



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual reporting guidance
Reporting period: January 1, 2019 – June 30, 2019
SAR 3.0

Release date: January 31, 2019

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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 on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance 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 year of the Medicaid Transformation:

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

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. The Washington State Health Care Authority (HCA) and the state's contracted Independent Assessor (IA) will review semi-annual report submissions.

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

Reporting requirements

The semi-annual report for this period (January 1, 2019 to June 30, 2019) includes three sections as outlined in the table below.

Semi-annual reporting requirements (January 1, 2019 – June 30, 2019)		
Section	Item num	Sub-section components
Section 1. ACH organizational updates	1-8	Attestations
	9-14	Attachments/documentation <ul style="list-style-type: none"> - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	15-17	Attachments/documentation <ul style="list-style-type: none"> - Implementation work plan - Partnering provider roster - Quality improvement strategy update
	18-19	Narrative responses <ul style="list-style-type: none"> - General implementation update - Regional integrated managed care implementation update
	20	Attestations
Section 3. Pay-for-Reporting (P4R) metrics	21	Documentation

There is no set template for this semi annual report. ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

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 they completed reporting requirements and demonstrated performance on outcome metrics. The amount of Project Incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given payment period.

For DY 3, 75% of all Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of January 1 through June 30, 2019, determines achievement for half of the available P4R-associated Project Incentives. The remaining half of the P4R Project Incentives will be earned through the semi-annual report covering the period from July 1 to December 31, 2019.

ACHs will earn AVs and associated incentive payments for demonstrating fulfillment of expectations and content requirements. AVs associated with this reporting period are identified in the table below.

Table 1. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period Jan. 1- June 30, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	8	6	-	-	7	-	-	6	27
Cascade Pacific Action Alliance	7	6	6	-	7	6	-	6	38
Greater Columbia ACH	8	-	6	-	7	-	-	6	27
HealthierHere	8	-	6	-	7	-	-	6	27
North Central ACH	8	6	6	6	7	-	-	6	39
North Sound ACH	8	6	6	6	7	6	6	6	51
Olympic Community of Health	7	-	-	6	7	6	6	6	38
Pierce County ACH	8	6	-	-	7	-	-	6	27
SWACH	8	6	-	-	7	-	-	6	27

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than July 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: <https://cpaswa.mslc.com/>.

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 3 – July 31, 2019.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → *Semi-Annual Report 3 – July 31, 2019*.

See WA CPAS User Guide available in each ACH’s directory on the CPAS website for further detail on document submission.

File format

ACHs must submit semi-annual reports that provide HCA and the IA an update on regional project implementation progress during the reporting period. Reports should respond to all required items in this guidance document. ACHs are encouraged to be concise in narrative responses.

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. 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, Microsoft Excel, and/or a searchable PDF format. Below are examples of the file naming conventions ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR3 Report. 7.31.19
- *Attachments:* ACH Name.SAR3 Attachment X. 7.31.19

Upon submission, all submitted materials will be posted publicly to HCA’s Medicaid Transformation resources webpage.¹

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2019 – June 30, 2019.

¹ <https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents>

ACH semi-annual report 3 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report template and workbook for reporting period January 1 – June 30, 2019 to ACHs	HCA	February 2019
2.	Submit semi-annual report	ACHs	July 31, 2019
3.	Conduct assessment of reports	IA	Aug 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 26-31, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 27- Sept 15, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Aug 28-Sept 30, 2019
7.	Issue findings to HCA for approval	IA	September 2019

Contact information

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

ACH contact information

Include in the semi-annual report the 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 Phone number E-mail address	Hadley Morrow (509) 954-0831 hadley@betterhealthtogether.org
Secondary contact name Phone number E-mail address	Alison Poulsen (509) 499-0482 alison@betterhealthtogether.org

Section 1. ACH organizational updates

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

Foundational ACH requirements	Yes	No
1. 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	
2. The ACH has an Executive Director.	x	
3. 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: <ul style="list-style-type: none"> • 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 • 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	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	x	
5. Meetings of the ACH's decision-making body are open to the public.	x	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits. ²	x	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	x	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	x	

² <https://wahca.box.com/s/nfjesjaldc5m1ye6a0bhiouu5xeme0h26>

If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

Attachments

The ACH should provide applicable attachments or additional context for clarity that addresses the following:

9. Key staff position changes. If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

If applicable, attach or insert current organizational chart.

See Attachment A

10. Budget/funds flow.

- Financial Executor Portal activity for the reporting period. The Financial Executor will provide to the Independent Assessor an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. Use Category reconciliation documentation will be included, if applicable. No action is required by the ACH for this item.
 - Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal, etc.).

Documentation

The ACH should provide documentation that addresses the following:

11. Tribal Collaboration and Communication. Provide two examples that demonstrate how the ACH furthered the relationships with Tribes and Indian Health Care Providers (IHCPs) with whom the ACH shares the region.

Better Health Together convenes and provides project support for the monthly Tribal Partners Leadership meetings. During this past six months, the Tribal Partners have been discussing a collaboration between their organizations where they could implement a community-based care coordination project. With the Medicaid state plan amendment, tribes are able to designate themselves as Tribal Federally Qualified Health Centers. They'd be able to bill for services outside of their clinics, and contract with other providers such as the American Indian Center Good Heart Behavioral Health program who is working to expand their care coordination services. The Tribal Partners will create a network for referrals which will allow better service within their tribal health systems.

BHT Board approved an alternative payment method that would give tribes the flexibility to implement transformation efforts that are culturally appropriate for within their health systems. Through this Tribal Carve-out option, Tribal Partners can earn \$50,000 through the next three years by identifying a Medicaid transformation project specific to their needs. In turn, Tribal Partners will remain active participants in the TPLC, participate in their respective County Health Collaboratives, participate in the ongoing Network Analysis work, and provide yearly Aim statements and miles for their chosen projects. Projects selected includes care coordination, mental health peer support specialists in a rural school district, dental health aide therapy implementation, and electronic health record system implementation.

12. Design Funds.

- Provide the ACH's total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.

Earned Design Funds	Estimated Design Fund expenditures	Remaining Design Fund balance	Percent remaining Design Fund balance
\$6,000,000	\$2,383,586	\$3,616,415	60%

Use Categories	Design Fund Expenditures	Expenditure details (narrative)
Administration	\$ 673,675.20	Pays for back office services and staffing in Finance and HR as part of shared services agreement with Empire Health Foundation.
Community Health Fund	\$ -	10% was set aside upon receipt. This has not yet been spent, but set aside in a reserve account.
Health Systems and Community Capacity Building	\$ 1,132,382.48	Consulting services for support of BHT organizational assessments, planning templates, review of proposed plans and development of learning cohorts. Additional support with data analytics and VBP consulting support
Integration Incentives	\$ -	
Project Management	\$ 407,527.82	Pays for staff salaries and benefits, as well as consulting services to support IP development and submission.
Provider Engagement, Participation and Implementation	\$ 170,000.00	Provider incentives to complete Health Systems and Care Coordination inventory to support Project Plan development.

Provider Performance and Quality Incentives	\$ -	NA
Reserve/Contingency Fund	\$ -	NA
Shared Domain 1 Incentives	\$ -	NA
Other (describe below):	\$ -	NA
Total	\$2,383,586	

- If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

We expect design funds not yet expended will continue to support the infrastructure investment of BHT. These will primarily be related to Project Management and Administration use categories. This includes supporting our recent office move to consolidate from two office locations into one so the Better Health Together Navigator Network team and ACH team can be in the same space, and with better public bus and parking access. This improved space also has informal and formal convening space we can share with ACH partners.

Design funds will also continue to support staff salary as described in the table above. Additionally, BHT is currently searching for and will be hiring a full time CFO. These funds also support a .60 FTE Director and a .75 FTE Program Assistant dedicated to work with our 3 tribes plus Urban Indian partners. It is also expected that design funds will continue to support program development for BHT including our equity work, policy work and cross-ACH collaboration. Finally, BHT will continue to utilize Design funds to support our ongoing Pathways pilot project in Spokane County, as a supplement to ACH project funds.

The BHT board is utilizing the Design Funds conservatively at this point to ensure that as we near year 4 and 5 that we have funds to sustain internal operations and collaborative projects across the region.

13. Funds flow. If the ACH has made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission, attach:

- The ACH's current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.
- Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.

BHT has made no significant changes to our funds flow methodology.

14. Incentives to support integrated managed care. Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care.

- Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- ACHs may use the table below or an alternative format as long as the required information is captured.
- Description of use should be a brief line item (not narrative).

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected
<p>BHO Contracted BH Provider Incentive: BHO Contracted Behavioral Health Providers were offered a total of \$55,000 for completion of three IMC milestones. Milestones reflect the actions BHT believes organizations need to take in order to be ready to contract with MCOs in 2020, and were reported to BHT in December 2018:</p> <ol style="list-style-type: none"> 1) Completing an IMC Transition Plan by 8.1.2019 (\$20,000) 2) Attesting to having an Electronic Health Record in place (\$30,000) 3) Attesting to being ready to submit claims and encounters to contracted MCOs by January 2019 (\$5,000) <p>Completion of the milestones was triggered by a Pay-for-Reporting activity due December 31st, 2018, and payout was completed until DY 3 Q1 for the majority of Partnering Providers, with the exception of a few who completed milestones early and were paid in 2018, reported in the SAR 2. Two Partnering Providers were late to submit and join the portal, they will be paid in SAR 4 period.</p>	\$1,265,000	\$1,375,000
<p>Tribal BH Provider Incentive: Tribal Behavioral Health Providers were offered a total of \$30,000 for completion of three IMC milestones. Milestones reflect the actions BHT believes organizations need to take in order to be ready to contract with MCOs in 2020, and were reported to BHT in December 2018:</p> <ol style="list-style-type: none"> 1) Completing an IMC Transition Plan by 	60,000	90,000

8.1.2019 (\$15,000)

- 2) Attesting to having an Electronic Health Record in place (\$10,000)**
- 3) Attesting to being ready to submit claims and encounters to contracted MCOs by January 2019 (\$5,000)**

The Tribal incentive payment is smaller than the BHO payment because Tribes are not held to the same IMC expectations, and this work is considered optional. B Completion of the milestones was triggered by a Pay-for-Reporting activity due December 31st, 2018, and payout was completed until DY 3 Q1 for the majority of Partnering Providers, with the exception of a few who completed milestones early and were paid in 2018, reported in the SAR 2. One partner experienced some issues with the portal and has completed the milestone but was not paid till July 2019, to be reported in SAR 4.

Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attachments

The ACH should provide applicable attachments or additional context for clarity that addresses the following:

15. Implementation work plan

Implementation plans are “living documents” that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA with the information required to monitor the ACH activities and project implementation timelines.

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.³

- The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
 - Work steps and their status.
 - At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:
 - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
 - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
 - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
 - Not Started: Work step has not been started.
 - The ACH is to add a “Work Step Status” column to the work plan between the

³ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan. Semi-annual reporting guidance
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“Work Step” column and the “Timing” column. This column should reflect the status assigned to the work step.

- The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to be started.
- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

Submit updated implementation work plan that reflects progress made during reporting period.

See Attachment B

16. 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 through the ACH under Medicaid Transformation.⁴ ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:⁵

- *Health systems and community capacity building*
- *Financial sustainability through participation in value-based payment*
- *Bidirectional integration of physical and behavioral health*
- *Community-based whole person care*
- *Improve health equity and reduce health disparities*

The partnering provider roster is a standard component of semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in Medicaid Transformation activities.

To earn the achievement value associated with this reporting component, ACHs are required to confirm and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites (“potential site list”), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites (“potential site list”) to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific “potential site list” to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
 - Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).
 - When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

Submit partnering provider roster.

⁴ Partnering providers are defined as any 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.

⁵ <https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf>

See attachment C.

Documentation

The ACH should provide documentation that addresses the following:

17. Quality improvement strategy update

The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and the IA apprised of quality improvement activities and findings. ACHs may determine the format to convey this information.

Semi-annual updates should demonstrate that the ACH has insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided by the ACH to partnering providers to promote achievement of transformation outcomes and objectives.

Through these updates, ACHs are expected to report developments over the reporting period, such as:

- Modifications to the ACH's quality improvement strategy
- Summary of findings, adjustments, and lessons learned
- Support provided to partnering providers to make adjustments to transformation approaches
- Identified best practices on transformation approaches

For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of forward momentum, including evidence that partnering providers have the resources and support required for success.

Attach or insert quality improvement strategy update.

See Attachment D

Narrative responses.

ACHs must provide **concise** responses to the following prompts:

18. General implementation update

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols:* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.

- Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?
- Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.
- Describe any challenges faced by partnering providers in the adoption of policies, procedures and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?
- Describe the key challenges or risks identified in implementing selected transformation strategies, including potential impacts and mitigation strategies for specific transformation project areas or Domain I strategies. Include impacts across projects, as well as within a specific project area.

BHT entered into contract with 19 behavioral health and primary care Partnering Providers starting April 1, 2019. We call this group of Partnering Providers the January Cohort. An additional 22 will enter into contract in October of 2019, called the August Cohort. After submitting a first draft of their Transformation Plans in 2018, Partnering Providers worked with BHT staff and consultants to refine and update their Plans. These finalized Plans are due on August 1 and will include two condensed aim statements for each ACH projects they are participating in, with each aim statement to have 2-5 accompanying milestones. Partners were given TA to support the writing of clear and complete aim statements and milestones. The milestones must include an anticipated completion month & year, extending out to September 2020. These milestones are populated directly into each Partnering Providers' contract, and 40% of the dollars Partnering Providers are eligible to earn in their Year 1 contracts are tied to the completion of these milestones. As we near the end of the contract for year 1, we will repeat this annual contracting cycle and set milestones for the next contract year.

An additional component of these Plans included Partnering Providers selecting four Pay-for-Achievement (P4A) measures (See Attachment E). Partners selected four Pay-for-Achievement measures tied to completing specific activities related to Transformation success. Another 40% of dollars Partnering Providers are eligible to receive are tied to completion of these P4A measures. These P4A measures are also included as part of their contract and Partnering Providers will report to BHT on progress of milestones and P4A measures semi-annually. These reports, combined with monthly staff check-ins, tell BHT when a milestone has been complete, and when there are challenges or risks being experiences.

BHT staff conduct monthly check-ins to all contracted Partnering Providers, and ask at minimum the following three questions:

1. How are your contract milestones/P4A coming along? Successes? Barriers?
2. Is there anything BHT can do to help?
3. How is it going for you at the Collaborative meetings?

As one specific example of this process, we'll highlight Northeast Washington Alliance Counseling Services (NEWACS) and some of their opioid work. NEWACS submitted an aim statement to "Begin offering MAT – specifically suboxone – in NEWACS SUD treatment programs by January 2020." The first Milestone in this AIM was "By May 1, 2019, develop policies and procedures for MAT services to be offered at NEWACs." NEWACS informed BHT in their monthly check-ins that this milestone had been complete – they had procedures in place and staff trained and ready to implement. In their Semi-Annual report due in October 2019 they will officially report this milestone as complete to BHT, triggering a payout for completion.

To support success in these activities, BHT offered a monthly Learning Cohort with opportunities for training, TA, and shared learning between Partnering Providers. TA was provided by the UW AIMs center and other independent health care consultants. Much discussion and support was offered to Partnering Providers towards the implementation of policies, procedures and/or protocols, and Partnering Providers had the chance to share out successes and discuss challenges with TA and other participating Partnering Providers. Topics offered included:

- January: Intros to Change Management, Team Building, Measurement-Based Health Care
- February: Planning Sustainable Team Roles; Building & Testing Team Workflows; Readiness Factors and Planning a Model of Integrated Care
- March: SDOH Screening & Referral Frameworks; Care Compacts; 42 CFR; PreManage
- April: Whole Person Chronic Care Management; the Chronic Care Model; Framing Complex Care
- May: Creating a Culture of Patient-Centered Care; Patient & Family Engagement Strategies
- June: Creating Aim Statements & Milestones; individual workshop on August Cohort plans

These Learning Cohorts and the TA offered ensured that BHT provided our Partnering Providers the right support to be successful in implementation. These gatherings also created a place for Partnering Providers to share challenges and get support overcoming specific challenges.

BHT continues to face challenges related to the insufficient behavioral health workforce. Low reimbursement rates continue to make it hard to recruit providers, especially in more rural communities. With insufficient reimbursement rates, we fear behavioral health organizations that serve predominantly Medicaid will not be able to compete to recruit providers, furthering the access gap for Medicaid patients. This payment structure perpetuates the cycle of poverty and trauma, as there is less incentive to carry risk for individuals with the highest need and least resources.

BHT also continues to run into challenges related to MCO contracting to pay for outcomes under the Pathways Hub model. MCOs have not had an appetite to engage, which creates risk that funding for this model is not sustainable.

Health information technology, include health and/or community information exchange, is another significant problem. After many discussions with partnering providers and managed care plans in our region, as well as with other ACHs across the state, it's clear that a statewide vision and solution is necessary due to the need for statewide interoperability and the significant investment that will be required to move this work forward.

BHT would be remiss if we did not acknowledge that perhaps the greatest challenge to transformation is not logistical but cultural. We must acknowledge that many of the practices and policies that govern the institutions that make up a health system, perpetuate inequities. We continue to see unfair and avoidable health outcomes as a result of ongoing stigma and systemic racism that is deeply rooted in the cultures and histories of these institutions and the United States as a whole. BHT it is taking steps to ensure our Partnering Providers engage in critical self-reflection around how the culture and policies of their agencies either perpetuate or disrupt inequities. There is still much work to be done at the state and federal policy level to insure equitable distribution of resources and services. The region does not currently have the capacity and resources to train and staff a workforce that is culturally aware, has lived experience, is trauma-informed, and available translation services to effectively disrupt the systemic patterns of behavior that are the root causes of our biggest health inequities.

19. Regional integrated managed care implementation update

- **For 2019 adopters**, list the date in which the ACH region implemented, or will implement, integrated managed care.
- For **January 2019 adopters**, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken to address these challenges?

Early in 2019 the BHT region did experience some challenges. Delays in claims testing in 2018 meant not all providers were up and running for billing on 1/1/19, and there were some issues with the payment reconciliation process. Some providers had challenges enrolling in NPI numbers (particularly interns) and generally experienced challenges with how long and complicated the process for credentialing can be. Many of our rural providers rely on locums, for whom getting credentials for a short-term employment was a big hassle. We received a lot of questions about the provider roster, and folks wished that had been available much earlier. The final big issue relates to prior authorization and client eligibility. This has been particularly challenging and confusing for agencies working with individuals being released from incarceration for SUD in-patient referrals. Referring agencies were not getting notifications of approval for authorizations and there were issues transferring authorization from the BHO to MCOs. There we some issues around determining client enrollment and payment reconciliation when clients change MCOs as well.

To support our Partnering Providers, BHT has held monthly IMC workgroup meetings since mid-2018 and to address provider questions and issues. We worked closely with MCOs and the HCA to answer to hundreds of provider questions we received over the last 12 months and continue to connect providers to the right contacts for answers. We also used this workgroup and contacts to field questions about the new SERI guide and other relevant topics.

The workgroup also continues to elevate longer-term issues to the state, to make sure policy decisions and next steps at the state level are in line with local provider needs. For example, we worked with Interpreter Services to request better options for our rural providers, including reimbursement for telephonic interpreters. Although that is not an option under their current contract/agreement with the third party hired by the state, we hope it informs next rounds of negotiations. Another example, the workgroup elevated issues around payment delays resulting from needing a denial from a primary (commercial or Medicare) insurance to be able to bill Medicaid/MCOs as secondary insurance for services that are not covered by those primary insurances (e.g. WISE services) so the HCA and MCOs can look at opportunities to streamline payment processes.

BHT maintains IMC webpage on our website, which acts as a one-stop resource source for our providers. We post meeting notes, including provider questions and answers, resources from the state and MCOs, as well as upcoming meetings and trainings.

- For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.
- For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the ACH has identified as it pertains to integrated managed care. What steps has the ACH taken to address these needs?

Attestations.

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

	Yes	No
<p>20. 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:</p> <ul style="list-style-type: none"> • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects 	X	

	Yes	No
and related activities.		

If the ACH checked “No” in item 20 above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

Section 3. Pay-for-Reporting (P4R) metrics

Documentation.

21. P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.⁶ Twice per year, ACHs will request partnering providers respond to a set of questions. ACHs will gather the responses and report them to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets.](#)⁷
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under *ACH pay for reporting metrics.*⁸
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.
- It is HCA’s expectation that ACHs will facilitate participation of practice/clinic sites and CBOs and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to summarize the number of potential sites and actual respondents by provider type for each reporting period.

Instructions:

- Submit line-level P4R metric responses collected from partnering provider sites. Include

⁶ For more information about ACH pay for reporting (P4R) metrics, see Measurement Guide Chapter 6 and Appendix K. Link: <https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf>

⁷ <https://www.hca.wa.gov/assets/how-to-read-p4p-metric-specifications.pdf>

⁸ <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics>

partnering provider organization name and site name for each respondent.

- Provide a count of partnering provider sites participating in Project 2A and 3A, and a count of P4R metric respondents, stratified by provider type (practice/clinic site and community-based organization).

Format:

- ACHs have the option to submit P4R metric information using the workbook provided by the state or via an alternative format (as long as all data fields are represented and consistent with the P4R metric required data fields list).

Submit P4R metric information.

See Attachment F



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.

Improving Access to Integrated Whole-Person Care

- 100% on SAR2
- 100% on SAR3
- Retain 95% of staff team on Transformation Team
- Increase team satisfaction to 85%
- 95% of January Cohort complete activities
- 75% of August Cohort complete activities
- 85% of Cohort participants rate training valuable/VV
- Retain 95% of medium and large providers
- Retain 75% of small providers
- 90% of implementation plans are accepted for contracting
- Implement Xpio IT/EHR TA Bank
- Business plan developed for 2020 budget
- MCO independent practice training
- Implement Lunch and Learns
- Monthly Podcasts-MTD
- IMC Transition
- Spokane Collaborative
- Provider Champions Council

Promoting Health Equity

- Monthly check in with all Rural Collaboratives
- Launch advocacy and policy work group
- Board equity agreements
- Community Resiliency Fund
- Collaborative Equity Projects
- Develop Equity Assessment
- Develop Equity Curriculum for Partnering Providers
- Pay-for-Equity Partnering Providers
- Monthly Community Voices meeting
- Develop a business plan in preparation for 2020 budget process

Community-Based Care Coordination

- Align Navigator services with Hub team
- Serve 120 jail transition clients via 2 Care Coordinating Agencies
- Develop a Community-based care coordination project within Collaboratives
- Align CBCC with overall transformation (BH/PC)
- Align CBCC to Equity goals
- Develop a community-based care coordination project within Collaboratives
- Develop a business plan in preparation for 2020 budget process
- Explore and develop a plan to be a subcontractor for BHT region of Health Homes
- Earn 100% of QHP bonus for enrollment of 2300 QHP which includes 700 COFA
- Develop a plan in compliance with HBE for Brokers to be in Storefront by OE7
- Lead TPLC to identify 3 goals for 2019

Operations

- 95% staff retention rate
- 85% of partners rate communication to be “effective/very effective” & “helpful/very helpful”
- Increase or maintain scores from internal staff survey
- Increase or maintain team satisfaction to 85% (Best Places to Work)
- Increase audience engagement with external communication
- Increase website Survey “usability” and “usefulness” scores
- 100% accurate & timely meeting management
- 100% accurate & timely credit card reconciliation
- Fully developed Operations Manual
- Develop a functional CRM system
- Maintain FE portal management
- Evolve file/contract management system
- Efficient office space management



Better Health Together

ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

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	\$ 5,874,023.00
2B: Community-Based Care Coordination	\$ 4,038,391.00
2C: Transitional Care	\$ -
2D: Diversion Interventions	\$ -
3A: Addressing the Opioid Use Public Health Crisis	\$ 734,253.00
3B: Reproductive and Maternal/Child Health	\$ -
3C: Access to Oral Health Services	\$ -
3D: Chronic Disease Prevention and Control	\$ 1,468,505.00
Integration Incentives	\$ 4,981,123.00
Value-Based Payment (VBP) Incentives	\$ 300,000.00
Indian Health Care Provider (IHCP)-Specific Projects	\$ -
Bonus pool/High Performance pool	\$ -
Total Funds Earned During Reporting Period	\$ 17,396,295.00

Funds Distributed by ACH During Reporting Period, by Use Category ³	
Administration	\$ 897,986.70
Community Health Fund	\$ -
Health Systems and Community Capacity Building	\$ 3,640,201.00
Integration Incentives	\$ 1,355,000.00
Project Management	\$ -
Provider Engagement, Participation and Implementation	\$ 269,500.00
Provider Performance and Quality Incentives	\$ -
Reserve / Contingency Fund	\$ -
Shared Domain 1 Incentives	\$ 2,009,321.00
Total Funds Distributed During Reporting Period	\$ 8,172,008.70

Funds Distributed by ACH During Reporting Period, by Provider Type ³	
ACH	\$ 897,986.70
Non-Traditional Provider	\$ 866,500.00
Traditional Medicaid Provider	\$ 4,070,201.00
Tribal Provider (Tribe)	\$ 75,500.00
Tribal Provider - Urban Indian Health Programs (UIHP)	\$ 252,500.00
Shared Domain 1 Provider	\$ 2,009,321.00
Total Funds Distributed During Reporting Period	\$ 8,172,008.70

Total Funds Earned During Reporting Period	\$ 17,396,295.00
Total Funds Distributed During Reporting Period	\$ 8,172,008.70

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 July 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019.

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](#)