



**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**  
***(Updated May 20, 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
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-14	Attachments/documentation <ul style="list-style-type: none"> <li>- Key staff position changes</li> <li>- Budget/funds flow update</li> </ul>
<b>Section 2. Project implementation status update</b>	15-17	Attachments/documentation <ul style="list-style-type: none"> <li>- Implementation work plan</li> <li>- Partnering provider roster</li> <li>- Quality improvement strategy update</li> </ul>
	18-19	Narrative responses <ul style="list-style-type: none"> <li>- General implementation update</li> <li>- Regional integrated managed care implementation update</li> </ul>
	20	Attestations
<b>Section 3. Pay-for-Reporting (P4R) metrics</b>	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](#).<sup>1</sup>***

***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.

ACH semi-annual report 3 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe

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

<b>ACH semi-annual report 3 – submission and assessment timeline</b>			
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](mailto: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.

<b>ACH name:</b>	Pierce County ACH, dba Elevate Health of Washington ("EH")
<b>Primary contact name</b>	Alisha Fehrenbacher
<b>Phone number</b>	(253) 370-9242
<b>E-mail address</b>	<a href="mailto:alisha@elevatehealth.org">alisha@elevatehealth.org</a>
<b>Secondary contact name</b>	Meg Taylor
<b>Phone number</b>	(206) 399-2815
<b>E-mail address</b>	<a href="mailto:meg@elevatehealth.org">meg@elevatehealth.org</a>

## 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"> <li>• Primary care providers</li> <li>• Behavioral health providers</li> <li>• Health plans, hospitals or health systems</li> <li>• Local public health jurisdictions</li> <li>• Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region</li> <li>• 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.</li> </ul>	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 <a href="#">template</a> or a similar format) that addresses internal controls, including financial audits. <sup>2</sup>	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	

<sup>2</sup> <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.***



## 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.).

To date, there is a total of \$4,511,370 in distributions to partners that are improperly classified as “Traditional Medicaid Provider” and should be reclassified to “Non-Traditional Provider”.

## 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 February we participated with other ACH’s, HCA, and the American Indian Health Commission for Washington State in collaborating and sharing information.

In May we participated in the Tribal EHR Summit, along with Better Health Together and Greater Columbia ACH, with the goals of gaining a better understanding of the legacy system most Tribal Nations are utilizing and laying the groundwork to have future discussions for what resources and vendors Tribes maybe able

to utilize to help with system migrations.

Elevate Health has entered into a contract to help support the Puyallup Tribe of Nations in implementing the Nurse Family Partnership (NFP) program in conjunction with funding from the Tacoma Pierce County Health Department. This evidence-based program matches a registered nurse with low-income mothers in early pregnancy, continuing until the child’s second birthday.

**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.

**Design Funds earned and expended to date through June 30, 2019:**

Earned Design Funds	Expenditures to Date	Remaining Design Funds	% Remaining
\$ 6,000,000	\$ 1,645,800	\$ 4,354,200	73%

Use Category	Expenditures to Date	Expenditure Details
Administration	\$ 272,400	Operational costs to build infrastructure of the ACH and manage start-up activities.
Health Systems and Community Capacity Building	\$ 828,500	Costs incurred to build the community engagement strategy and project plan for the ACH. Includes investments in systems and processes to support community care coordination and integration projects.
Project Management	\$ 376,200	Outside consulting expertise for strategic planning and organizational development and support while the internal team was being recruited.
Provider Engagement, Participation and Implementation	\$ 168,700	Funds used to engage partners and the community at large in the new of the ACH as it launched in 2017.
<b>Total</b>	<b>\$ 1,645,800</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.

Remaining design funds will be kept in reserve and used over the course of the transformation project for gaps that are identified that are not specific to incentives and support in the binding agreements with partners. Examples include community and consumer engagement activities, sponsorship of regional stakeholder forums, development of population health and care management tools and processes, and administration of the Community Resiliency Fund.

**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.

**No substantive changes.**

- 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.

**No substantive changes.**

**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).

<b>Use of incentives to assist Medicaid behavioral health providers</b>		
<b>Description of Use</b>	<b>Expenditures (\$)</b>	
	<b>Actual</b>	<b>Projected</b>
Allocation of integration incentive funds to Pierce County to be used to support projects around integration, transitions of care and crisis/diversion	\$3,700,000	\$120,000
Transition support incentives to behavioral health providers	\$1,000,000	
Regional investments in IMC Learning Network	\$500,000	\$200,000
Direct technical assistance from Strategic Improvement Team	\$2,000,000	\$600,000
Sponsorship and management of the Whole-Person Care Collaborative for primary care and BH clinic teams	\$500,000	
Investments in centralized technical assistance and data tools for behavioral health	\$700,000	
<b>TOTAL</b>	<b>\$8,400,000</b>	<b>\$920,000</b>

## 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*.<sup>3</sup>

- 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

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<sup>3</sup> 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 bet 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.***



## 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.<sup>4</sup> 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:<sup>5</sup>

- *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.

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<sup>4</sup> 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.

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

## ***Submit partnering provider roster.***



### **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.***



### **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?

**Elevate Health** utilized a structured set of criteria for contracting with providers on transformation projects. The level at which their action plans demonstrated depth in the various categories was key to defining the specific project statements of work and the incentive levels. In addition to committing to operate under Elevate Health’s *Rules of Engagement*, a set of strategies and approaches designed in collaboration with Elevate Health’s governance bodies and embedded within the Action Plans, they agreed to demonstrate high and increasing levels of partnership with collaborators outside of their organization and to embracing a culture of learning by committing to participate in learning collaboratives convened by the ACH.

For all partners under contract with Elevate Health, a clinical improvement advisor is assigned to assist with project planning and project management and to monitor results. Our statements of work require regular quarterly reporting on progress and project plan status updates, as well as P4R reporting requirements. Project charters are documented, and levels of partnership is tracked across the spectrum from common goals and coordinated activities to formal collaboration with agreements and perhaps shared governance to legal partnerships or affiliation where there is shared governance and resources are pooled.

Within the learning collaboratives established by Elevate Health, partners are convened to share best practices, work as teams to develop shared policies and procedures, and report on issues or challenges experienced as they implement various models. Elevate Health brings in subject-matter experts to provide technical assistance and provides a forum for sharing resources.

**Example of Transformative Partnerships: *Bridge of Hope***

**Coming together in partnership:**

- HopeSparks and Pediatrics Northwest have entered into a comprehensive partnership, termed ‘Bridge of Hope’, to increase early access to behavioral health care services for pediatric patients with mild to moderate mental health needs.
- The two groups entered into a formal partnership on November 1, 2018 and committed to utilizing the Collaborative Care Model to ensure patients have wrap-around, whole person care.

- Elevate Health contracted with the Bridge of Hope partners under a shared statement of work in which outcomes are measured for the partnership and earned incentives are shared.
- Primary care services and screening for behavioral health needs will occur at the primary care site, Pediatrics Northwest. HopeSparks will provide a behavioral health therapist and pay for psychiatric consultative services.
- Beginning in August, the partnership will begin billing Medicaid for the Collaborative Care codes for initial patients screening into the program.
  - The ability to bill Medicaid for Collaborative Care codes indicates a successful adoption of the Collaborative Care Model and cross-organization partnership.

**Progress in adoption and sharing of policies, procedures and protocols:**

- HopeSparks’ and Pediatrics Northwest’s clinical and executive leadership teams meet monthly to review policies, procedures, workflows and internal and external communication plans for this partnership.
- HopeSparks and Pediatrics Northwest have shared and co-developed policies, procedures and job descriptions to ensure the successful launch of their Collaborative Care Program.
- HopeSparks and Pediatrics Northwest have developed a shared method for deploying screening to identify patients for behavioral health services (GAD-7, PHQ9); developed a risk stratification methodology for services to be rendered based on patient’s needs and diagnoses; developed a job description for a Behavioral Health Integration Program Manager, and even have meetings between their respective Boards of Governance to share policies and strategic direction.

**Challenges:**

- Initial challenges were faced in tracking data, establishing a shared cohort and defining measures for tracking patient access to services.
  - To address these challenges, Elevate Health provided a Clinical Improvement Advisor to assist the two teams in chartering their work, establishing data and workflows that will be tracked and updated as the project progressed and provided oversight and project management to joint meetings. Additionally, Elevate Health, through its Binding Letter of Agreement, have awarded the Bridge of Hope Partnership funds which allowed them to hire a long-term Project Manager to oversee the scope and cross-functional partnership.
  - Quarterly, the Bridge of Hope Partnership shares a workplan and the measures they are tracking for their scope of work with Elevate Health as required in their Binding Letter of Agreement
- **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.**

**Risks for Behavioral Health/SUD Clinical Integration:** Pierce County went live with Integrated Managed Care on January 1, 2019. We have worked continuously over the past year with the behavioral health and SUD partner organizations within our IMC Network to adapt to new authorization and billing procedures, partner with the MCOs and HCA to develop ongoing referral processes, and to help them understand nuances of the MCOs authorization criteria.

This effort has been administratively challenging for smaller providers, many of whom were concurrently implementing new electronic health record systems. With the focus on managing the new processes for managed care billing, there is a question of financial and operational capacity in these smaller providers to be able to also work toward clinical integration and implement practice change management strategies.

*Mediation Strategies:* To assist with these challenges, Elevate Health, through the IMC Learning Network, is continuing to offer focused workgroups on future-state process changes, including the regional plan for residential treatment facilities, MAT adoption, and referral processes. We are also supporting providers through the transition by investing in our strategic improvement and innovations teams, who offer support and technical assistance to partners, and by exploring the rollout of a *managed services team* who will be focused on behavioral health operations and value-based care delivery.

**Threats to the Care Continuum Network Model (CCN) for Community-Based Care Coordination:**

Our ability to maintain support for the CCN strategy of coordinated, community-based care coordination is dependent on showing its success, but it takes time to fully complete a rigorous empirical evaluation of its impact with strong enough evidence behind it to ensure partners will buy in for a sustainable financial model.

*Mediation Strategies:* Elevate Health continues to work with MCO partners to: 1) develop potential funding models for the Pathways model, and 2) mutually commit in advance to the outcomes that will prompt partners to invest completely in those funding models. We are also piloting other projects focused on using the CCN to improve clinical-community integration, including complex care teams designed to embed within partner organizations to bend the cost curve for high-cost patients with complex health challenges.

To support our range of CCN strategies, we have engaged an evaluation partner, CORE (the Center for Outcomes Research & Education) to perform an independent scientific evaluation of our CCN strategy, including the Pathways model and other CCN programs. We have shared the evaluation plan with our MCO partners and secured agreements that its measures of success are appropriate, and its standards of evidence are sufficient, to secure a decision on their part to help sustain the program. The full CCN evaluation plan will take several years to provide final results, but interim reporting focused on process and intermediary outcome measures will be used to help sustain the commitment of partners to the model. Ultimately, evaluation results will be used not only to secure partner commitment, but to model outcomes across our network of community partners, link social determinants data with clinical outcomes to help demonstrate the value proposition of our CCN work, and lay the foundation for movement toward value-based contracting built off an empirical understanding of both clinical and social complexity.

**Challenges with Bi-Directional Integration and Collaboration:** Our Whole-Person Care Collaborative, comprised of primary care and behavioral health providers working toward the collaborative care model, has convened throughout the year to work on processes, policies and procedures that support information flow on shared clients and create the structures for integrating teams in one location. These challenges are especially difficult for organizations that are not using the same EHR, making the exchange of data and management of shared rosters difficult.

*Mediation Strategies:* Elevate Health has helped mitigate these challenges by partnering with the AIMS Center to share best practices and work through issues in a shared-learning environment. Additionally, the AIMS Center has provided a tool by which teams can track shared client rosters. Elevate Health is also investing in a data-driven population health strategy and technology platform

that will allow for sharing data across providers, facilitate shared-care planning, and simplify referrals to services.

**State Data Access Limitations:** A fourth threat to our work is continued limitations on direct access to state data to support a more informed view of the clients in our region. Given the magnitude of what we are accountable to accomplish, data access is critical: only a strong, data-driven approach can hope to advance the ambitious goals of the Demonstration project in ways that also provide good stewardship of the public and private resources being brought to bear in this effort. If we cannot access timely data from the state, our ability to track performance and make data driven decisions that help with rapid-cycle improvements will be sorely limited.

*Mediation Strategies:* Pierce County ACH is mitigating risks by developing alternative ways to aggregate and use key data sources. We are actively developing a regional data-driven population health strategy built on community and provider-led data sharing. Our regional integrated data will be linked with reporting and analytic tools designed to understand gaps and risks and provide “smart targeting” of our interventions and investments. Results will inform our strategic improvement processes to ensure that every opportunity for advancing the work and reducing costs is optimally utilized, and that the impacts of our work are visible to our diverse array of partners.

## **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.

**January 1, 2019**

- 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?

**Challenges:** Any large-scale change like implementing integrated managed care is bound to face some barriers, but there were several unique challenges in Pierce County, including:

- **Exit of the prior BHO:** Optum was the BHO for Pierce prior to IMC. Although they completed their required reporting to the HCA under their existing contract, they did not freely share historical data or information about existing programs and payment models with the incoming MCOs or with providers. This led to a lack of knowledge on the part of the MCOs and ASO on how programs were historically funded and how case management was handled in Pierce.
- **SERI Updates:** In September 2018 it was announced that the Service Encounter Reporting Instructions (SERI) would need to be updated, and there were several subsequent delays in releasing the update. These delays caused unanticipated issues, including: providers not being able to configure EHR and billing systems; claims testing not being able to be completed with all MCOs prior to the 1/1 go-live, and lack of understanding of new billing criteria (units vs minutes and modifiers).
- **Taxonomy Codes:** WA State taxonomy codes provided by HCA specific to behavioral health professionals were not valid for National Taxonomy (NPI) registration. This caused delays in

some providers being able to register with HCA, which then caused a delay in providers becoming “rostered” with MCOs.

- **Claims Processing Readiness:** The majority of MCO claims systems weren’t ready to accept claims for processing in the beginning of January 2019. This caused a delay in processing of claims and therefore payment delays. If claims were denied or had to be reprocessed, the payments were delayed even further. For small providers accustomed to receiving predictable monthly contract payments, this created cash flow challenges.

**Elevate Health** took the following steps to mitigate the challenges experienced:

- **Convened Impacted Partners:** The ACH held knowledge gathering meetings with providers explaining processes for patient care coordination, authorizations, lengths of stay and subsequent reviews, assessment of client’s needs, payment for services, court-mandated service reimbursements, and bed management for the County. Subsequent meetings were hosted by Elevate Health to help cross walk all payers’ processes and policies and try to align as many as possible between the payers.
  - **Implemented SERI Contingency Protocols:** Elevate Health worked in collaboration with all payers in Pierce County and with the HCA to implement a contingency plan for providers to be able to utilize when delays in the SERI update impacted their system builds. This plan was developed by Elevate Health and presented to the HCA with MCO and provider support. It was subsequently widely adopted across the state.
  - **Created a Resource Library:** Elevate Health created a single source document to house all information for IMC related topics. This document allowed providers a single source to pull MCO contact information for all departments, as well as guides on billing, the authorization cross walks, and every form each MCO utilizes for referral requests, authorizations, and appeals.
  - **Stepped in as a Liaison Between Providers and Payers:** Elevate Health coordinated conversations helped connect providers experiencing significant payment delays with MCO/ASO leadership teams to assist in mitigating financial stresses. The ACH also initiated a data request of claims payment data from providers so that HCA could address concerns over delayed processing of claims and reprocessing of “aged” claims.
  - **Providing Ongoing Support:** Our IMC Learning Network continues to meet regularly to share best practices, discuss ideas for better coordination with all parties, and to mitigate any concerns as they occur. We also continually re-evaluate where improvements can be made and what opportunities as an IMC community we can explore.
- 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
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: <ul style="list-style-type: none"><li>• Identification of partnering provider candidates for key informant interviews.</li><li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li><li>• 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.</li></ul>	X	

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 (*updated May 2019*)

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.<sup>6</sup> Twice per year, ACHs will request partnering providers 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. 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,

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<sup>6</sup> 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>

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*.
- 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 respondents by provider type for each reporting period.

*Instructions:*

- Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g. count of sites that selected each response option).
- Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the [reporting template](#).

*Format:*

- ACHs submit P4R metric information using the [reporting template](#) provided by the state.

***Submit P4R metric information.***





August 23, 2019

Dear Ms. Fehrenbacher:

Thank you for the submission of Elevate Health of Washington's Semi-Annual Report Assessment 3. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project, Myers and Stauffer LC (Myers and Stauffer) has assessed the Semi-Annual Review 3 submission requirements.

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

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

Please post your response in PDF, Excel or Word format following the resubmission instructions below to WA CPAS (<https://cpaswa.mssl.com/>) within the Request for Information folder (pathway is Semi-Annual Report > Semi-Annual Report 3 – July 31, 2019 > Request for Information). **We ask for your response no later than 5:00 p.m. PST, September 9, 2019.** Information received after this date will not be considered.

Thank you,  
Myers and Stauffer LC



**Healthier Washington Medicaid Transformation  
Accountable Communities of Health  
Semi-Annual Report 3 Assessment  
*Reporting Period: January 1 to June 30, 2019***

**Request for Supplemental Information**

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

- If the question applies to the project narrative, please provide a response within this document. The naming convention should be as follows: "RESPONSE ACH name.SAR3.RFI.Date"
- If the question applies to any attachments, please respond with an **updated** attachment. The naming convention should be as follows: "REVISED ACH Name.SAR3 Attachment Name"

**Section 2: Project Implementation Status Update**

**Question 15 - Implementation work plan:** The ACH must submit an updated implementation plan reflecting progress made during the reporting period. The updated implementation plan must clearly indicate progress made during the reporting period.

1. **Independent Assessor Question:** The Opioid Project indicates work step "Conduct evaluations." has been "Fulfilled for quarter, remains in progress." However, the Key milestone indicates "Completed evaluations results." Have evaluations been completed?

- RESPONSE ElevateHealth.SAR3.RFI.9.5.19

**Answer: Yes- Evaluations are ongoing and will be re-distributed bi-annually.**

2. **Independent Assessor Question:** Project 3A and 3D do not have deliverables under two work steps for milestone "Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2)." Please confirm deliverables.

**Answer: See Attached document – Revised -Elevatehealth.SAR3 IMPLEMENTATION WORK PLAN.8.30.19**

**Question 17 – Quality improvement strategy update:** The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and 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: 1) modifications to the ACH's quality improvement strategy, 2) summary of findings, adjustments, and lessons learned, 3) support provided to partnering providers to make adjustments to transformation approaches, 4) identified best practices on transformation approaches.

3. **Independent Assessor Question:** Can Elevate Health further describe the status of current implementation activities related to Project 3D: Chronic Disease Prevention and Control? Are there measure results available?

• RESPONSE ElevateHealth.SAR3.RFI.9.5.19

- **Answer:** Status update of current implementation activities related to chronic disease prevention and control include:
  - **Pathways-Community HUB:** Population focus in 2019 includes individuals with at least one chronic disease. Pathways remains a core initiative to target chronic disease management and prevention via care coordination. We are working with community partners to enhance workforce training for community health workers to support chronic disease self-management and prevention. The goal is to roll out chronic disease self-management education for our CHW workforce in 2020. Measure collection on chronic conditions is in early stages due to difficulties in pulling chronic disease data from our current technology solution. We will be moving to a new technology solution Innovaccer by EOY 2019 to improve clinical outcomes collection, including chronic disease metrics, and performance monitoring for each of our contracted care coordination partners.
  - **Health Homes:** Live with Health Homes as a lead organization, with a population focus on individuals with complex or multiple comorbidities. Program launch was August 1, 2019. We are in the early



stages of implementation and are working on an outcomes monitoring and performance dashboarding. Chronic disease outcomes monitoring and dashboarding will be collected on our new care coordination solution, Innovaccer, beginning September/October.

- **Strategic Improvement Partnerships:** Workplan development with partners in binding letters of agreement is focused on Elevate Health core projects – bi-directional integration of care and care coordination. Partners are recommended to align internal priorities with Elevate Health’s core projects, including chronic disease self-management. Collection of outcomes metrics at the provider level is in early stages of collection with our partners. We provide P4P reports at a regional level on baseline performance on metrics tied to chronic disease. In addition, we have one partner providing reports on comprehensive diabetes management within their organization on a quarterly basis.

### Section 3: Pay-for-Reporting (P4R) Metrics

**Question 21 - Implementation work plan:** Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g. count of sites that selected each response option). Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the reporting template.

4. **Independent Assessor Question:** The summary indicates 25 respondents to Project 2A, but on the 2A tab it indicates 30. Please clarify and confirm the counts on the Project Summary tab.

**Answer: Summary count corrected. See Attached document:  
Revised-ElevateHealth.SAR3 P4R METRIC REPORTING 8.30.19**



## Pierce County Accountable Community of Health

### ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority<sup>1</sup>

Funds Earned by ACH During Reporting Period <sup>2</sup>		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	6,408,024.00
2B: Community-Based Care Coordination	\$	4,405,517.00
2C: Transitional Care	\$	-
2D: Diversion Interventions	\$	-
3A: Addressing the Opioid Use Public Health Crisis	\$	801,004.00
3B: Reproductive and Maternal/Child Health	\$	-
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	1,602,006.00
Integration Incentives	\$	5,593,073.00
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus Pool/High Performance Pool	\$	-
<b>Total Funds Earned</b>	<b>\$</b>	<b>19,109,624.00</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
Administration	\$	-
Community Health Fund	\$	-
Health Systems and Community Capacity Building	\$	102,010.00
Integration Incentives	\$	2,230,724.00
Project Management	\$	-
Provider Engagement, Participation and Implementation	\$	160,000.00
Provider Performance and Quality Incentives	\$	5,217,952.80
Reserve / Contingency Fund	\$	-
Shared Domain 1 Incentives	\$	2,191,986.00
<b>Total</b>	<b>\$</b>	<b>9,902,672.80</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
ACH	\$	-
Non-Traditional Provider	\$	-
Traditional Medicaid Provider	\$	7,710,686.80
Tribal Provider (Tribe)	\$	-
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	2,191,986.00
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>9,902,672.80</b>

<b>Total Funds Earned During Reporting Period</b>	<b>\$</b>	<b>19,109,624.00</b>
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>9,902,672.80</b>

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> Definitions for [Use Categories and Provider Types](#)

