Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 4.0
Reporting Period:
July 1, 2019 – December 31, 2019

Template Release Date: August 8, 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 (July 1, 2019 to December 31, 2019) includes four sections as outlined in the table below.

Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)		
Section	**Item num**	**Sub-section components**
Section 1. ACH organizational updates	1-8	Attestations
	9-13	Attachments/documentation - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	14-16	Attachments/documentation - Implementation work plan - Partnering provider roster - Quality improvement strategy update
	17-19	Narrative responses - General implementation update - Regional integrated managed care

		implementation update
	20	Attestations
Section 3. Value-based payment	21-23	Narrative responses
Section 4. Pay-for-Reporting (P4R) metrics	24	Documentation

There is no set template for the 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).
3. Reporting on Value Based Payment (VBP) milestones (Pay-for-Reporting, or P4R).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. The amount of 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 Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of July 1 through December 31, 2019 determines achievement for half of the available P4R-associated Project Incentives.

AVs associated with Project Incentives for this reporting period are identified in the table below.

Table 1. Potential P4R Achievement Values (AVs) by ACH by Project for Project Incentives, Period July 1, 2019 – December 31, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23

North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Pierce County ACH	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

Table 2 provides the AVs associated with VBP Incentives for this annual reporting period.

Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
Potential AVs	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2020 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 4 – January 31, 2020."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 4 – January 31, 2020.

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 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.SAR4 Report. 1.31.20
- *Attachments:* ACH Name.SAR4 Attachment X. 1.31.20

Upon submission, all submitted materials (except for the P4R metrics reporting workbook) 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 July 1, 2019 – December 31, 2019.

ACH semi-annual report 4 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2019 to ACHs	IA	August 2019
2.	Submit semi-annual report	ACHs	January 31, 2020
3.	Conduct assessment of reports	IA	Feb 1-25, 2020
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2020
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2020
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2020
7.	Issue findings to HCA for approval	IA	April 2020

Contact information

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

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, also include their information.

ACH name:	Better Health Together
Primary contact name **Phone number** **E-mail address**	Alison Poulsen 509.499.0482 alison@betterhealthtogether.org
Secondary contact name **Phone number** **E-mail address**	Hadley Morrow 509.954.0831 hadley@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: • 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/nfesjaldc5m1ye6a0bhiouu5xeme0h26

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.**

    a) 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. 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).

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.

In 2019, the BHT Board approved an alternative partnering provider payment structure for engaged Tribal Partners enabling them to earn a set amount the next three years for transformation efforts. This gave our Tribal Partners the flexibility to work on transformation projects that are specific to their needs, and ability to work within their billing/payment systems. The Tribal Carve Out was an attempt to provide an equitable payment tier recognizing Indian Health Care Providers deal with historically harder to treat patients and must work within their existing payment models. The American Indian Community Center, Colville Tribe, Kalispel Tribe, Spokane Tribe, and Lake Roosevelt Health Centers are all signed onto the Tribal Carve Out and began implementation activities:

1. Monthly participation in BHT Tribal Partners Leadership Council
2. Monthly participation in their respective County Health Collaborative (Spokane, Stevens, Ferry, or Pend Oreille)

3. Participation in BHT's Network Analysis
4. Selected one of four options for health transformation efforts, providing one Aim Statement with a minimum of three milestones for the project year beginning July 1, 2019 through June 30, 2020.

In 2019, the Health Care Authority (HCA) awarded Better Health Together a $50,000 Trauma Informed Approach (TIA) grant to BHT to support work within our region. BHT allocated $8,000 to support TIA training specific to our Tribal Partners needs. In September 2019, all of our Tribal Partners attended a training facilitated by a national TIA practitioner, Dr. Darryl Tonemah. With 35 attendees, 100% of surveys completed strongly agreed/agreed that the content was valuable, relevant to their organization and work, and increased their knowledge of Trauma Informed Approaches.

12. Design Funds.

a) 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.

b) 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.

Earned Design Funds	Estimated Design Fund expenditures	Remaining Design Fund balance	Percent remaining Design Fund balance
$6,000,000	**$2,974,120**	**$3,025,880**	**50%**

Use Categories	Design Fund Expenditures	Expenditure details (narrative)
Administration	$ 841,303.20	Payed for back office services and staffing in Finance and HR as part of shared services aggreement with Empire Health Foundation from 2016-2019, as well as rent for office space.
Community Health Fund	$ -	10% was set aside upon receipt. This has not yet been spent, but set aside.
Health Systems and Community Capacity Building	$ 1,157,807.48	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	$ 805008.82	Pays for staff salaries and benefits, travel reimbursments

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	**$2,974,119.50**	

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, including continued staff salary and consultant support. 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. **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.

    a) Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

    b) ACHs may use the table below or an alternative format as long as the required information is captured.

    c) Description of use should be specific but concise.

    d) List of use and expenditures should reflect a cumulative accounting of all incentives distributed or projected to support behavioral health providers transitioning to integrated managed care. It is not limited to the reporting period.

    BHT has $1,846,872.00 left in IMC dollars for the BHT Board to allocate. The BHT Board is utilizing the IMC funds conservatively at this point to ensure that as we near year 4 and 5 that we have funds to support continued quality improvement and problem solving for IMC related issues. IMC spending date is detailed in the following chart.

ACTIVITY	Total Allocated/Projected	Total Paid
$50,000 was offered to rural partners as a Rural Accelorator Payment	$ 250,000.00	$ 250,000.00
$10,000 was offered to Tribal Partners for sending a Letter of Commitment to IMC Transition	$ 50,000.00	$ 50,000.00
$25,000 was offered to BHO Partners for sending a Letter of Commitment to IMC Transition	$ 625,000.00	$ 600,000.00
$15,000 was offered to Tribal Partners for completion of an IMC Readiness Assessment	$ 75,000.00	$ 75,000.00
$20,00 was offered to BHO Partners for Completion of an IMC Readiness Assessment	$ 500,000.00	$ 500,000.00
$15,000 was offered to Tribal partners wo submitted an IMC Transition Implementation Plan	$ 75,000.00	$ 45,000.00
$20,000 was offered to BHO partners who submitted an IMC Transition Implementation Plan	$ 500,000.00	$ 480,000.00
$5000 was offered to Tribal Partners for attesting to IMC Readiness	$ 25,000.00	$ 15,000.00
$5000 was offered to BHO Partners for attesting to IMC Readiness	$ 125,000.00	$ 115,000.00
$10,000 was offered to Tribal Partners for EHR readiness	$ 50,000.00	$ 40,000.00
$30,000 was offered to BHO partners for EHR readiness	$ 750,000.00	$ 720,000.00
BHT purchased TA for partners from Xpio	$ 40,000.00	$ 40,000.00
Behavioral Health Access Inventory	$ 100,000.00	$ -
Develop a TeleMedicine Stratey via ECHO	$ 750,000.00	$ -
Behavioral Health Access Pilot: Criminal Justice Spokane	$ 2,000,000.00	$ -
Behavioral Health Access Pilot: Criminal Justice Rural	$ 500,000.00	$ -
Support CDP Training and credentialing for 10 rural Clinicians and 10 Spokane Clinicians with the requirement that they remain employed by the requesting agency for at least 12 months	$ 40,000.00	$ -
Total	**$ 6,455,000.00**	**$ 2,930,000.00**

Section 2. Project implementation status update

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

Attachments

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

14. 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]

a) 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:

   i. Work steps and their status.

      1. 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.

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

2. 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.

b) 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.

c) If the ACH has made substantial changes to the work plan format since the last 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

15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.[4] To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.

b) By **October 15,** HCA will provide ACHs a clean version of the ACH's partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.

i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.

c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Place an "X" in the appropriate project column(s).

ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

d) Update partnering provider site information as needed over each reporting period.

Submit updated 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.

See Attachment C.

Documentation

The ACH should provide documentation that addresses the following:

16. 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.

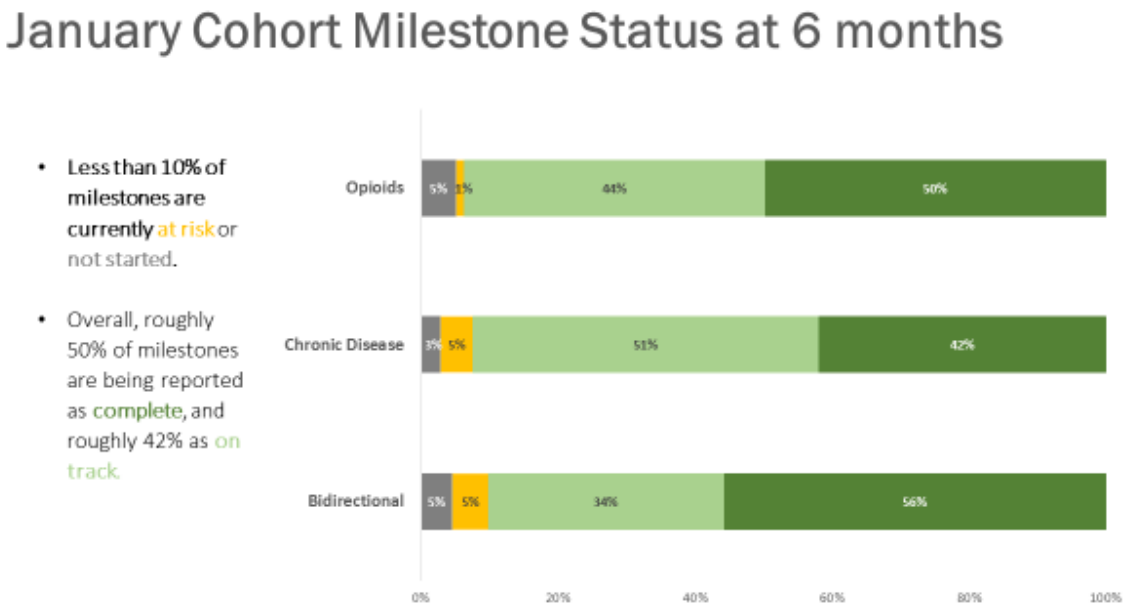
Attach or insert quality improvement strategy update.

Quality Improvement Strategy Update

BHT did not made any significant modifications to its QI strategy in the latter half of 2019.The main elements—expectations for partnering providers and for BHT, monitoring strategies, support activities via BHT's Learning Cohort and Technical Assistance Bank—remained in place. However, we did adjust the guidance and support offered to August cohort partners to help develop their own Transformation Plans, based on lessons learned from work with the January cohort partners. Rather than just offering the opportunity of 1-on-1 support for developing a Transformation Plan, BHT required all August cohort partners to submit initial drafts of their plans for review by staff and contractors. This was followed by individual meetings with each partner to help clarify plans and timelines, assist with developing realistic and measureable aims and milestones, and identify areas of synergy between plans.

Findings from BHT's first round of required reporting by contracted providers (January Cohort) suggest that the vast majority of partners are on track with the transformation aims & milestones specified in their individual contracts. The chart below is a summary of milestone

status across partners; BHT staff used more detailed reports by partner to conduct individual follow-up with each provider.



A few providers noted that behavioral health workforce shortages were an ongoing challenge. For example, one reported that "filling newly added positions to help with integration efforts has been difficult" and another commented that "MAT providers are hard to find and lock down." One behavioral health agency reported a helpful partnership with primary care training programs, saying "Working with the medical and nursing schools has been extremely beneficial for both parties in terms of learning opportunities and student to staff hiring opportunities." In fall 2019, BHT's Board approved using the remainder of the ACH's IMC funds to make an investment in improving access to behavioral health in the region. Part of that investment will support expanded telepsychiatry services and participation in tele-mentoring programs like Project Echo to increase the supply of behavioral health providers.

BHT continues to offer a range of group and individualized support to partnering providers including a learning collaborative series, facilitation and programming support for Spokane and rural collaboratives, and individualized assistance as needed. These activities are described in more detail under Question 17(a) below.

Narrative responses

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

17. General implementation update

a) *Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities.

i. Across the project portfolio, provide three examples of *each* of the following:

1. Trainings and technical assistance resources provided to or secured by partnering providers or members of care teams necessary to follow required guidelines and to perform their roles in an approach in a culturally competent manner. Be

specific when describing the project(s), partnering provider(s), the guidelines or evidence-based approaches, specific needs that the training and/or technical assistance addresses and describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner. Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future.

BHT Provided Trauama Informed Approach trainings for our Collaborative members and Partnering Providers in primary care, behavioral health, SDoH. In addition, we provided financial and staff support to our Tribal Partnership Leadership Council to secure their own Trauma Informed trainer and curriculm relevant to their partners.

In conjuction we provided 130 slots for a two-day Motivational Interviewing training that was open to any staff from partner organizations that was interested within our six county region. BHT surveyed participants of the trainings of which 87% of participants rated the training as valuable/very valuable. These two trainings gave providers an approach and tools in which to better meet the needs of the individuals they serve.

Remaining gaps that providers indicated in regard to following evidence based guidelines include funding limitations and reimbursement rates, as well as, work-force. Providers indicated that it is difficult to allow staff to attend trainings when they are often so short staffed to begin with.

2. Implementation of bi-directional communication strategies/interoperable HIE tools to support project priorities. Be specific when describing the project(s), partnering provider(s), strategies and/or tools, and how these activities support project priorities.

BHT contracted with Xpio to perform an HIE assessment of our region as well as recommendations going forward. They identified 10 key findings including lack of best practices in data standards and lack of best practices in data integration techniques. Currently available vendor systems do not "talk" the same language in a way that is conducive to effective data sharing. Organizations lack of data models to define scope. Access to individual behavioral health background data is not readily availably, with inconsistancicies in data access as well as measuremes and analytics. Many organizations still rely on fax and paper referals and data sharing. There are disparite resources for accessing information about community services, which limits awareness of services and ability to refer.

BHT conducted our second Network Analysis survey this year to analyze the strength og the collaboration, data exchanges, and referral networks in the BHT region, and compare them to our 2017 survey. Detailed results are still being analyzed, but initial findings saw a reduction of silos and increase in collaboration and exchange. Participants identified 350 new linkages between organizations across 150 organization that participating in the ACH work has helped to facilitate.

	2017 Collaboration + Referral + Data Exchange	2019 Collaboration + Referral + Data Exchange	Change
# of identified organizations in system	564	617	+ 53 organizations
# organizations with reported activity	402 (163 isolates)	593 (24 isolates)	+ 85 active organizations
% organizations with reported activity	71%	96%	+ 25% active organizations
Silos	167	28	- 139 silos
Reported linkages	5,885	7,219	+ 1,334 linkages

Detailed results will pinpoint by organization where there are opportunities to make data and referral linkages that will reduce silos. The 2019 Network Analysis also included qualitative questions about community-based care coordination and Community Information Exchange, to support more information gathering related to community-based care coordination linkages. An understanding of what connections and restrictions currently exist on the network will help inform our HIE strategy.

To support partners, BHT continued to contract with Xpio to offer free TA to behavioral health and tribal providers specifically in regard to EMR's, trainsitioning to Integrated Managed Care, and billing/encounters.

In addition, the UW AIMS Center in conjunction with Dr. Ron Stock offered a specific training in regard to Patient Registries and specifically how to use them without relying on an EMR.

Finally, all ACH Executive Directors are collaborating to develop an *ACH Health IT Strategy* comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities.

The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

Better engage people, organizations, and community partners in the circumstances, health events, and care-system encounters to enable whole-person care in traditionally-disconnected care settings and services through the use of health IT.

To achieve this vision, the ACHs are working to identify a set of initial goals and recommended activities that support each goal.

The ACHs will discuss the goals and recommendations with stakeholders and determine how each fits with the ACHs' priorities, projects, and roadmaps, and adding relevant activities to their plans for 2020 and beyond. The ACHs are also identifying best practices to be shared and potentially scaled among ACHs and developing individual action plans for accomplishing priority recommendations. Later in 2020, the ACHs plan to begin implementing their action plans.

The ACHs plan to share the Health IT Strategy with HCA in the first quarter of 2020 and look forward to discussing partnership opportunities in pursuit of the collective ACH vision.

3. Mechanisms that have been established for coordinating care management and/or transitional care plans with related community-based services and supports such as those provided through supported housing programs. Be specific when describing the project(s), partnering provider(s), care management

and/ or transitional care approaches/supports, and how these activities support project activities.

BHT hosted a specific training for partnering providers around transitions of care given by Dr. Eric Coleman, who is widely recognized as a expert in the field.

Better Health Together (BHT) has been awarded a Department of Commerce Contract for a "Better Health through Housing" (BHH) pilot program. We worked with many partners including Providence, MultiCare, SNAP, Spokane Housing Authority, Molina, Community Health Plan of Washington, and Amerigroup to submit the winning proposal. This project kicked off in September 2019, and will enroll 50 individuals during the 20 month pilot. We are working with Providence and Multicare Emergency Department to idenfity individuals experiencing homelessness who also have at least 4 ED visits. ED's will refer eligible patients to SNAP who will conduct an assessment of needs and enter into the Housing system. In addition, the seven partners have agreed to participate in our first Reinvestment Fund. We will collect total cost of care, intervention and identify if they are any "savings" to be reinvested in the stytem. This model is key for BHT's long term sustainability plan.

In October 2019 we released an RFP to seek proposals that included specific partnerships between primary care/behavioral health and social determinants of health partners working in food, housing, and transporation, to work collaboratively to serve a specific target population. The two partners will be working conjunction with one another around care transitions, coordination of care, and tracking outcomes/measurements in 2020.

4. Systems or rapid-cycle quality improvement processes that have been developed to monitor performance, provide performance feedback, implement changes and track outcomes.

Examples of systems or process for improvement

BHT has developed a system of regular monthly check-ins with each partnering provider to monitor performance and provide timely feedback and assistance. Usually conducted by phone, these check-ins cover current status of the partnering provider's transformation work, what's going well, and any significant difficulties. Notes from these conversations—including any BHT actions or responses—are stored centrally and reviewed as a group among BHT staff once per quarter to inform ACH-wide quality improvement plans or strategy. BHT has found value in these regular check-ins: the majority of challenges noted by partners in more formal reporting (see Example 2 below) were already known to our staff as a result of this regular contact.

In October 2019, BHT fielded the first round of required reporting by contracted provider partners on the progress of their Transformation Plan aims and milestones. Partners reported the current status of each milestone (complete, on track, at risk, or not started) and provided mitigation plans for at-risk or non-started milestones. A summary of findings from the October 2019 reporting cycle is included under Question 16 – Quality Improvement Strategy Update: fewer than 10% of partners' milestones were at risk or not started.
For each project area, partners also reported any notable successes or lessons learned, and indicated needs for technical assistance or other support from BHT. Technical assistance requests varied from the truly technical, such as a request for suggestions for data analytic tools, to training for staff or assistance in brokering relationships. ACH staff uses this reporting to inform content for our learning collaboratives and other technical assistance. Performance monitoring and follow-up process will be repeated every 6 months with all contracted providers, alongside data collection required for statewide Pay-for-Reporting measures.

In our Learning Cohort curriculum, we used a standard evaluation form that participants completed after each training. We adjusted how we set up agendas, selected trainers/presenters, and added new topics based on this feedback throughout 2019. Also asked for feedback as we finalize the framework and curriculum for the Learning Cohorts in 2020. In 2019, some of the most successful and well received training were those where the topic was covered from big picture overview, to staffing and processes, all the way down to billing codes. We have taken that into account both in the individual meetings and in how we plan topics. We also learned that our partners loved learning from their peer organizations. Seeing actual successes, implementation steps, pitfalls, lessons learned, and real experiences from administrative and clinical staff. We've increasingly incorporated that into trainings.

ii. For each project in the ACH Project Plan, provide clear, specific, and concise responses to the below as applicable. For projects the ACH is not implementing, indicate "Not Applicable."

1. Project 2A: Provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.

Partinering Providers submit a contract budget based upon their own identified AIMS/milestones under bi-directional integration, chronic disease, and opioids to support the costs of the infrastructure needed to perform the activies. The funding is not intended to pay for "services" but the infrastructure needed to provide transformation activities. Examples include EMR's, community health workers, registries, and care compacts.

During this reporting period, over $2.5 million in contract payments for AIMS/milestones & P4A related to Medicaid transformation has been payed out to contracted partners. This includes payment 1 for August Cohort for contract signing (1m), and payment 2 for January Cohort for mid-contract reporting (1.5m)

BHT supported Tribal partners in purchasing EMR's and all behavioral health providers with free technical assistance specific to integrated managed care and their billing and claims encounters.

2. Project 2B: Provide information related the following:

a. Schedule of initial implementation for each Pathway.

Pathway	**Date of implementation** (actual or anticipated)	**Notes** (optional)
Adult education	March 2017	
Employment	March 2017	
Health insurance	March 2017	
Housing	March 2017	
Medical home	March 2017	
Medical referral	March 2017	
Medication assessment	March 2017	
Medication management	March 2017	
Smoking cessation	March 2017	
Social service referral	March 2017	
Behavioral referral	March 2017	
Developmental screening	March 2017	
Developmental referral	March 2017	

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Education	March 2017	
Family planning	March 2017	
Immunization referral	March 2017	
Lead screening	March 2017	
Pregnancy	March 2017	
Postpartum	March 2017	

b. Partnering provider roles and responsibilities to support Pathways implementation.

Our two CCA organizations meet twice monthly with our housing support provider to collaborate, identify gaps, share resources and learning, and case consult. They have also received additional training on Trauma Informed Care, and Motiviational Interviewing so they can better support the individuals they serve.

c. Inventory of Care Coordination Agencies (CCAs) and the number of referrals initiated to date.

CCA Name	Total # of Referrals to CCA for any Pathway
Community Minded Enterprises	**36 in 2019**
SNAP	**32 in 2019**

d. Systems the HUB lead entity is using to track and evaluate performance. Provide a list of the related measures.

BHT as the Hub Manager is tracking the number of Pathways that are able to be closed by each CHW within our CCAs for each client with the CCS system.

e. Success in hiring staff, a listing of open positions and efforts to fill those. Describe barriers or gaps that exist in retaining staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.

Our Pathways providers have had challenges hiring and retaining staff. One challenge has been that community based organizations have low pay scales and during this time of abundant employment opportunities potential employees are often taking higher paying positions. Those that our organizations have been able to employ are starting their work careers, have lived experience that drives them to "give back" and a strong sense of mission. Currently both of CHW positions are filled. Partner organizations have stated that supervising CHWs as new positions in the organization is a new challenge and that additional training and support would be helpful.

f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How

does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.

Our HUB Manager is able to train on Trauma Informed Care, Motivational Interviewing and has a significant history of working with incarcerated individuals and individuals with severe mental illness. She is a Master's level social worker. During the twice monthly HUB/Pathways meetings our HUB manager uses a lot of time to do case consultation which informs her of additional training and/or support needed while also being able to use the opportunity for just-in-time training.

g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.

BHT and our CCAs all use the Care Coordination Systems Platform. We are not sharing our information from the CCS platform with clinical partners nor through the statewide health information exchange. At this time, there is not enough relevant information to merit the cost to develop this type of exchange.

h. Include two examples of checklists or related documents developed for care coordinators.

See attachment D1 for Adult Checklist and and D2 for Intake Form

3. Project 3A: Provide two examples of the following:

a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recover supports.

Every primary care and behavioral health provider that is contracted with us has to identify two AIMS and subsequent milestones to support the Opioid Project. All SUD organizations except one that was in contract with the BHO is not only under contract with BHT but is also a part of our County Collaborative. Our partner organizations have received free training on Narcan, Care Transitions, Care Compacts, Patient Registries, Trauma Informated Approaches, and Motivaional Interviewing. All trainings except Motivaitonal Interviewing are available on our website to attend via zoom and then review later for our rural partners.

b. Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.

BHT maintains a Provider Champions Council that meets quarterly, and who is tasked with monitoring and providing feedback to bht on modification and implementation of the Interagency Opioid Working Plan. We are working in conjunction with the Spokane Regional Health District and the Spokane Regional Opioid Task Force to not only monitor state-level modifications, but also emerging best practices. We have a Program Manager who leads the provider education component for the Task Force and we partnered with a local access TV station and Washington State University School of Medicine faculty to air a program around Opioids for our community and "lay persons"

to increase reach of message and decrease stigmatization.

c. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.

Better Health Together has partnered with the Spokane Regional Opioid Task Force to drive the collaboration of numerous organizations within our community. The task force began with five steering committees, but over the last year found synergies between the efforts of three of them and have combined the work. Currently, a Better Health Together employee chairs the Continuum of Care/Response/Provider Education group. This group meets monthly and opens the floor for group discussion to share successes and challenges. It creates an opportunity for attendees to identify other organizations that offer services they're patients need, and/or sparks ideas for how organizations might implement similar services. Most recently, we had a representative from Bright Heart Health discuss what they offer SUD patients. The biggest hurdle is insurance.

Additionally, Better Health Together participates in the community education group. Most recently, we conducted an interview with Dr. Matt Layton of the Elson S. Floyd School of Medicine which was covered by our partners at CMTV. This segment has been airing on CMTV's local station and is available via social media platforms. This project delivered the education directly to the community, which captured a much broader audience.

The non-opioid pain management committee also meets on a monthly basis and reports back to the steering committee. The most frequent challenge amongst this group is lack of insurance coverage for this evidence-based approach for treating chronic pain.

There are two Peer Recovery organizations in Spokane who are active participants in our Spokane Collaborative. BHT reached out to Peer Spokane to support increasing peer recovery including possible models and framework to our rural partners and they were able to connect with Vince Collins (formaly with DBHR) and Jac Davies of the Northwest Rural Health Network to provide training in Stevens County.

The Spokane Collaborative has chosen Behavioral Health as one of it's focus areas, and will be developing and implementing a public awareness campaign to promote preventative behavioral health care and early identification of behavioral health risk factors. Though in it's early planning stages we expect at least 20 organization to participate in development of the campaign, and opioids prevention and awareness will likely be a prioritized topic.

d. Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH's planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

The region is still very short on behavioral health workforce in general, and what workforce there is faces high turnover and burnout rates struggling to keep up with demand. Our rural regions struggle to find enough providers who will agree to offer

MAT. Individuals leaving jail with an MAT prescription are not able to get them filled, or find a pychaiatrist who will follow up with them. To increase workforce development, the BHT Board approved funds to support CDP Training and credentialing for 10 rural Clinicians and 10 Spokane Clinicians with the requirement that they remain employed by the requesting agency for at least 12 months.

BHT has focused on incentivizing partnership through care-compacts between behavioral health and other settings, to increase access to preventative and intervention services. BHT has offered trainings to both providers and community members on Narcan and Naloxone to both our rural and urban partners to increase awareness of and number of providers offering overdose prevention tools to their services users.

4. Project 3D: Provide the following:

    a. Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

Our Better Health Through Housing is a project aimed at cooridinating multiple partners around a specific target population (homeless, co-morbid conditions, frequent ED utilization) including communication, referral, processes, and flow of individuals. Significant time was taken to identify roles and responsibilities of each organizations/staff involved. It is our intent that the model, as well as, lessons learned are shared with our region as a road map for future projects and coordination.

    b. Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).

In our Pay-for-Achievment measures SDoH screening tools are an option and in our SDoH contracts the Pay-for-achievment measures there is also the opportunity for them to implement an SDoH screening tool to further identify needs of individuals. The SDoH RFP that was released is based on the foundation of partnership around a targeted population and two distinctly different organizations organizing themselves around referrals, communication, workflow, and data.

b) 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 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. The rates that providers are reimbursed are not allowing orgaizations to expand or

meet salary expectations as they are increasingly competing with bigger health systems and FQHCs.

Partners also share frustration and concerns around data sharing. 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.

18. Pre- and post-project implementation example

a) Highlight a success story during the reporting period that was made possible due to DSRIP investments, including how DSRIP removed the barrier to implementation and lessons learned that the ACH has used to make modifications moving forward.

With funding from their Transformation Plan contract, Planned Parenthood of Greater Washington & Northern Idaho (PPGWNI) launched their Behavioral Health program and saw their first patients in August. At present, their staff will be seeing up to 40 patients a week. The BH program is serving ages 18+, but they are working on a waiver to serve ages 13-18. The program is focusing on mild to moderate BH, particularly depression/anxiety/stress. The program is accepting Medicaid, commercial, AND they established an affordable self-pay scale. They are also looking to build in walk-in time. Julie said that the support from BHT is what allowed them to launch the BH program.

The national Planned Parenthood organization is keeping an eye on this BH program as a model for other sites nationwide.

In addition to launching their BH program, they are also expanding their primary care work beyond reproductive health. They have started pre-diabetes screening and education and have hired a PC, and are applying for a PPFA grant to expand the PC work more. The PC they hired is also interested and excited in doing medication mgmt, so they'll begin that soon.

19. Regional integrated managed care implementation update

a) For **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, in partnership with providers and MCOs, to address these challenges?

BHT heard issues from our partners around MCO contracting & communication as we approached end of the reporting period. Providers were not hearing from MCOs about contracting for 2020 so we facilitated direct introductions to help our partners get in touch.

Partners report challenges with scope of practice for billing, particularly for care coordination services and positions.

BHT continued to share new/updated resources and contacts as they became available both by email and via our IMC webpage, including:

- Sharing MCO webinar information and materials for BH Supplemental Data Provider Support directly to providers
- Updated MCO & HCA contact lists
- MCO Prior Authorization resources
- Interpreter Services updates
- Q&As on updated SERI

b) 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.

c) For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the region has identified as it pertains to integrated managed care. What steps has the ACH taken, in partnership with providers and MCOs, 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
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: • 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 and related activities.	X	

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

Section 3. Value-based Payment

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 3, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2019).*

Narrative responses

21. Identification of providers struggling to implement practice transformation and move toward value-based care

a) Describe methods the ACH uses to identify providers struggling to implement practice transformation and move toward value-based care and a general overview of activities the ACH conducted to support those providers. **Include one detailed example** of the ACH's efforts to support a provider to address the identified struggles, progress that was made, and lessons learned.

BHT staff checks in with providers around their contract and progress to gauge if there are emerging concerns. Free Technical Assistance is available and offered to support providers at anytime.

CHAS built an ambitious plan in their contract for bi-directional integration, but was struggling with where to begin. BHT contracted with the UW AIMS Center to provide TA on request to our contracted providers, including offering up to 30 hours of 1-on-1 TA to our 4 large volume providers like CHAS. Mike Wiser, VP of Planning, shared this about the AIMS support:
"The AIMS Center has been very responsive and available to meet with us when needed. We have been meeting 1-2 times a month for several months. The feedback has been very helpful to understand a model for CHAS and inform our BH Associate program definition. We've had a couple major changes in BH staff lately, so things have slowed down a bit in using AIMS support. But their expertise in Collaborative Care is unparalleled and much appreciated. They have been flexibile and allowed us to learn and consider approaches that are unique to our situation, staffing, and patient situations."

22. Support providers to implement strategies to move toward value-based care

a) **Provide three examples** of how the ACH has supported providers to implement strategies to move toward value-based care, including provider type, provider needs, supportive activities, description of action plan, and key milestones that have been achieved. 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.

BHT offered free technical assistance to behavioral health and tribal partners to support their tranisition to integrated managed care, EMR's, and billing.

Our previously described SDoH RFP is further supporting our primary care partners in working with community based organizations that will help their population achieve greater outcomes and meeting VBP expectations.

Supporting Care Compacts in Pay for Achievement measures for primary care and behavioral health. We offered specific training in regard to care compacts and included SDoH providers.

All primary care and behavioral health providers were offered free training around patient registries, care transitions, Trauma Informed Approaches, and care compacts.

23. Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey

a) **Provide three examples** of the ACH's efforts to support completion of the state's 2019 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

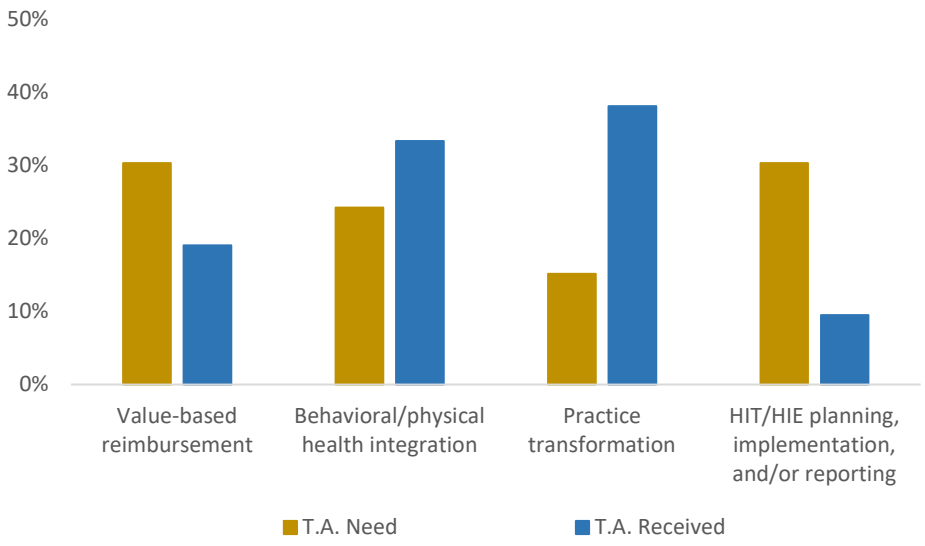
BHT included participation in the VBP survey as a requirement in all of our primary care and behavioral health Medicaid transformation contracts. For 2019, that was a total of 20 organization.

In addition to the contract requirement, BHT made the following communication efforts to promote participation in the survey. No incentives were offered to non-contracted partners to take the survey.

- July - posted blog on our website linking to survey
- July - posted on all social media outlets linking to survey
- August - included in montly enewsletter - 544 recipients
- July & August – link to survey was posted on the BHT Collaborative webpage (online portal for all BHT partners) and the Learning Cohorts webpage (online workspace for all contracted partners)

b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

BHT relies primarily on its own communications with providers and MCOs in the region to gauge progress and challenges related to VBP. But staff recently prepared a presentation for our Board using the results of the 2019 Provider and MCO surveys. The presentation highlighted gaps from the provider survey in technical assistance needs vs. technical assistance received. Similar to the statewide results, BHT region providers received a good deal of technical assistance related to practice transformation and behavioral health integration, but would find more direct assistance with VBP mechanisms and with HIT/HIE development more helpful. See example chart below.



c)

Please note: In HCA's 2019 Provider VBP survey, twenty-four (24) organizations indicated having a presence in the BHT region. However, it's not clear how respondents were interpreting that question. While providers may occasionally serve BHT region *residents*, 8 of the 24 organizations do not appear to have a service location in our 6-county region. Examples of organizations in this group include Seattle Children's, Confluence Health, and Three Rivers Hospital. BHT recommends providing more explicit instructions for this question on future surveys.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

24.P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.[5] Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A. ACHs will gather the responses and report an aggregate summary 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.
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under "ACH pay for reporting metrics."
- The value of the P4R metric information to HCA is to track progress by primary care, behavioral health and community based organizations in implementing changes that advance clinical integration and strengthen statewide opioid response. Reporting may evolve over time to ask ACHs to generate reports or increase the participation among providers as needed to track progress on Projects 2a and 3a.

Instructions:

a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).

b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the reporting template.

Format:

a) ACHs submit P4R metric information using the reporting template provided by the state.

Submit P4R metric information.

See Attachment E

[5] 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

Better Health Together (BHT)

July 1, 2019- December 31, 2019

Source: *Financial Executor Portal*

Prepared by: *Washington State Health Care Authority*

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A	$ -	$ 1,247,738.00	$ 1,247,738.00
Project 2B	$ -	$ 857,821.00	$ 857,821.00
Project 3A	$ -	$ 155,968.00	$ 155,968.00
Project 3D	$ -	$ 311,935.00	$ 311,935.00
Integration	$ -	$ -	$ -
VBP	$ -	$ -	$ -
Total	$ -	$ 2,573,462.00	$ 2,573,462.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	$ 31,357.17	$ 35,505.71	$ 66,862.88

Table 3: distribution of funds for shared domain 1 partners

	Q3	Q4	Total
Shared domain 1	$ -	$ -	$ -

Table 4: incentive funds distributed, by use category

	Q3	Q4	Total
Adminstration	$ -	$ 172,708.95	$ 172,708.95
Community health fund	$ -	$ 2,929,314.40	$ 2,929,314.40
Health systems and community capacity building	$ 742,500.00	$ -	$ 742,500.00
Integration incentives	$ 120,000.00	$ -	$ 120,000.00
Project management	$ -	$ -	$ -

Provider engagement, participation, and implementation	$ 1,715,967.00	$ 4,623,754.99	$ 6,339,721.99
Provider performance and quality incentives	$ -	$ -	$ -
reserve/contigency fund	$ -	$ -	$ -
Total	$ 2,578,467.00	$ 7,725,778.34	$ 10,304,245.34