



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual report Template
Reporting Period: July 1, 2018 – December 31, 2018

October 17, 2018

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• Semi-annual report workbook	
• Organizational self-assessment of internal controls and risks	

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports to report on project implementation and progress milestones. ACHs will complete a standardized semi-annual report template and workbook developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved Project Plans and corresponding Implementation Plans. HCA and the IA will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted at any subsequent time for purposes of monitoring and auditing, or general follow-up and learning discussions with the state (HCA), the Independent Assessor (IA) and/or the Independent External Evaluator (IEE).

Reporting requirements

The semi-annual report template for this reporting period includes four sections as outlined in the table below. With one exception, the reporting period for this semi-annual report covers July 1, 2018 to December 31, 2018.¹ Sections 1 and 2 instruct ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 4 per the Medicaid Transformation Toolkit. Sections 3 and 4 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Note: Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:

- The ACH as an organization
- The ACH's Partnering Providers
- The ACH and its Partnering Providers

Please read each prompt carefully for instructions as to how the ACH should respond.

¹ The reporting period for Value-based Payment (VBP) milestones covers the full calendar year, January 1 through December 31, 2018.

ACH semi-annual report 2		
Section	Reporting period	Sub-section description
Section 1. Required milestone reporting (VBP Incentives)	DY 2, Q1-Q4	Milestone: Inform providers of value-based payment (VBP) readiness tools to assist their move toward value-based care
		Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH
		Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey
		Milestone: Support providers to develop strategies to move toward value-based care
Section 2. Required milestone reporting (Project Incentives)	DY 2, Q3-Q4	Milestone: Support regional transition to integrated managed care (2020 regions only)
		Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)
		Milestone: Engagement/support of Independent External Evaluator (IEE) activities
Section 3. Standard reporting requirements (Project Incentives)	DY 2, Q3-Q4	ACH organizational updates
		Tribal engagement and collaboration
		Integrated managed care status update (early- and mid-adopters only)
		Project implementation status update
		Partnering provider engagement
		Community engagement and health equity
		Budget and funds flow
Section 4. Provider roster (Project Incentives)	DY 2, Q3-Q4	Completion/maintenance of partnering provider roster
Section 5. Integrated managed care implementation (Integration Incentives)	N/A	Milestone: Implementation of integrated managed care (mid-adopters only)

Key terms

The terms below are used in the semi-annual report and should be referenced by the ACH when developing responses.

1. **Community engagement:** Outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, that are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.
2. **Health equity:** Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.²
3. **Integrated managed care:**
 - a. **Early-adopter:** Refers to ACH regions implementing integrated managed care prior to January 1, 2019.
 - b. **2020 adopter:** Refers to ACH regions implementing integrated managed care by January 1, 2020.
 - c. **Mid-adopter:** Refers to ACH regions implementing integrated managed care on January 1, 2019.
4. **Key staff position:** Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, and Program Management and Strategy Development.
5. **Partnering provider:** Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
6. **Project areas:** The eight Medicaid Transformation projects that ACHs can implement.
7. **Project Portfolio:** The full set of project areas an ACH has chosen to implement.

Achievement Values

Throughout the transformation, each ACH can earn Achievement Values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).
2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).

ACHs can earn AVs by providing evidence of completion of reporting requirements and demonstrating performance on outcome metrics. The amount of incentive funding paid to an ACH will be based on the number of earned AVs out of total possible AVs for a given payment period.

² Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.

All possible earned incentives for the second semi-annual report are associated with P4R. The required P4R deliverables and milestones for the second semi-annual reporting period are identified in the table below.

Deliverable/Milestone	One-time / Recurrent	Reporting Period	AVs
Section 1. Required milestone reporting (VBP Incentives)			
<i>Milestone:</i> Inform providers of VBP readiness tools to assist their move toward value-based care	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support providers to develop strategies to move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Section 2. Required milestone reporting (Project Incentives)			
<i>Milestone:</i> Support regional transition to integrated managed care (2020 regions only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Engagement/support of Independent External Evaluator (IEE) activities	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 3. Standard reporting requirements (Project Incentives)			
<i>Deliverable:</i> Complete and timely submission of SAR. <i>Note: All non-milestone, standard reporting requirements are a part of the SAR 1.0 AV.</i>	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 4. Provider roster (Project Incentives)			
<i>Deliverable:</i> Completion/maintenance of partnering provider roster	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 5. Integrated managed care implementation (Integration Incentives)			
<i>Milestone:</i> Implementation of integrated managed care (mid-adopters only)	One-time	N/A	N/A

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the Independent Assessor **no later than January 31, 2019 at 3:00p.m. PST.**

Washington Collaboration, Performance, and Analytics System (WA CPAS)

ACHs must submit their semi-annual reports through the WA CPAS, which can be found at <https://cpaswa.mslc.com/>.

ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled “Semi-Annual Report 2 – January 31, 2019.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → Semi-Annual Report 2 – January 31, 2019.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

File format

ACHs must respond to all items in the Microsoft Word semi-annual report template and the Microsoft Excel semi-annual report workbook based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word and Microsoft Excel or a searchable PDF format. Below are examples of the file naming conventions that ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR2 Report. 1.31.19
- *Excel Workbook:* ACH Name. SAR2 Workbook. 1.31.19
- *Attachments:* ACH Name.SAR2 Attachment X. 1.31.19

Note that all submitted materials will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).³

³ <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

ACH semi-annual Report 2 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report template and workbook for reporting period 2 to ACHs	HCA	August 2018
2.	Submit semi-annual reports	ACHs	Jan 31, 2019
3.	Conduct assessment of reports	IA	Feb 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2019
7.	Issue findings to HCA for approval	IA	End of Q2

Contact information

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH contact information

Provide contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's semi-annual report. If secondary contacts should be included in communications, please also include their information.

ACH name:	Better Health Together
Primary contact name	Hadley Morrow
Phone number	(509) 954-0831
E-mail address	Hadley@betterhealthtogether.org
Secondary contact name	Alison Poulsen
Phone number	(509) 499-0482
E-mail address	Alison@betterhealthtogether.org

Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

Not Applicable

- In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
<i>Provider with low VBP knowledge</i>	Required all Partnering Providers in Behavioral Health setting to complete Qualis Billing and Information Technology assessment.	Assessments Due by April 2018, results compiled and shared in summary in	Qualis Billing and Information Technology Assessment, and summary of resulting themes and challenges.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
		June 2018.	
<i>Small (and rural) providers</i>	Linked on BHT’s Collaborative webpage – a resource targeting our 5 rural Collaboratives which are made up almost entirely of small, rural providers.	November 2018	Rural Health Value Team’s Comprehensive Value Based Care Strategic Planning Tool
<i>Behavioral health provider</i>	Links to resources posted on BHT’s IMC Transition website – our resource page targeting Partnering Providers in Behavioral Health.	November 2018	NACHC Payment Reform resources AMA Steps forward

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response:

Not Applicable

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
Partnering BH & SUD providers moving to IMC	Readiness for IMC – IT/EHR readiness, billing and claims testing	BHT contracted with Xpio to provide one-on-one support and TA to Partnering Providers around billing and claims testing, and IT/EHR readiness.
Partnering BH & SUD providers moving to IMC	Readiness for IMC – billing and operations, IT/EHR readiness, provider communication with clients, interpreter services change, etc.	BHT staff convened 3 IMC workgroups (IT/EHR, Early Warning, Communications), and maintain an IMC webpage of resources for our Partnering Providers. The IT/EHR Workgroup met monthly starting in May 2018 to connect providers to MCOs and HCA around billing and operations questions. The Early Warning System group developed indicators to monitor IMC starting in Feb. 2019. The Communications workgroup, made up of members of BHT’s Community Voices Council, developed recommendations and materials to help providers help their clients understand changes with IMC. BHT continues to maintain IMC webpage with resources, notes, and other materials for providers.
Staff & Providers from BH, SUD, and PC	Naloxone training to address opioid overdose in the community	On Dec. 10, BHT and WSU School of Pharmacy hosted a Naloxone training as part of our provider education efforts. The training included an overview of the opioid epidemic locally, how to identify signs and symptoms of possible opioid overdose, and how to respond in an overdose situation, including the proper use and administration of different available forms of naloxone. We had 32 participants from 13 organizations, including behavioral health, SUD, and primary care providers and staff.

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH’s efforts to support completion of the state’s 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
Survey Announced in ACH newsletter	No	No
Survey advertised on top of BHT Collaborative webpage, the online work portal for BHT partners. This ensures all BHT Partnering Providers see a banner advertising the survey, when they log in to access regular ACH communications and documents	No	Yes
Personal email from BHT staff to Partnering Providers, encouraging them to complete survey	No	No
Second reminder email from BHT staff to Partnering Providers, encouraging them to complete survey	No	No
Survey advertised on BHT Facebook page	No	Yes
Second announcement of survey on BHT Facebook page	No	Yes
Tweet survey link on BHT twitter	No	Yes
Re-tweet HCA tweet of survey	No	Yes

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique

provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
<i>Provider with low VBP knowledge</i>	<p>Greater clarity on roles and expectations for VBP transition</p> <p>Education on work done to date on VBP, and role of MVP</p>	<p>September 5th, hosted VBP feedback session with MCOs and Partnering Providers</p> <p>Presentation from VBP MVP team member</p>	Continued education to be provided in 2019 Learning Cohorts	Developed a robust set of community feedback on VBP to send to HCA
<i>Small provider</i>	<p>To develop Value Propositions for services with smaller capacity</p> <p>Education on billing and contracting with MCOs</p>	<p>Hosted two trainings on Billing with Adam Falcone</p> <p>Hosted MCO meet and greet between MCOs and providers</p>	Continued education to be provided in 2019 Learning Cohorts	Education and networking provided
<i>Behavioral health provider</i>	Training on new workflows, technology, and billing	BHT required that all BH Providers take Qualis Self Billing assessment, and offered payment for completed assessment	Continued education to be provided in 2019 Learning Cohorts	<p>All Partnering Providers in BH completed assessment, to help inform organizations strategy development</p> <p>Providers received an incentive for completion</p>

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

This section is Not Applicable for Better Health Together.

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond “Not applicable.”

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity’s qualifications. Include a description of the HUB lead entity’s organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response: Better Health Together (BHT) has chosen to be the lead entity of the Hub. BHT has demonstrated our organization’s qualifications to be the lead entity by implementing a Pathways pilot in Ferry County in 2017. BHT is a non-profit and an Accountable Community of Health (ACH). BHT ACH has fully staffed the Hub management.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response: While BHT has chosen not to pursue Hub certification, we will closely follow the certification path to maintain model fidelity, quality assessment, and improvement in all Hub operations to include CHW and clinical processes.

3. Describe the Project 2B HUB lead entity’s role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

ACH response: In May 2018 BHT adopted a HIPAA and Security Compliance policy to

ensure that all personal identifying information and protected health information are accessed and stored within requirements. In December 2018, BHT began an organization wide HIPAA and Security assessment with a third-party security audit company. The remediation process will further strengthen our compliance program. All contracted Care Coordination Agencies, referring partners, and Managed Care Organizations are required to sign a Business Associate Agreement, which requires the organizations to have in place, and comply with HIPAA and Security processes.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not applicable.”

ACH response: Not Applicable

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

- Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

- If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes,” to all items respond “Not applicable.”

ACH response: Not applicable

- Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

- If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If

the ACH checked “Yes,” to item A.3 respond “Not applicable.”

ACH response: Not Applicable

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period	X	

If the ACH checked “Yes” in item A.4 above:

Insert or include as an attachment a current organizational chart. Use **bold italicized font** to highlight changes, if any, to key staff positions during the reporting period.

Organization Chart attached as Attachment A.

B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).⁴

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response: Not Applicable

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

⁴ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

ACH response: Not Applicable

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response:

Recognizing the importance of maintaining our Behavioral Health provider capacity throughout IMC transition, BHT has coordinated a number of technical assistance and support activities for our partners, including:

- IT/EHR workgroup – the purpose of the group is to identify and resolve IT/EHR issues including but not limited to MCO/ASO billing capacity, EHR compatibility, provider data reporting requirements, and other technical assistance needed by providers. During the last 6 months, BHT convened this group monthly, and provided additional communication, assistance, and resources in between as needed. The group was primarily a convening place where providers got their questions for the MCOs and HCA answered, including topics:
 - Billing readiness - Credentialing, provider NPI, taxonomy codes, SERI, clearinghouses
 - Monitoring claims testing and making sure it was progressing for all providers in advance of 1/1
 - Maintaining a regional Question Tracker, and sharing MCO Question Tracker once it was created
 - Interpreter services, including a presentation and Q&A with HCA's Interpreter Services
 - Patient assignment and eligibility – questions about ProviderOne, what communication patients are receiving and how to talk to patients about change, when to expect new client assignments, what to do with out-of-region patients with MCOs not in the region, etc
- Early Warning System workgroup – BHT guided the group in developing recommendations for an Early Warning System that allows a feedback loop and triage process to identify and resolve system issues as they arise. In addition to the Standard Indicators from the state, the group also included added indicators from the SFD CARES Team and FBH's two ride-along programs, with the goal of monitoring other places/systems where Medicaid clients might show up.
- Communications workgroup – primarily consumer education, but also helped create language/communication to help providers communicate with patients about changes.
- Xpio contract assistance for providers – one-to-one assistance for providers with technology readiness, particularly around EHR system.

- IMC webpage – one-stop-shop for resources: meeting notes, FAQs, MCO billing guides and other resources, HCA guides & resources, etc. This page received 1,345 page views during this reporting period for an average of approximately 225 visits per month. Collectively, the resources provided on that page had nearly 3,000 clicks. One blog post, a provider-specific toolkit on how to communicate to Medicaid recipients, received 1,089 clicks.
 - Additional liaising between HCA and MCOs for providers – BHT acting as central point of contact for provider questions and concerns, particularly when they were having a hard time getting a response from these entities.
 - Monthly emails blasts out to providers – highlighting new content and updates that were added to the webpage, and summarizing activities in the workgroups.
2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response: BHT recognizes that if our behavioral health providers are unsuccessful in their transition to IMC, access too and quality of our system of care will be negatively impacted. BHT conducted outreach to all of the BHO contracted providers in our region, and maintains engagement with all but one organization which chose to opt-out of our support activities. We supported and facilitated IT/EHR, Early Warning System (EWS), and Communications workgroups specifically for our behavioral health providers during their transition to IMC. BHT developed a robust website specific to IMC with numerous resources, FAQ's, guidance documents, and links to further support our partners. We will continue with the IT/EHR and EWS work through January of 2019 and are exploring a TA Bank concept specific to IT/EHR and billing for our behavioral health partners throughout 2019 as we acknowledge their needs will continue to evolve within their new contracting arrangements.

The Spokane Collaborative will continue to focus on our regional system of care and whole person integration. This is a forum for multiple different sector providers to work together and our local BHO/BHASO is invited and has made a commitment to be more involved in 2019. In conjunction, BHT leadership continues to meet with BHO/ASO leadership to align work and identify areas of needed collaboration and support of our behavioral health partners. BHT is routinely invited to present at BHO/ASO specific meetings to support alignment and our commitment to providers.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding

through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

Allocation of all Behavioral Health Integration incentives for the BHT ACH are all run through community process. Recommendations for funds allocations begin at the Waiver Finance Workgroup, comprised of multi-sector Partnering Provider organizations. As needed, recommendations will also go to Technical Councils for input and refinement. The Waiver Finance Workgroup then votes whether to recommend that policy to the BHT Board. The proposal then goes to the BHT Board for final approval.

BHT tied incentive payments to Partnering Providers readiness for IMC. The final milestone for 2018 was to complete and attestation of Provider Readiness for IMC, and a commitment to serve Medicaid clients in 2019. The intent of this attestation is to verify that partners were ready to serve Medicaid in 2019. Moving forward, we will continue to verify this in our ACH's semi-annual reporting process with our Partnering Providers.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

BHT has supported Behavioral Health providers by offering many opportunities for technical assistance and support, including:

- Xpio technical assistance – this support will continue to be available to providers thru Jan. 31
- Rapid Response calls – BHT is part of the HCA's Rapid Response calls. We are collecting questions from providers and making sure they are answered, communicating answers and other resources out to providers, and taking notes on the calls. Notes and any other resources that come from the calls are also being posted on the IMC webpage.
- Early Warning System – Starting in February, BHT will support the monthly state-led Early Warning System webinars, including help facilitate communication and data collection from providers, ensuring the right participants are on the calls, following up with any issues/concerns that emerge from the EWS, and any other assistance needed by the state or providers to make the system successful.
- Maintaining IMC webpage
- Continuing to be a central point-of-contact/liaison for provider question about IMC, including helping providers get the answers and resources they need from the MCOs and HCA.
- Submission of Partnering Provider Transformation Plans that address the four

key projects of the Medicaid Waiver. 44 Partnering Providers developed and are now finalizing Transformation Plans. BHT will be supporting them through the operational & administrative changes needed for successful transformation.

- Learning Cohorts – The Learning Cohorts will provide TA to our Partnering Providers, including for their bidirectional integration projects. Practice and financial integration are necessarily linked, and TA toward admin/ops improvements can include improvements to workflows, EHR systems, and more.

5. Complete the items outlined in tab 3.C of the semi-annual report workbook.

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.⁵

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.

1. Provide the ACH’s current implementation plan that documents the following information:

- a. Work steps and their status (in progress, completed, or not started).

The workplan can be found in Attachment B.

- b. Identification of work steps that apply to required milestones for the reporting period.

These milestones are noted with an Asterix (*) in the workplan, listed as Attachment B.

Required attachment: Current implementation plan that reflects progress made during reporting period.

⁵ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

See Attachment B.

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

ACH response:

Achievements:

1. In DY2 Q3 BHT received 44 Transformation Plans from Partnering Providers from Behavioral Health and Primary Care settings. This includes plans from six of the seven Tribal providers in the BHT region. This represents a great achievement, as the majority of the Medicaid delivery system in the region is committed transformation efforts.
2. BHT's Spokane Jail Transitions Pilot utilizing the Pathways Hub model launched in November of 2018. RFPs were released and two local organizations, SNAP and Community Minded Enterprises, were selected as the Care Coordination Agencies for this project. Agency staff were successfully trained on the model, and starting seeing clients on November 30th 2018.
3. BHT is enormously proud of the evolution of our Equity work. In partnership with the Spokane Regional Health District, BHT has developed a framework for identifying and measuring equity gaps in our community. Up to this point, Partnering Providers were feeling a lot of confusion about what health equity means. The development of this framework has helped bring clarity about what we mean when we ask our Partnering Providers to address equity, and will help our Collaborative test the mechanism of collective impact with an equity lens.

Risks:

1. Given just how critical IMC is to success in transformation, being on the mid-adopter timeline carried inherent risk. The region is already struggling from an incredible shortage of providers, so we could not risk losing any providers in the process without critically damaging regional capacity for service. Recognizing the importance of success here, BHT dedicated 0.7 FTE to staffing IMC efforts and supporting partners through the transition. BHT used our IMC dollars to support extensive training for providers on Medicaid billing. BHT also launched an IMC website that served as a single reference point for IMC news, updates, resources, and meeting schedules.
2. BHT continues to view the lack of security around human services funding in our current political climate another risk to transformation. Housing instability threatens to undermine much of the community resiliency work ACH projects are attempting to enact. BHT continues to monitor policy opportunities closely. Throughout the reporting period we conducted conversations with our Technical Councils on potential priorities for our Community Resiliency Fund. Based on these conversations, we expect there will be high interest in directing those dollar towards housing and human services related

opportunities to support the social determinants. Additionally, at the request of our partners, BHT intends to launch a policy and advocacy agenda in 2019 to begin tracking policy opportunities more closely.

3. BHT struggled to maintain consistent attendance from Medicaid Beneficiaries in our Community Voices Council. Lack of consistency hurt the group’s cohesiveness and readiness to support BHT decision-making. If consumer voice is not meaningfully integrated into the decision-making process, we risk building programs that may unintentionally exclude or harm communities. BHT brought some of these challenges to the HCA Learning Symposium for shared learning with fellow ACHs to develop new strategies to increase engagement in 2019. In response, BHT has developed a plan to restructure our CVC from a traditional council to a smaller engagement team. Instead of a council of 30, we will recruit 4-8 Medicaid beneficiaries to serve as an outreach team with BHT. These folks would be offered trainings on public speaking, advocacy 101, and Medicaid Transformation to support them in being allies and liaisons to the work. Team members will receive a monthly stipend and be expected to complete monthly report outs of any questions, issues, or concerns rising from the community. We believe investing more time and support into these community members will lead to more meaningful engagement.

3. Did the ACH make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
X	

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response:

BHT has adjusted our target population related to the Community Based Care Coordination pilot since submitting our Implementation Plan. The IP indicated that each Collaborative would be eligible to pursue a Care Coordination Pilot specifically with the Jail Transitions population or with High-Risk Pregnant Mothers. We are removing this expectation for our five rural collaboratives, and instead are inviting them to participate in design sessions in DY3 Q1 and Q2 to make their own decision on what population they would like to focus on. Spokane County has already launched with a Jail Transitions population for Care Coordination and will continue to provide services to that population.

Additionally, we have found that MCOs are not prepared to execute contracts to support the outcome payment element of the Pathways model. BHT is willing to subsidize

outcome payments for a time. However, we have concern about the long-term sustainability if we are unsuccessful in getting MCOs to contract for a portion of these contracts, which has made launching in multiple counties financially unviable.

We found in our Ferry County Jail Transitions Pilot that the program struggled to reach a high enough number of clients to be sustainable because of the size of the jail. Similarly, outside of Adams County, most of our rural counties do not have a high enough rates of Medicaid births to ensure enough of a target population to reach. At the same time, we believe allowing our rural partners to select their own population will lead to projects that are more in-line with community priorities and strengths.

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>Pathways evaluation</i>	Prove value proposition of Pathways model	BHT has contracted with Providence CORE to evaluate our Community-Based Care Coordination Pilot with Pathways, as have a number of additional ACHs. In October 2018 BHT led a meeting with HCA, MCOs, and the other ACHs to discuss how we could align our Pathways work and prevent duplication of efforts for this evaluation. That we are all using the same evaluator will help with alignment and more thorough evaluation of the model.
<i>IMC transition</i>	Ensure all partners have access to most up to date IMC information.	Throughout our mid-adopter IMC transition, BHT leaned on North Central as an early adopter for support and lessons learned. Similarly, BHT is scheduling conversations with Olympic and

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
		other on-time (late) adopter regions to “pay if forward” in more lessons learned from our region. BHT has hosted an IMC Transition Webpage with resources and updates, which other ACHs are using as a resource. We are happy to share this to reduce duplication of work and messaging.
<p>Regular cross-ACH calls and meetings, including but not limited to:</p> <ol style="list-style-type: none"> 1. Wednesday AM ED Huddle call 2. Monthly ACH ED Meeting 3. ACH program leads call 4. ACH Communications call 5. ACH Community Engagement call 	<ul style="list-style-type: none"> • Regular updates, shared learning, and collaboration • Identify shared risks and mitigation strategies • Discuss opportunities for alignment and partnership 	<p>ACH staff meet to discuss topics related to:</p> <ul style="list-style-type: none"> • Data • Coordination with MCOs • Shared learning and strategy • Communications and Community Engagement

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response:

Not applicable.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for IMC, etc.

ACH response:

MCO representatives have been invited to engage at all levels of the ACH decision-making process. They attend our Collaborative meetings to participate in transformation

planning discussions with Partnering Providers. MCO representatives sit on the Provider Champions Council and Waiver Finance Workgroup to support alignment with provider reporting and contract requirements. They were also active participants in the Community Voices Council, creating a space where MCOs could hear directly from their members about what issues or concerns they had around integration and transformation. MCO representatives frequently attend our BHT Board Community Comment hour as well as open meetings in order to stay up to date on ACH decisions. Each MCO has been invited to engage in a monthly check-in meeting with BHT's Executive Director in an effort to maintain open communication and opportunities for alignment. To date, only Molina has set up regular conversations.

F. Community engagement and health equity

- 4. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

- 5. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”

ACH response:

Not Applicable

- 6. Provide three examples of the ACH’s community engagement⁶ and health equity⁷ activities that occurred during the reporting period that reflect the ACH’s priorities for health equity and community engagement.

ACH response:

Community Voices Council (CVC):

The ACH Community Voices Council, comprised of both Medicaid Beneficiaries and Community Health Workers and Advocates who serve Medicaid clients, met monthly

⁶ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH’s projects.

⁷ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

from June-December 2018 to serve as a mechanism to make sure consumer voice was embedded in the ACH decision-making structure.

The CVC also took on the roles of the Communications Workgroup for IMC this year, the outcome of which served as a great example of the CVC as a community engagement mechanism. The council's Medicaid Beneficiaries brought to light some of the confusing rumors and misconceptions they had around the IMC transition, and what it meant that their options had changed from 5 to 3 plans. We were able to offer education on the transition that not only quelled their fears, but also empowered them to inform their peers about the changes. Some council members began asking around low-income housing sites in Spokane to see if people had questions. They found there were, in fact, many questions. These folks worked with BHT staff to organize an on-location Q&A to make sure folks had their questions answered.

Aligning Rural Community Priorities with ACH Equity Goals:

It has been incredibly fortunate that the launching of our Rural Collaborative work aligned with all three of our Rural health departments undertaking their Community Health Needs Assessment work. A central community engagement tactic of BHT has been to find ways to honor and embed local priorities into the ACH to ensure the work stays true to community momentum. The five rural counties in our region spent this reporting period working through formalizing the selection of their priorities (which will be finalized in DY3 Q1). During this time, BHT staff were able to work in partnership with local health district staff and ACH Collaborative Leads to develop a framework for identifying health inequities that exist within those priorities. This framework will help each Collaborative practice the mechanism of collective impact, with an equity lens. In 2019 we will explore potential allocation of funds for this work. Funds will be contingent upon the Collaborative's members agreeing on an equity gap and target population, and documenting and reporting on their committed activities.

Pay for Equity

In DY2 Q4, the BHT Board approved a policy of tying 20% of all Pay-for-Reporting dollars each Partnering Provider are eligible to earn in 2019 to equity related activities. In 2019, Partnering Providers will be expected to take an organizational equity assessment, meant to help identify potential areas of improvement related to achieving equity. The results of this assessment will help BHT select a menu of equity activities on which to provide technical assistance. Partnering Providers will be expected to set internal equity goals as a result of that assessment, and as a milestone for earning payments. A percentage of dollars will also be held pending report out and involvement on the organizations activities in the previously mentioned Collaborative Equity goal project. By tying dollars to participation in this collective impact project, we are not only practicing using an equity lens but strengthening the natural network of care needed to steward this long term work.

G. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. Earned Project Incentives

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

Care Coordination Evaluation: BHT is using Health Systems and Community Capacity investments to fund an evaluation for our Community-Based Care Coordination Pilot by Providence CORE. BHT was an early adopter of the Pathways model, and believes standardizing and centralizing referral services will improve access and outcomes. BHT is funding this evaluation to ensure we capture the efforts and outcomes of the many partners involved and prove the model. This will produce the evidence we need to negotiate payments for outcomes with potential payers like health plans, governments and philanthropy to ensure sustainability of the model.

Technical Assistance Contracts with Subject Matter Experts: Funds were used to pay for contracts with the AIM center and HMA to hire subject matter experts to deliver technical assistance to our Learning Cohorts in 2019. These subject matter experts will conduct in person trainings on topics related to change management, AIM statements, bi-directional integration, opioids, and chronic disease to support Partnering Providers in developing a more whole person care approach, and position them to be successful providers of value-based care.

Collaborative Lead Management: BHT paid \$50,000 of Health System and Community Capacity dollars to the 5 organizations who have taken on a "Collaborative Lead" position in one of our 5 rural collaboratives. Each Collaborative nominated and unanimously selected a Collaborative Lead agency who is responsible for organizing meetings, submitting county-wide plans and reports, and being a liaison back to BHT. This investment builds on current networks of care, and supports local collaboration and solutions. We see these

partnerships and networks as crucial to sustaining transformation efforts once Medicaid Transformation dollars are gone.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

BHT ACH will withhold 10% of all Transformation dollars to invest in a Community Resiliency Fund. The fund will align with ACH community priorities to strengthen the linkages between the health care systems and providers who focus on social determinants of health. It is the intent of the BHT ACH to leverage these dollars to influence increased, targeted investment in population and community health improvement, including aligning nonprofit hospital community benefit dollars, philanthropic funders, and shared savings investment models based on data. BHT has begun early design work for this fund through our Technical Councils, and intends to approach funders about aligning resources in 2019.

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁸

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:

⁸ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

- a. All active partnering providers participating in project activities.
- b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
- c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response: BHT is currently projecting that 44 Partnering Providers will enter into transformation contracts for 2019. Among this group of 44 organizations, less than half have more than one service location.

For the most part, BHT’s Partnering Providers are developing and implementing Transformation Plans at the organizational level, rather than by individual clinic or site. While there may be some variation in specific strategies or timing to account for site-specific circumstances, BHT’s partners have been asked to describe their transformation aims, milestones, and key activities for each project for the organization as a whole.

However, BHT’s partner reporting mechanisms will include data collection at both the clinic / site and organization level. To support this data collection, BHT will maintain records of which sites are participating in which DSRIP project.

Per the specifications, BHT will collect information for HCA’s P4R metrics at the clinic / site level. Prior to the first round of data collection, BHT will verify site type (practice/clinic site vs. CBO) and whether the site is participating in the bi-directional integration project, the opioids project, or both, so that sites are only asked to report on the P4R items that pertain to them.

BHT will collect information about partners’ progress towards their own milestones and towards the measures they have selected from BHT’s Pay-for-Achievement (P4A) menu at the organization level. See [this link](#) for more information on the P4A measures menu.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not Applicable

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Executive Director

Alison Poulsen

As the work BHT leads in the community makes the shift from planning to action, internally BHT moves from startup to established. We structured the team to align with organization efforts and key strategies. To this end, we prioritized recruitment and nurturing a diverse range of skills, life experience, and professional expertise.

Director of Clinical Integration

Charisse Pope

Senior Program Manager

Sarah Bollig Dorn

Director of Equity & Engagement

Hadley Morrow

Program Assistant

TBD

Director of Community Service

Jenny Slagle

Hub Manager

Jamie Wiggins

Program Assistant

Symetria Gongyin

Navigator Manager

Alicyn Elder

Lead Navigator

Israel Vidales

Director of Communications & Operations

Kim Brinkmann

Operations Manager

Hailey Muto

Administrative Assitant

Alethea Dumas

Communications Assitant

Garrett Saiki

Back office Services

Daphne Williams, HR Director
Wendy Xue, Accounting Manager

Rebecca Johnston, HR Generalist
Tristen Canfield, Reception



Better Health Together

ACH Earned Incentives and Expenditures

July 1, 2018 - December 31, 2018

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period ²	
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$5,873,973
2B: Community-Based Care Coordination	\$4,038,357
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing the Opioid Use Public Health Crisis	\$734,247
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	\$1,468,493
Integration Incentives	\$3,320,749
Value-Based Payment (VBP) Incentives	
Indian Health Care Provider (IHCP)-Specific Projects	
High Performance Incentives	
Total Funds Earned During Reporting Period	\$15,435,819

Funds Distributed by ACH During Reporting Period, by Use Category ³	
Administration	\$135,171
Community Health Fund	
Health Systems and Community Capacity Building	\$435,000
Integration Incentives	\$320,000
Project Management	
Provider Engagement, Participation and Implementation	\$965,000
Provider Performance and Quality Incentives	
Reserve / Contingency Fund	
Shared Domain 1 Incentives	\$3,055,594
Total Funds Distributed During Reporting Period	\$4,910,765

Funds Distributed by ACH During Reporting Period, by Provider Type ³	
ACH	\$385,171
Non-Traditional Provider	\$258,500
Traditional Medicaid Provider	\$967,500
Tribal Provider (Tribe)	\$199,000
Tribal Provider - Urban Indian Health Programs (UIHP)	\$45,000
Shared Domain 1 Provider	\$3,055,594
Total Funds Distributed During Reporting Period	\$4,910,765

Total Funds Earned During Reporting Period	\$15,435,819
Total Funds Distributed During Reporting Period	\$4,910,765
Total Funds Left Available for Distribution During Reporting Period	\$10,525,054

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 4, 2019 to accompany the second Semi-Annual Report submission for the reporting period July 1 to December 31, 2018.

² For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.
- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

³ Definitions for [Use Categories and Provider Types](#)

Organizational Self-Assessment of Internal Controls and Risks

ACH NAME: Better Health Together

Date Prepared: 1/11/2019

Answer "Yes" if the activity in question is performed internally or externally (unless specified). Each "No" answer indicates a potential weakness of internal fiscal controls. All "No" answers require an explanation of mitigating controls or a note of planned changes. If the activity does not apply to your organization, answer N/A.

I. CONTROL ENVIRONMENT

A. Management's Philosophy and Operating Style

Yes N/A No

- | | | | |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Are periodic (monthly, quarterly) reports on the status of actual to budgeted expenditures prepared and reviewed by top management? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Are unusual variances between budgeted revenues and expenditures and actual revenues and expenditures examined? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the internal control structure supervised and reviewed by management to determine if it is operating as intended? |

B. Organizational Structure

- | | | | |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Is there a current organizational chart defining the lines of responsibility? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Have all staff been sufficiently trained to perform their assigned duties? |

C. Assignment of Authority and Responsibility

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Are sufficient training opportunities to improve competency and update employees on Program, Fiscal and Personnel policies and procedures available? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Have managers been provided with clear goals and direction from the governing body or top management? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Is program information issued by the Health Care Authority distributed to appropriate staff? |

II. HUMAN RESOURCES

A. Control Activities/Information and Communication

Yes N/A No

- | | | | |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Are personnel policies in writing? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Are personnel files maintained for all employees? |

II. HUMAN RESOURCES (continued)

A. Control Activities/Information and Communication

Yes **N/A** **No**

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Are payroll costs accurately charged to grants using time spent in each program? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Are accurate, up-to-date position descriptions available? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Do all supervisors and managers have at least a working knowledge of personnel policies and procedures? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Does each supervisor and manager have a copy or access to a copy of personnel policies and procedures? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Does management ensure compliance with the organization's personnel policies and procedures manual concerning hiring, training, promoting, and compensating employees? |
| | | | 8. Are the following duties generally performed by different people? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. Processing personnel action forms and processing payroll? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Supervising and timekeeping, payroll processing, disbursing, and making general ledger entries? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Personnel and approving time reports? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. Personnel and payroll preparation? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Recording the payroll in the general ledger and the payroll processing function? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Is access to payroll/personnel files limited to authorized individuals? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are procedures in place to ensure that all keys, equipment, credit cards, cell phones, laptops, etc. are returned by the terminating employee? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Is information on employment applications verified and are references contacted? |

III. ACCOUNTS PAYABLE

A. Control Activities/Information and Communication

Yes **N/A** **No**

- | | | | |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Has the organization established procedures to ensure that all voided checks are properly accounted for and effectively cancelled? |
|-------------------------------------|--------------------------|--------------------------|---|

III.ACCOUNTS PAYABLE (continued)

A. Control Activities/Information and Communication

Yes N/A No

2. Do invoice-processing procedures provide for:

- | | | | |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. Obtaining copies of requisitions, purchase orders and receiving reports? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Comparison of invoice quantities, prices, and terms with those indicated on the purchase order? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Comparison of invoice quantities with those indicated on the receiving reports? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d. As appropriate, checking accuracy of calculations? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Alteration/destruction of extra copies of invoices to prevent duplicate payments? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | f. All file copies of invoices are stamped/marked paid to prevent duplicate payments? |

3. Are payments made only on the basis of original invoices and to suppliers identified on supporting documentation?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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4. Are the accounting and purchasing departments promptly notified of returned purchases and are such purchases correlated with vendor credit memos?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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5. Are monthly reconciliations performed on the following:

- | | | | |
|-------------------------------------|-------------------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | a. All petty cash accounts? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. All bank accounts? |

6. Are the following duties generally performed by different people?

- | | | | |
|-------------------------------------|-------------------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | a. Requisitioning, purchasing, and receiving functions and the invoice processing, accounts payable, and general ledger functions? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Purchasing, requisitioning, and receiving? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c. Invoice processing and making entries to the general ledger? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | d. Preparation of cash disbursements, approval of them, and making entries to the general ledger? |

7. Is check signing limited to only authorized personnel?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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8. Are disbursements approved for payment only by properly designated officials?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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III.ACCOUNTS PAYABLE (continued)

A. Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Is the individual responsible for approval or check signing furnished with invoices and supporting data to be reviewed prior to approval or check-signing?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Are unused checks adequately controlled and safeguarded?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is it prohibited to sign blank checks in advance?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Is it prohibited to make checks out to the order of "cash"?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. If facsimile or e-signatures are used, are the signature plates adequately controlled and separated physically from blank checks?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Are purchase orders pre-numbered and issued in sequence?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Are changes to contracts or purchase orders subject to the same controls and approvals as the original agreement?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Are all records, checks and supporting documents retained according to the applicable record retention policy?

IV. COMPLIANCE SUPPLEMENT ELEMENTS

A. Cash Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Are requests for advance payment (A-19's) based on actual program needs?
			2. Are the following duties generally performed by different people?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Preparing the request for payment from HCA (A-19)?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Reviewing and approving the request for advance payment from HCA (A-19)?

B. Equipment and Real Property Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Are all disposals of property approved by a designated person with proper authority?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Has organization management chosen and documented the threshold level for capitalization in an internal policy/procedure book?

IV.COMPLIANCE SUPPLEMENT ELEMENTS (continued)

B. Equipment and Real Property Management

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Is someone assigned custodial responsibility by location for all assets?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is access to the perpetual fixed asset records limited to authorized individuals?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Is there adequate physical security surrounding the fixed asset items?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Is there adequate insurance coverage of the fixed asset items?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Is insurance coverage independently reviewed periodically?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Is a fixed asset inventory taken annually?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Are missing items investigated and reasons for them documented?

C. Procurement and Suspension and Debarment

Non-Federal entities are prohibited from contracting with or making sub awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of \$100,000 and all non-procurement transactions. [Http://www.sam.gov/](http://www.sam.gov/) This website is provided by the General Services Administration (GSA) for the purpose of disseminating information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits.

Control Activities/Information and Communication

<u>Yes</u>	<u>N/A</u>	<u>No</u>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Is there established segregation of duties between employees responsible for contracting; accounts payable and cash disbursing.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Is the contractor's performance included in the terms, conditions, and specifications of the contract monitored and documented?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do supervisors review procurement and contracting decisions for compliance with Federal procurement policies?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Are procedures established to verify that vendors providing goods and services under the award have not been suspended or debarred by the Federal government?

**C. Procurement and Suspension and Debarment
Control Activities/Information and Communication**

Yes N/A No

			5. Are there written policies for the procurement and contracts establishing:
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	a. Contract files
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. Methods of procurement
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. Contractor rejection or selection
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d. Basis of contract price
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	e. Verification of full and open competition
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	f. Requirements for cost or price analysis
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	g. Obtaining and reacting to suspension and debarment certifications
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	h. Other applicable requirements for Federal procurement
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	i. Conflict of interest
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	6. Is there written policy addressing suspension and debarments of contractors?
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7. Are there proper channels for communicating suspected procurement and contracting improprieties?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Does management perform periodic review of procurement and contracting activities to determine whether policies and procedures are being followed?

Explanation of Nos

- 5. BHT has no written policies for procurement and contract. The following items are managed by BHT team.
 - a. All contracts are kept in an up to date contract file in both accounting office and on BHT's SharePoint
 - b. If specialized needs aren't required, BHT procurements contracts through an RFP process
 - c. When procurement is utilized, all contractors are notified of selection or rejection.
 - d. Contract amount is based on BHT board approved budget
 - e. BHT does not have the staff capacity to do this, if required by HCA we will move to implement.
 - f. BHT does not have the staff capacity to do this, if required by HCA we will move to implement.
 - g. BHT does not have the staff capacity to do this, if required by HCA we will move to implement.
 - h. If BHT has federal procurements required per contract, BHT will implement.
 - i. Many of BHT's contracts have a Conflict of Interest clause included. There is no formal process to review this at this time. If required by HCA, we will move to implement.
- 6. BHT has no written policy for addressing these issues, if required by HCA we will put in place.
- 7. BHT does not have the staff capacity to do this. If issues arise, they are handled by BHT's Executive Director and CFO. If required by HCA, BHT will move to implement.

**D. Reporting
Control Activities/Information and Communication**

Control Activities/Information and Communication

1. Are personnel responsible for submitting required reporting information

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes	N/A	No

adequately trained?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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2. Does management review required reports before submitting?

E. Single Audit

Control Activities/Information and Communication

Yes N/A No

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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1. Was the organization audited by an objective accounting firm this past fiscal year?

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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2. Did appropriate organization staff review the findings of the previous years' audit as preparation for the current year audit?

E. Single Audit (continued)

Control Activities/Information and Communication

Yes N/A No

3. Have all audit findings and questioned costs from previous years been appropriately resolved?

V. CERTIFICATION

I hereby certify that the information presented in this self-assessment of internal controls and risk is true, accurate, and complete, to the best of my knowledge.

Organization Name: Better Health Together

Authorized Official Signature

Date 1/29/2019



February 18, 2019

Dear Ms. Morrow:

Thank you for the submission of Better Health Together's Semi-Annual Report Assessment 2. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project, Myers and Stauffer LC (Myers and Stauffer) has assessed the Semi-Annual Review 2 submission requirements.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information.

Please feel free to contact Myers and Stauffer at WADSRIP@mssl.com for additional information should you need clarification about the request. In your email, please specify your questions, or request a conference call if a discussion would be preferred. If requesting a conference call, please provide two or three available timeframes.

Please post your response in PDF, Excel or Word format following the resubmission instructions below to WA CPAS (<https://cpaswa.mssl.com/>) within the Request for Information folder (pathway is Semi-Annual Report > Semi-Annual Report 2 – January 31, 2019 > Request for Information). **We ask for your response no later than 5:00 p.m. PST, March 12, 2019.** Information received after this date will not be considered.

Thank you,
Myers and Stauffer LC



**Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report 2 Assessment
*Reporting Period: January 1 to December 31, 2018***

Request for Supplemental Information

Upon review of the ACH's Semi-Annual Report Assessment, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification.

- If the question applies to the project narrative, please provide a response within this document. The naming convention should be as follows: "RESPONSE ACH name.SAR2.RFI.Date"
- If the question applies to the workbook, please respond with an **updated** workbook. The naming convention should be as follows: "REVISED ACH Name.SAR2 Workbook.Date"

Section 2: Required Milestone Reporting (Project Incentives)

Milestone 2, Question 3: Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

1. **Independent Assessor Question:** Provide a detailed description of the role and processes Better Health Together, as the Project 2B HUB lead entity, will engage to manage HUB information technology requirements. Your response should include a description of your data governance that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities. Please address processes to manage clinical and administrative data collection and reporting.

In May 2018, Better Health Together adopted a Confidentiality, and Data Security policy along with an annual required training. As the Hub lead entity, BHT has a Business Associate Agreement with the referring entity, evaluators, Care Coordinating Agencies (CCAs) and Care Coordination Systems (CCS). The Care Coordinating Agencies employ the Community Health Workers (CHWs) who provide care coordination services to the target population (clients) and document all case management activity directly into the CCS platform. Any notes or documentation captured on paper is transferred to the CCS platform and properly disposed of. Prior to establishing a care coordination plan, the CHWs obtain a



Release of Information from the client. Access to client data and health information is limited to CCAs, Evaluation team, and Hub Operation personnel. Communication between Hub Operation staff and CCAs about specific clients is conducted through the secure message center within the CCS platform. Reports; such as for billing; that must have Client Personal Identifying Information (PII) is stored the local hard drives of Hub personnel workstations. These workstations are only accessible to the designated personnel and use multifactor authentication. Other reports; such as general Hub status reports; do not have PII, and consist of disaggregated information.

Section 3: Standard Reporting Requirements (Project Incentives)

Part C, Integrated Managed Care Status Update, Question 6: Complete the items outlined in tab 3.C of the semi-annual report workbook.

2. ***Independent Assessor Question:*** Please provide more detail on the use of incentives to support Integrated Managed Care on tab 3.C of the Semi-annual report Workbook. Include how the listed items are being used to help providers transition to integrated managed care.