project planning process, and will continue to be key partners throughout Transformation implementation. We are very aware of the need to align our efforts to achieve outcomes with our MCO partners so that we are achieving aligned goals.

Caitlin Safford, with Amerigroup, chairs the work group that is working on RMCH strategies. Kolbi Peach, with Coordinated Care, has been working with the ACEs Work Group (the pre-curser of the RMCH Work Group) to deliver ACEs trainings in four communities. Many of the health plans have been engaged in the development of the project plan and participation will be encouraged throughout project implementation planning and subsequent implementation. Appendix TK lists MCO representatives and the organizations they represent.

Our close partnership with MCOs will ensure that the question of aligning payment mechanisms with project interventions will be considered at all times. This is crucial for the long-term sustainability of the capacity we are building through our projects. It will also ensure that there is no duplication of existing services or other inefficiencies and will help align coordination and referral into home visiting programs and reproductive health services.

Regional Assets, Anticipated Challenges and Proposed Solutions

Assets the CPAA and Regional Partnering Providers Will Bring to the Project

One of the principal assets CPAA brings to this project is CHOICE's broad and well-established network of positive, collegial relationships with clinical providers, community-based organizations, and health plans developed over more than two decades of community-led health improvement and collective action. In its project planning and implementation, CPAA can readily build on this strong, trusting foundation.

Partnering providers throughout the CPAA region bring a wealth of knowledge from many different sectors of health care, urban and rural perspectives, and small clinics to large hospital systems. The amount of in-kind time contributed through work groups and advisory groups is substantial and demonstrates the deep commitment of our partners. Our implementation partners have shown consistent engagement in project work groups, advisory committees, and the council and board of directors. Additionally, the major Medicaid providers in the CPAA region continue to express their commitment to this ongoing collaborative effort.

Regarding the RMCH project, CPAA partners bring a wealth of knowledge and experiences to help families thrive. This region has extensive experience working together and partnering to see the health of children improved. For example, CPAA currently implements the Youth Marijuana Prevention and Education Program across seven counties to reduce the number of 10th graders using marijuana. CPAA also has worked in the region for the last two years to implement the Youth Behavioral Health Care Coordination program to reduce the number of children with unmet behavioral health needs in four counties. Additionally, CHOICE manages the Access to Baby and Child Dentistry program in Thurston and Mason counties to prevent cavities in young children. The CPAA region is home to the Pediatric Transforming Clinical Practice Initiative to change the systems in which care is provided to children. We also have very strong pediatric/family practice providers and family planning providers who are passionately engaged in regional health improvement. For instance, the Adolescent and Family Clinic in Longview, WA is a leading pediatric practice regarding the transformation of clinic practice initiative[18]. Our region and partners are passionate about the health of children in the CPAA region and have a long history of improving their health outcomes. Moreover, we are strategically positioned by having the state capitol in our region, which provides opportunities to help bring about policy changes to improve payment structures, increase access to care for children, and provide additional resources. Finally, our region has implemented home visiting programs in all seven counties across the region.

Moreover, since the ACEs Work Group was already in existence prior to the Medicaid Transformation, we have a good general understanding of the number and reach of home visiting programs in all seven counties. All seven counties have a home visiting program within their boundaries and funding for each of these programs comes from different sources. An area of opportunity is to help children older than 3 years of age with home visiting; this is a clear gap in our region. This initial environmental scan has already generated additional partnerships to expand home visiting programs, which CPAA plans to expand further with Transformation funding. See attachment ??

Challenges to Improving Outcomes and Lowering Costs for Target Population and Strategy to Mitigate Risks and Overcome Barriers

There are a number of challenges and barriers to overcome in order to achieve the intended project outcomes. Broadly speaking, these fall into two categories: (1) general challenges and barriers, and (2) project-specific challenges and barriers.

[18] Transforming Clinic Pediatric Initiative (2015) Retrieved from: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

General Challenges and Barriers

All Transformation projects require:

- **Data:** CPAA must have access to timely, accurate data to:
  - Identify/refine target populations, partnering providers, and interventions, and
  - Monitor the performance of our partnering providers under the Transformation to determine partner compensation, course correct if milestones and performance metrics are not being achieved, and conduct continuous quality improvement efforts.
- **Health Information Systems:** Our partnering providers must have the ability to exchange information about patients and care plans in order to avoid care gaps and duplication of services. Currently, there is no consistent standard and/or IT system for information sharing in our region, especially between providers that serve patients with multiple chronic illnesses and behavioral health conditions.
- **Workforce:** Our partnering providers must have access to the right workforce to implement the evidence-based interventions in the chosen project areas. This includes personnel with the right general professional qualifications, expertise and experience in the project area, and training in the specific methods and approaches of the chosen interventions. Ensuring ready access to this workforce is a major concern, especially in rural, under-resourced areas.
- **Finances:** Our partners need to be clear on:
  - Fund flows, i.e., they need to understand when, how and how much they will be paid in order to inform their decision-making about investments in the Transformation.
  - Financial sustainability, i.e., they need to understand what payment mechanisms are being developed to sustain their investments beyond the Transformation. The principal barrier in this arena is the fact that the vast majority of purchasing activities occur in other venues and are controlled by other parties. Most medical purchasing is conducted by MCOs, while behavioral health services are currently purchased under the rubric of BHOs.

Project-Specific Challenges and Barriers

In addition to these general challenges and barriers, there are a number of project-specific challenges and barriers to overcome. The following is a list of selected key challenges and barriers specific to reproductive, maternal, and child health:

- **Geography:** There is a large geographical distance between people needing resources and the physical location of the service providers, due in part to the rural nature of much of the region. This is compounded by transportation barriers.
- **Lack of Provider Capacity:** Overcoming provider capacity limitations will be a significant challenge for this project. There is a shortage of OB/GYN and primary care providers in the region, and in particular, certain areas of Grays Harbor, Mason, Lewis, and Pacific counties[19]. Long vacancies for necessary positions include registered nurses and medical assistants;[20]

[19] Health Professional Shortage Areas (2017) Retrieved from: https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx

[20] Washington Sentinel Network. Health Workforce Council 2016 Annual Report. http://www.wtb.wa.gov/Documents/HWCReport-

- **Lack of Standardized Referrals:** At present, referral streams for home visiting programs are not standardized. Thus, coordinating referral streams is a major challenge, leading to many individuals not being offered home visiting services at all while some may be receiving duplicative services.
- **Lack of Care Coordination**: The existing workforce of community health workers is small in the CPAA region. Care coordinators can be recruited from within the region, but we will need to ensure we have robust training available since most workers will be new to the role.
- **Lack of Cultural Competency and Trauma-Informed Care**: Sexual and reproductive health services and ACEs are deeply personal, sensitive topics and target population/s would greatly benefit from a provider who "speaks their language"
- **Politics:** Expanding capacity for sexual and reproductive health services can be politically controversial, especially in politically more conservative, rural areas. The CPAA region is mostly composed of rural communities.

CPAA Strategy for Mitigating the Identified Risks and Overcoming Barriers

The following lists various mitigation strategies to address the identified challenges and barriers.

Barrier	Potential Solutions
Data	• Partner with CORE, state, and providers to identify/refine target populations, partnering providers, and interventions (underway) • Partner with providers and MCOs to obtain close to real-time provider performance information; explore contracting with a third-party data aggregator with data analytics capabilities (underway).
Health Information Systems	• Partner with state, MCOs, providers, and other ACHs in developing interoperability between health information systems; expedite planning for and implementation of clinical integration of behavioral health
Workforce	• Invest in training of partnering providers in evidence-based methods/models • Explore shared workforce options, e.g., through telehealth • Develop a regional recruitment plan for providers
Finances	• Funds Flows: Work with CPAA Finance Committee to clarify funds flows (underway) • Financial Sustainability: Work with payers (health plans and state) to support transition to value-based purchasing; state needs to adjust contracting w/ MCO who in turn modify provider payment approaches accordingly • Work with state and MCOs on how to include sexual and reproductive health into value-based payment contracts with providers • Expand payment mechanism beyond traditional providers (PCPs and pediatric clinics) to all types of providers from which Medicaid beneficiaries receive sexual and reproductive health care
Lack of Provider Capacity	• See *Workforce* mitigating strategies above • Develop loan forgiveness and conditional scholarship programs

Barrier	Potential Solutions
	• Train and expand availability of "adjunct" professionals and para-professionals who can support the limited number of physicians in areas with capacity bottlenecks. • Investigate how to connect more non-traditional providers and locations (i.e., schools and child care centers)
Lack of Standardized Referrals	• Map current referral streams for home visiting programs • Create more standardized referral streams for home visiting programs • Ensure equitable distribution of referrals so that one county does not benefit disproportionately • Connect project with the Pathways Hub (community-based care coordination) to support coordination of referrals
Politics	• Be open and transparent about strategies related to sexual and reproductive health interventions • Engage with any providers or stakeholders that may take issue with this project to work toward common ground • Engage early and often with Tribal officials, and local- and state-level elected officials on RMCH strategies and the expected impact on the region's health

Monitoring and Continuous Improvement

Plan for Monitoring Project Implementation Progress, Including Addressing Delays in Implementation

CPAA will implement a rigorous project monitoring approach to implementation of the project. The same approach will be employed across the entire portfolio of projects. This includes entering into contracts that clearly spell out partnering providers' responsibilities, including reporting requirements, and supports CPAA can offer as well as employing project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones. Each project implementation plan will define critical paths and key dependencies. Key indicators will be determined for each project area that will serve as an early warning system to detect when implementation challenges are encountered. A monthly performance dashboard report will compare actual performance of key indicators against targets within and across all project areas. This will allow the project managers as well as the CPAA Support Team, which includes the chairs of each project work group, to identify both implementation problems and early wins. For example, if we are not seeing an increase in all contraceptive-related claims or attrition of clients, fidelity to the model, rate of referrals to enrollment, including contraception counseling, 3-6 months post training of providers, we will know providers may need more resources to effectively provide pregnancy intention screening/counseling and the full range of contraceptives. At that point in time, we will reach out to training participants to determine the next level of assistance they need (i.e., precepting).

We expect that early indicators related to home visiting programs to be more anecdotal since we do not have established processes to gather systemic "encounter-like" data for MCH home visiting programs. Certain anecdotes that will raise red flags include challenges staffing for programs, particularly NFP since it requires nurses, and low caseloads for staff (indicator of lack of referrals).

CPAA has hired dedicated support staff for each project area (project managers). It is the responsibility of the project managers to stay in close contact with all partnering providers in their respective project area. Specifically, the project managers are responsible for:

- Identifying support needs of partnering providers throughout the duration of the Transformation;
- Serving as subject matter experts for partnering providers or, if additional expertise is required, identify and facilitate external subject matter experts providing enhanced technical assistance to partnering providers; and
- Monitoring overall partnering provider performance toward milestones and performance metrics (see below for details).

Project implementation monitoring is closely tied to performance monitoring of partnering providers. The next section of the project plan discusses in detail how CPAA will monitor the performance of individual partnering providers. The data reporting and analytics tools used to hold individual partnering providers accountable to agreed upon deliverables will provide CPAA also with a clear sense about the project's overall implementation progress, as individual provider performance data rolls up into a region-wide performance summary. See next section for details.

Plan for Monitoring Continuous Improvement, Supporting Partnering Providers, and Determining Whether or Not CPAA is on Track to Meet Expected Outcomes

CPAA will set up a progressive implementation and performance monitoring structure with tiered interventions up to termination of partnering provider contracts. This will include regular meetings with our partnering providers to assess implementation progress and challenges. If project implementation progress becomes questionable or is delayed, the project manager will inform his or her immediate supervisor (Clinical Director or Program Director) of the concern. The senior project management team will assess the severity of the situation. When possible, we will seek to mitigate the risk or delay by providing technical assistance to help the partnering provider/s to get back on track. This will include seeking advice from clinical experts, including Provider Champions serving on the CPAA Clinical Provider Advisory Committee. The partnering provider and CPAA will agree on an action plan (Performance Improvement Plan) to resolve the issue or renegotiate the contract deliverables, if necessary. In severe cases or if the technical assistance does not correct the problem, we will escalate the issue to our Clinical Provider Advisory Committee for a more comprehensive review. The committee may identify additional problem solution strategies, ask our Provider Champions to intervene, help access additional external technical assistance resources, or engage other key stakeholders in addition to affected providers to remedy the cause of delays. If the problem cannot be resolved, is of a major magnitude or involves key partners that serve large numbers of Medicaid beneficiaries, the CPAA Council and Board will be informed. The board will make the final decision about modifying or terminating contracts with partnering providers.

Access to timely and relevant data will be critical to our ability to monitor project implementation and support continuous improvement. Measurement is an integral part of quality improvement. We will enter into a contract with each partnering provider that will detail the provider's responsibilities, including the nature and scope of investments to be made; implementation of the key components of each selected approach; adherence to project guidelines, policies and procedures, and protocols; the target population(s) and any geographic sub-regions on which the interventions will be focused;

reporting requirements (milestones and outcome metrics as well as frequency of reports); participation in peer learning collaboratives; and payment modalities.

Partnering providers will be required to submit performance information monthly. We are exploring utilizing the Washington Hospital Association's (WSHA) updated QBS business intelligence system to capture and analyze provider data that is not already reported through other systems. Our goal is to place minimal reporting burdens on our partnering providers while providing CPAA with an effective performance monitoring tool that provides us with timely performance data so that we can actively monitor and track partnering provider performance. QBS is easy to populate by our partners (including automated data uploads) and easy for us to analyze (inbuilt reporting tools, including comparison of actual achievement against goals, trend information over time, and comparative performance evaluation across providers). We plan to augment this information system through less frequent region-wide data reports on key regional performance measures, including claims-based data. The latter may require us to contract with a third-party data aggregator with sufficient data analytics capability to validate and augment the performance information reported by our providers through the QBS system.

CPAA will be using data from the above sources and analytical tools to issue regular reports to participating providers. These reports will serve two purposes: 1) inform providers on where to target their efforts; and 2) advise providers on progress toward meeting required objectives. For example, if a provider is working to reduce readmissions, CPAA will need to advise practices on clients with high hospital admission rates and clients with conditions that put them at high risk for readmission. This will enable provider practices to proactively engage these clients and provide care and patient education interventions to reduce the incidence of readmissions. Second, CPAA will need to report to provider practices their overall progress on meeting the required metrics for each project. For example, CPAA will need to monitor hospital utilization to determine readmission rates and will need to correctly associate individual clients with responsible practices. CPAA or its designated partner will provide regular reports (e.g., quarterly) to providers for this purpose.

As detailed above, when a provider or a group of practices is not making adequate progress on meeting key milestones and metrics, CPAA will reach out to the provider in question and develop a plan of action with the provider to remedy identified gaps or barriers. For example, CPAA and the provider might agree to additional workforce training to assure best practices are fully employed in working with the target population.

Additionally, CPAA will convene all partnering providers once per quarter to participate in a *peer learning collaborative*. Partnering providers will have the opportunity to share successes as well as to raise implementation challenges the partners can then engage on jointly to resolve. Likely, these meetings will result in the identification of additional technical assistance needs of partnering providers, on which CPAA will follow up accordingly. This learning collaborative will provide an important peer support function to our partnering providers and prove essential for the continuous improvement of our project.

Plan for Addressing Strategies That are Not Working or Not Achieving Outcomes

A similar approach will be used to assess overall progress of project initiatives and the efficacy of strategies within those initiatives. CPAA will use its quarterly performance reports along with semi-annual reports provided by the state with key metrics to determine whether the project initiative as a whole is on track and/or whether specific strategies within project areas are working as intended. If the

reports indicate that one or more strategies within the project area are not working, CPAA will convene key stakeholders to assess the reasons for the lack in effectiveness. This will include partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers). Based on this analysis, a recommendation will be made whether to continue the strategy in question with a revised approach or whether to discontinue the strategy in favor of a different one. The decision to change the approach or pursue a different strategy altogether rests with the CPAA Board based on a discussion and recommendation by the CPAA Council. However, given their key implementation role, any decision to change elements of a strategy or switch out an entire strategy will require the consent of our partnering providers. It may also require the approval of the state. If the CPAA Board authorizes a different approach or strategy, the project implementation plan will be revised accordingly, and CPAA will enter into a new or revised contract with partnering providers as the case may be.

Similarly, if the reports indicate that an entire project initiative is not achieving desired outcomes, CPAA will convene partnering providers, Provider Champions (Clinical Provider Advisory Committee), consumers (Consumer Advisory Committee), and subject matter experts (e.g., technical assistance providers) to analyze why the initiative is not effective. Every effort will be made to explore whether adjusting program elements or switching out certain strategies may lead to goal accomplishment. This may include consulting with other ACHs that work in a similar project area and are achieving success.

If the group believes changes to the project initiative will rectify the performance problem, a corresponding recommendation will be made to the CPAA Council, which will then discuss the matter and make a recommendation to the CPAA Board. Final decision-making rests with the board. As with switching out a specific strategy or changing a project approach within a project area, any such change requires the consent of our partnering providers that will need to implement the revised set of strategies. State approval may also need to be obtained. Assuming everyone approves the revised strategies, a detailed revised implementation will be developed with clear milestones, performance metrics, etc.

If, however, the group of key stakeholders concludes that the project initiative is irreparably compromised and no change in strategies will likely lead to success, a recommendation to discontinue the work in the project area altogether will be made to the CPAA Council. The council will discuss the matter and make a recommendation to the CPAA Board, which will make the final decision.

Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

CPAA's Strategy for Long-Term Project Sustainability and Impact on Washington's Health System Transformation Beyond the Demonstration Period

There are a number of factors that make it highly likely that our region will be able to sustain this project and provide lasting impact on Washington's health system transformation beyond the Transformation Project period:

1. The Reproductive and Maternal & Child Health project builds squarely on the work of the CPAA ACEs Work Group, which has expanded its scope to include reproductive, maternal, and child health. There is great interest in this project area in our region, and key stakeholders have already made substantial investments in whole-person health for women and children. Given the importance of this project area to the core mission of many of CPAA's health partners, it is highly likely that our key partners will continue their investments in this project area beyond the duration of the Medicaid Transformation as improved outcomes and efficiencies are being realized.
2. CPAA and CHOICE have a proven track record of developing innovative projects with pilot finding and then developing ways to sustain these efforts into the future. Key to our success

has been our ability to demonstrate to stakeholders, including payers, clinical providers, public health, and community-based organizations, that the project has enabled the stakeholders to achieve efficiencies, improve outcomes, or avert future costs. Recent examples of such projects include the Youth Behavioral Health Care Coordination Project, Youth Marijuana Prevention and Education Project.

3. As detailed above, in the course of this project, important investments into our region's health system transformation will be made that provide lasting benefits. The improvements to key health information systems; the expertise gained and skills built by training our partnering providers' workforce; the deep changes made to the workflows and business practices of our partners in the course of this project; and the partnerships built and strengthened through the collaborative planning and implementation of this project all combine to ensure that the improvements resulting from project initiative will be ongoing and sustained by our partners.
4. CPAA is planning to establish a regional innovation fund with a small portion of DSRIP project incentive funds earned through the Transformation Project. This funding pool will be available to support investments in community health improvements that emphasize the social determinants of health, i.e., the drivers of health outcomes that lie outside of the clinical sphere (health behaviors, built environment, socio-economic factors, etc.), as well as prevention and early intervention to improve community health and avert costs downstream. Given that the Reproductive and Maternal & Child Health project is rooted deeply in addressing social determinants of health and prevention and early intervention focused, we anticipate that resources from this regional fund may support the project beyond the Transformation Project period.
5. The development of value-based payment contracts is critical to the long-term sustainability of this and other Transformation projects. Some services, e.g., related to peri- and post-partum maternal care, and the resulting childcare, are currently covered in the Medicaid benefit. Similarly, increases in the capacity of providers to expand sexual and reproductive health services are more easily sustainable as contraceptive care and sexual health screenings are already Medicaid-covered benefits. However, the absence of viable payment models to support home visiting is a key barrier to improvements in this area. Reliable funding streams to support the full spectrum of reproductive, maternal, and child health tied to value-based care and expanding the types of organizations that can enter into such contracts will be central to the long-term sustainability of our region's investments in this project area. Because we will need to be creative in how we expand provider establishment and capacity, especially in rural areas, we will need to be creative in determining how these providers can be paid.
6. Our region will explore whether to establish a regional utility to make it possible for smaller agencies, especially social service providers, to bill Medicaid or be reimbursed for services rendered to Medicaid beneficiaries. Currently, many small providers are not equipped to administer Medicaid billing and reimbursement due to high administrative burden and costs, which limits their ability to provide services to the Medicaid population. CPAA may serve as a regional back office for small providers to handle Medicaid billing and reimbursements, thereby not only removing a major barrier to provider capacity expansion in our region, but also providing a stable funding source for reproductive, maternal and child health care.