



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

Table of contents

Table of contents.....	2
Semi-annual report information and submission instructions.....	3
ACH contact information.....	7
Section 1. ACH organizational updates.....	8
Attestations.....	8
Attachments.....	9
Documentation.....	9
Section 2. Project implementation status update.....	14
Attachments.....	14
Documentation.....	17
Narrative responses.....	18
Attestations.....	25
Section 3. Pay-for-Reporting (P4R) metrics.....	25
Documentation.....	25

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each year of the Medicaid Transformation:

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

The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state's contracted Independent Assessor (IA) will review semi-annual report submissions.

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

Reporting requirements

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

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

Section 3. Pay-for-Reporting (P4R) metrics	21	Documentation
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There is no set template for this semiannual report. ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

Achievement values

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

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

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

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

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

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

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

Semi-annual report submission instructions

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

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

ACHs must submit their semi-annual reports through the WA CPAS: <https://cpaswa.mslc.com/>.

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

The folder path in the ACH’s directory is:

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

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

File format

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

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

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

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

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

Semi-annual report submission and assessment timeline

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

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

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

Contact information

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

ACH contact information

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

ACH name:	Greater Columbia Accountable Community of Health
Primary contact name	Carol Moser, Executive Director
Phone number	(509) 851-7601
E-mail address	cmoser@gcach.org
Secondary contact name	Wes Luckey, Deputy Director
Phone number	(509) 851-7784
E-mail address	wluckey@gcach.org

Section 1. ACH organizational updates

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

Attestations

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

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: <ul style="list-style-type: none"> • Primary care providers • Behavioral health providers • Health plans, hospitals or health systems • Local public health jurisdictions • Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region • Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region. 	X	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH's decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits. ²	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation	X	

² <https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26>

Foundational ACH requirements	Yes	No
activities and to receive updates on progress.		

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.

GCACH Response:

See attached file: GCACH.SAR3.Attachment1.7.31.19

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.).

GCACH Response:

No action required

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.

GCACH Response:

Greater Columbia ACH is collaborating with the Yakama Nation to form a Health Commons Project tied to their Circles of Care Program (Skíí Nak Nú ii). Greater Columbia has been collaborating with the Yakama Nation since the beginning of the Transformation Project to improve outcomes of patient service delivery for American Indian/Alaskan Natives on the Yakama Reservation.

The Yakama Nation face many ongoing challenges in their delivery of healthcare and social services within the reservation, including the following:

- Inadequate and unreliable information technology infrastructure results in routine outages of Internet and phone service by their behavioral health program
- Clients routinely “gettin lost” between transitions in care and referrals between programs.
- A lack of complex care management
- Reliance on a paper-based system for patient records for tribal programs
- Resistance to change and acceptance of new processes
- Internal bureaucracy and “silos,” and little standardization in the forms and processes (e.g. Release of Information) being implemented by each program
- A lack of connectivity between programs and a lack of awareness about the scope of internal and external programs and capabilities.
- Missed opportunities in coordinating with wrap-around services

All this adds strain to a system that struggles with unique and sometimes daunting social and health challenges.

To help remedy some of these issues, the Yakama Nation received a Circles of Care Program grant from Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services. The three-year discretionary infrastructure grant will help serve children with severe emotional disturbances and their families within their home communities. The program’s goals include planning for a community-based system of care model for children with mental health challenges and their families through the planning and development of infrastructure, local capacity building, and overall systems change. Grantees must also strongly emphasize cross-system collaboration.

On May 29th, 2019, the Yakama Nation’s Circles of Care Database Work Group identified a project associated with family reunification that would be beneficial to Tribal members and meet the goals of the Medicaid Transformation Project. The project would be supported by the tribal Behavioral Health, Child Welfare, Youth Treatment, and Alcohol and Drug programs as well as Tribal Justice Services. The Circles of Care Database Work Group has identified internet connectivity as needing significant upgrades, and the need for an information exchange between the various program areas as their highest priority.

Recognizing the importance of this need, the GCACH agreed to fund the Yakama Nation Behavioral Health Services and their Circle of Care Program with a onetime payment of \$150,000 to use for upgrades to their internet, and to work with the consulting firm, Quad Aim Partners, a Social Purpose

Corporation to establish a Health Commons that will act as a communications and information exchange between the applicable Yakama Nation programs to implement the Family Reunification Workflow project.

The Health Commons is a technology platform that has an underlying system for delivery of whole-person care also known as a Natural Communities of Care. This fully integrated system of care where health and social service providers work together to ensure there is “No Wrong Door” for people to access the care and services they need. The Health Commons Network is a communication network that digitally connects health and social service agencies in a community.

Along with the software system architecture build-up, the GCACH will also cover the costs of system hardware needed to operate the Health Commons (e.g. system routers). In addition, Quad Aim Partners will facilitate HIPAA training and certification for all participating tribal programs and personnel linked to the Health Commons.

Following implementation of the Health Commons, the GCACH will provide the Yakama Nation Behavioral Health Services with additional funding to be used for near-term ongoing production system and maintenance costs associated with the Health Commons. Once these funds have been exhausted, the Yakama Nation will take responsibility for the ongoing maintenance fees of the Health Commons.

See attached file: GCACH.SAR3.Attachment2.7.31.19

GCACH is also working in partnership with the Yakama Nation to form a Local Health Improvement Network (LHIN) that would resource projects to address their communities’ social determinants of health. GCACH would fund the Yakama Nation with \$30,000 to convene with local partners, delivery system providers, school systems, local governments, etc. to review resources within in the tribe that strengthen the local health care delivery system by facilitating collaboration between physical and behavioral health providers, community-based organizations, and tribal programs.

Research points to the association between unaddressed social determinants and poor health outcomes. Factors such as food insecurity, lack of safe and affordable housing, historical trauma, inadequate education, lack of access to transportation, and social isolation have a significant impact on individual health and the collective health of our communities. GCACH considers the social determinants of health as part of our overall healthcare delivery system. The addition of a LHIN would play a key role in identifying and addressing these upstream determinants of health for the Yakama Nation.

In addition, the GCACH Community and Tribal Engagement Specialist, attended the 2019 American Indian/Alaskan Native Behavioral Health Conference in Albuquerque, New Mexico. The conference is the premier behavioral health event attracting over 500 Tribal behavioral health experts, public health professionals, federal employees, advocates, researchers and community-based providers.

Attending this conference helped reinforce the commitment from GCACH to collaborate with the Yakama Nation and show a desire to improve cultural knowledge. GCACH also sponsored a Yakama Nation Behavioral Health Therapist to attend the conference.

Previously, GCACH identified the need for a Dental Health Aid Therapist on the Yakama Reservation. Given the legal challenge by Centers for Medicaid and Medicare Services, the GCACH has redirected its efforts and resources toward the Health Commons project described above.

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.
- 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.

GCACH Response:

See attached files: Comments within Design Funds spreadsheet address the planned use of funds.

GCACH.SAR3.Attachment3.7.31.19

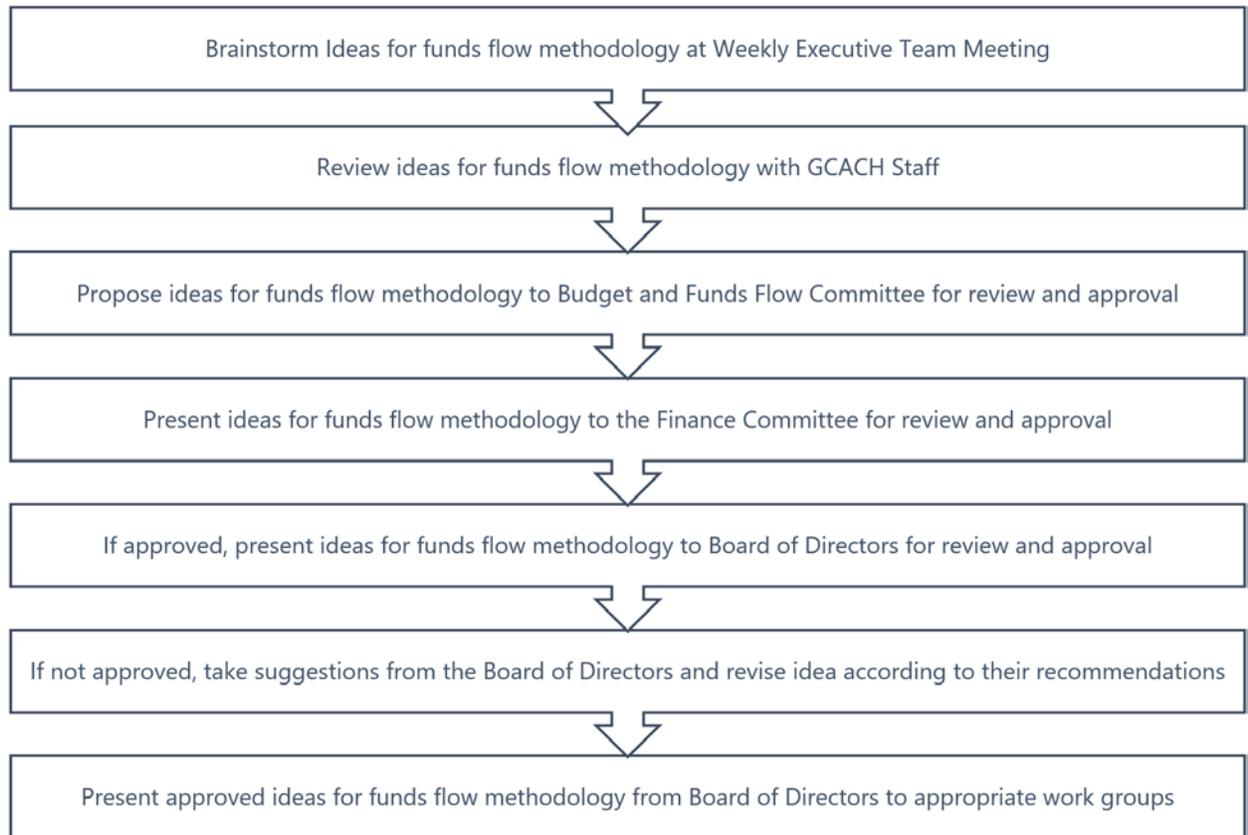
GCACH.SAR3.Attachment4.7.31.19

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

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

GCACH Response

The GCACH Board of Directors still serves as the primary decision-making body to select project areas and approve the funds flow allocation and distribution. Under the GCACH governance structure, the Finance Committee is responsible for the financial success of GCACH and for the establishment of financial controls to ensure compliance with project requirements. The Budget and Funds Flow (B&FF) Committee recommends a funds flow approach and distribution plan to the Finance Committee and project workgroups for review and recommendation to the Board for approval. The Committee serves as an advisory arm of the Finance Committee to develop provisions for monitoring and modifying the funds flow methodology. The chart below shows the current funds flow decision making process for all funding including reserve funds, the Community Health Fund and Contingency Fund:



Substantive Changes

GCACH has not made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission. The Board of Directors relies upon this to have confidence in the Budget and Funds Flow process.

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

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

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected

GCACH Response:

See attached file:

GCACH.SAR3.Attachment5.7.31.19

Section 2. Project implementation status update

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

Attachments

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

15. Implementation work plan

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

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

- The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
 - Work steps and their status.
 - At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH.

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

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

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

GCACH Response:

See attached file:

GCACH.SAR3.Attachment6.7.31.19

16. Partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.⁴ ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:⁵

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

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

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

A high-level overview of the process:

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

⁴ Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

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

Submit partnering provider roster.

GCACH Response:

See attached file:

GCACH.SAR3.Attachment7.7.31.19

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.

GCACH Response:

See attached files:

GCACH.SAR3.Attachment8.7.31.19

GCACH.SAR3.Attachment9.7.31.19

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?

GCACH Response:

As a result of the milestones included in the Practice Transformation workbook, many partnering providers have incorporated new procedures into their daily workflows. Most providers have updated their procedures to be able to accurately empanel patients and complete risk stratification of high risk patients. As a result of these changes several providers have added or enhanced their care management services. Many providers have changed their policies and procedures to accommodate bi-directional integration, which provides a combination of Behavioral Health, Substance Use Disorder (SUD), Mental Health services and/or primary care. For example, Tri-Cities Community Health set in place standard operating procedures (SOPs) for their behavioral health department. These SOPs put in place include things such as creating a workflow for reducing duplication of refill requests, development of referral tracking system that can track initial and subsequent contact for behavioral health patients, process development for patient check in and provider notification of check in. Standard operating procedures well also develop for the front desk staff that included development of how to check in new patients, workflow development of how to check in established patients and workflow development of the check out process and making sure that patients were scheduling follow up appointments before they leave. Comprehensive Healthcare in Ellensburg and Walla Walla Teams at both locations have been established and are beginning to work on risk criteria. The steps planned to finalize our risk stratification initiative includes but is not limited to; research risk criteria, define our risk categories, include social determinants of health screening, establish baseline number of clients, set goal for improvement, finalize report criteria, set policy and procedure for utilization of data, adjust interventions to meet the needs of high utilizing clients.

Other policy and procedure changes have been focused on providing self-management support and medication management services to patients. Additionally, some of the sites have incorporated a Patient and Family Advisory Council (PFAC) into their current procedures.

There have been positive patient outcomes as a result of Practice Transformation. Providence St. Mary Medical Center's Family Practice clinic discovered that they were only identifying patients with behavioral health needs, not addressing their needs. As a result of their work in Bi-Directional Integration (Milestone 2B.1), they found out that there have been 25 patients that had taken the Patient Health Questionnaire (PHQ-9) and scored 22 or above with a positive indication of suicide. Due to previous workflows, lack of training and EHR configuration, the Medical Assistants (MAs) were able to dismiss the notification that a patient flagged as suicidal. Furthermore, if "depression or behavioral health concerns" were not the primary reason for the visit, the providers would not be notified in the EHR. Since the team started Practice Transformation, they have updated their workflows to by adding a bright red magnetic card to the exam room door. This will show the patients PHQ-9 score and whether or not the patient has suicidal intent. Additionally, the EHR workflows will be updated. Since this discovery, the Family Practice clinic has reached out to and/or scheduled a Behavioral Health visit for all 25 patients.

Over the course of Practice Transformation, working with Tri-Cities Community Health there were many areas of opportunity that were identified. One of the first areas that we started to work on were standing operating procedures. These standing operating procedures were not only being implemented in the Practice Transformation sites but they were going to be implemented organization wide. Through the process of developing the procedures, staff from all departments were brought in and provided their input. These procedures impacted pharmacy, behavioral health, vision and front desk staff. The development of these procedures took several meetings and several tweaks. For example when the procedure to check in and check out was developed, the supervisor from that department trained her staff to make sure that they understood the the new process. Once staff was trained and once the quality improvement team agreed, PDSAs were put into place and tested the newly developed procedures. If something was not working, the we would regroup and discuss what needs to be fixed in order for the policy to fully be implemented and set in place. With the development of new standing operating procedures, new workflows had to be developed for staff. For the development of these new workflows, the QI team and leads from the different departments gathered and mapped out the current workflows and then discussed what process to change in order for the new policies to be fully implemented.

Throughout the reporting period there have been several instances of providers sharing their updated procedures, recently developed job descriptions, and best practices. This collaboration is typically done by the Practice Transformation Navigator scheduling and facilitating a discussion between organizations. During the reporting period, an exemplar organization that is PCMH certified discussed the pros/cons of PCMH certification with another organization. The conversation was so beneficial that the ACH determined it should become a panel discussion at an upcoming Learning Collaborative.

The ACH will know that successful adoption has occurred based on providers' reporting in the Practice Transformation Workbook. Additionally, the Practice Transformation Navigators meet with each organization at least monthly. In these meetings, the team discuss any changes to procedures, progress on milestone completion, needed technical assistance, data analysis, and opportunities for quality improvement at the site and organization level.

Working with Lewis & Clark CHAS Dental Clinic on Practice Transformation seemed to be somewhat of challenge for both GCACH and CHAS. From the first time that the Practice Transformation Navigators had their kick-off meeting, there were questions as to how the PCMH model would apply in a dental clinic, specifically how bi-directional integration was going to work. After a couple of meetings and brainstorming how to mold the PCMH model to fit a dental clinic setting, things started to make sense. Once the work that had to be done as part of Practice Transformation was understood, everything became much easier. One of the things that CHAS implemented as part of bi-directional integration was the implementation of the PHQ-2. At first leadership was not sure how the staff would react to having to do one more thing. To have less push back from staff, leadership decided to educate their staff on the PHQ-2 and why it was being implemented. As a result of this implementation patients have been identified that are in need of behavioral health services and connecting them to those services. One of the patients that was identified as needing behavioral health services, came back to the clinic and thanked them for what they had done for him. Staff at CHAS Dental Clinic have also been able to connect patients to primary care services. In one case a patient was on a six month wait list to see a PCPC, when he expressed this concern to the staff they were able to get him connected with a PCP with in the CHAS network right away. As part of Practice Transformation, CHAS has also been able to identify and follow up with patients that have been to the ED due to dental pain through the monitoring of the Emergency Department Information Exchange (EDIE) platform.

- 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.

GCACH Response:

Challenges have included the following:

- Provider communication within own organization. Providers not knowing what services are offered within the organization.
 - The Practice Transformation Team has worked with organizations to meet with key stakeholders at the same time. During these meetings the Navigators have conducted practice assessments (MeHAF and PCMH-A). The assessments have facilitated discussion on current workflows and shed light on opportunities for improvement.

- Staff turnover and recruiting barriers in rural areas.
 - Greater Columbia ACH gives the Practice Transformation organizations the ability to use their funding to enhance recruitment and/or retention.
- Senior leadership and the clinic site not agreeing what metrics to track or which are more valuable to track based on clinic location or patient population.
 - The Practice Transformation Team works with the clinic site and senior leadership to facilitate discussion on what metrics will be the most impactful for patients and the organization. Typically, organizations prefer to choose the same metrics for each site to make reporting easier. However, the Practice Transformation team highly recommends that each site chooses metrics specific to the need of their patients. This has proven effective at Providence St. Mary Medical Center. Their Family Practice clinic chose to track depression, heart failure, and COPD. The Urgent Care is tracking asthma and diabetes. While the hospital will be tracking Substance Use Disorder (SUD) Penetration Rate and Depression. Tracking these different metrics allows Providence to have a higher level of understanding of their patients' outcomes.
- Provider leadership/buy-in.
 - This is has been particularly challenging for organizations with a hospital participating in practice transformation. The GCACH Executive Team has met with several hospital leadership teams to further define the impact of practice transformation and discuss how practice transformation has been going from their perspective. Their results of these meetings have been very positive.
- Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, and population health management.
 - In order to mitigate this challenge the Practice Transformation team works closely with the organization's Quality Improvement and IT teams. We typically discuss what capabilities the new technology will need to have and prepare for any procedure changes.
- Organizations transitioning to new EHR systems
 - The Practice Transformation team will review best practices for transitioning EHRs. Through the Practice Transformation process, there were some organizations that had EHR transitions. When the Practice Transformation team would learn that there was going to be a transition, they made sure to ask the organization if they would like to talk to another organization that had the same EHR. The purpose for connecting both organizations was for them to be able to ask questions about the EHR and also share lessons learned and best practices on using the EHR.
- Complying with 42 CFR for sharing information from Behavioral Health providers to Primary

Care Providers or vice versa.

- The Practice Transformation team reviews 42 CFR with the Behavioral Health and Primary Care sites. Ultimately, each organization will need to have patients sign a consent form upon check in for their next appointment to be 42 CFR compliant.
- Enhancing billing workflows that will allow for sustainability
 - The Practice Transformation Navigators under the guidance/expertise of the Director of Practice Transformation advise organizations on the most profitable and accurate codes to use to maximize reimbursement. Additionally, the Practice Transformation team has worked extensively with Tri-Cities Community Health (TCCH) to update billing processes, identify expired codes, and train practice teams (including billing department staff) on billing workflows.
- Internal transitions and/or protocols. Some organizations are being bought out or decisions take a longer time to implement due to internal bureaucracy.
 - The Practice Transformation Team works with organizations during these times of transitions or extended decision making to determine what quality improvement efforts can be made within their current structure. For example, Lourdes has new owners and there was a delay with getting approval for additional staff. During this time we worked with Lourdes to determine what data analysis could be done within their current system at their current staffing level. Ultimately, Lourdes was able to accurately empanel their patients, stratify their highest risk patients, and determine the highest Emergency Department utilizers by insurance type.
- MCO sponsorship of the Collective Medical Platform for Cohort 1 and Cohort 2 organizations.
 - One of the milestones for Practice Transformation requires that practices implement Collective Medical to perform follow-up after Emergency Department visits and Inpatient discharges. The four MCOs in the area agreed to financially sponsor each organization. Over the past 6 months, there has been issues with beginning the sponsorship process, due to lack of communication from the MCOs to the practices. Currently, GCACH is in the process of facilitating the Collective Medical sponsorship by communicating with the MCOs and Collective Medical. Two of the four MCOs have reached out to practices to begin the implementation of Collective Medical. GCACH is in communication with the other two MCOs.

19. Regional integrated managed care implementation update

- **For 2019 adopters**, list the date in which the ACH region implemented, or will implement, integrated managed care.

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

GCACH Response:

At the beginning of 2018 the Greater Columbia Behavioral Health Organization (BHO) was very reluctant to work with the GCACH. There was not a good working relationship with the BHO and GCACH. They didn't attend any GCACH meetings we set up with the different committees. It wasn't until 6 months in that they started attending. It took GCACH reaching out to each BH Provider and developing a relationship with each one before the BH Providers trusted GCACH. We now have a strong working relationship with each BH Provider. Our plan now is to develop a better working relationship with Greater Columbia Behavioral Health Organization-Assigned Service Organization (BHO-ASO). We have set up a meeting to meet with the new management for July 15, 2019.

GCACH's BH Providers were ready to become January 2019 adopters. Some of the major challenges since the change have been the lag in claims being paid or the amount of claims being rejected for various reasons. Most of the issues are due to contracts not being fully configured and complete rosters uploaded into the MCO systems. This was because a handful of providers were still in the process of re-negotiating their contracts, which caused their claims to be rejected. Another issue was with SUD claims being rejected. We just had a meeting on June 27, 2019 with HCA, the MCOs, and the providers. It was reported that all the contracts have now been finished and that the MCOs will have all past claims and rejected SUD claims reprocessed and paid by the end of July 2019. The MCOs are on track to have everything cleaned up within the next two weeks and claims reprocessed by end of July.

GCACH has offered to provide any Technical Assistance that the BH Providers or MCOs may need. The MCOs have stated that they do not need TA at this time from the ACH on the billing side but will keep that offer in mind as they move into full configuration.

Some CPT codes in the new SERI Guide were also giving BH providers issues. HCA has updated the codes in the SERI guide. The update was just sent out today June 27th. HCA will work with their communications department to see about getting it uploaded to the website, as well.

There have been some questions on the process of getting residential treatment authorized. A meeting has been set up between HCA, MCOs and BH Providers on July 16, 2019 to discuss this issue.

GCACH has continued to meeting with the BH Providers on a monthly basis and making progress towards their milestones (see GCACH.SAR3.Attachment10.7.31.19). GCACH is still working with MCOs to get the BH Providers access to PreManage/EDIE. This will provide good information to the BH Providers on their patients.

GCACH has received the second round of funding. The Board of Directors and GCACH staff have decided on how it will be allocated. GCACH is working with the BH Providers to get the new contracts in place for the next set of Milestones to start in July 2019.

In June GCACH co-sponsored The Opioid Use Disorder and Trauma Informed Care Summit was a two-day

event attended by more than 250 providers, offered Continuing Medical Education credits and included 30 speakers who were national, state, regional and local experts in their respective areas. The four learning tracks included the following:

- Strategies for Managing Patients with OUD
- Patients, Payment, and Stigma
- Trauma Informed Care
- Innovative Models of Care

GCACH has developed a learning curriculum for the BH Providers for next 6 months. We surveyed the BH Providers to see what they would be like to have as learning collaboratives. One of the important things they wanted to have is a learning collaborative on contract negotiation, especially with Value Based Payments (VBP) coming in the near future. The biggest issue with VBP is the BH Providers aren't sure what VBP would look like for them and will the MCOs actually be ready to provide those payments by 2020. We want to provide the BH Providers with any resource we can. Having learning collaboratives is a good way to get the information to the providers.

See table below.

Month	Description	Date	Length	Presenter
Aug-19	Budget	7-Aug-19	2 Hours	GCACH Staff
Sep-19	QI Metrics/VBP and technology	Sept. 5, 2019	2 Hours	MCOs Department of Health - WA State VBP transformation Washington Rural Hospital Collaborative has a VBP & Coding Orientation Audit Worksheet Martin & Jenna -Present on data from Practice Transformation reporting EHR Reporting Breakouts
Oct-19	Kickoff and Rewards Dinner	10/30/2019	3 Hours	Panel of Exemplar Clinics / Newly identified Exemplar Clinics
Nov-19	Trauma Informed Care	11/4-5/2019	1-Day	Ken Kraybill
Dec-19	Contract Negotiation	12/11/2019	1 Day	Adam Falcone
Jan-19	Crisis Services	1/23/2019	3 hours	The five crisis providers are Lourdes Counseling Center, Comprehensive Healthcare, Palouse River Counseling, Quality Behavioral Health and Blue

				Mountain Counseling
Feb-19	Practice Guidelines	2/27/2019	3 hours	BHO-ASO

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

Attestations.

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

	Yes	No
<p>20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:</p> <ul style="list-style-type: none"> • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities. 	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

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

Related resources and guidance:

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

Instructions:

- Submit line-level P4R metric responses collected from partnering provider sites. Include partnering provider organization name and site name for each respondent.
- Provide a count of partnering provider sites participating in Project 2A and 3A, and a count of P4R metric respondents, stratified by provider type (practice/clinic site and community based organization).

Format:

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

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

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

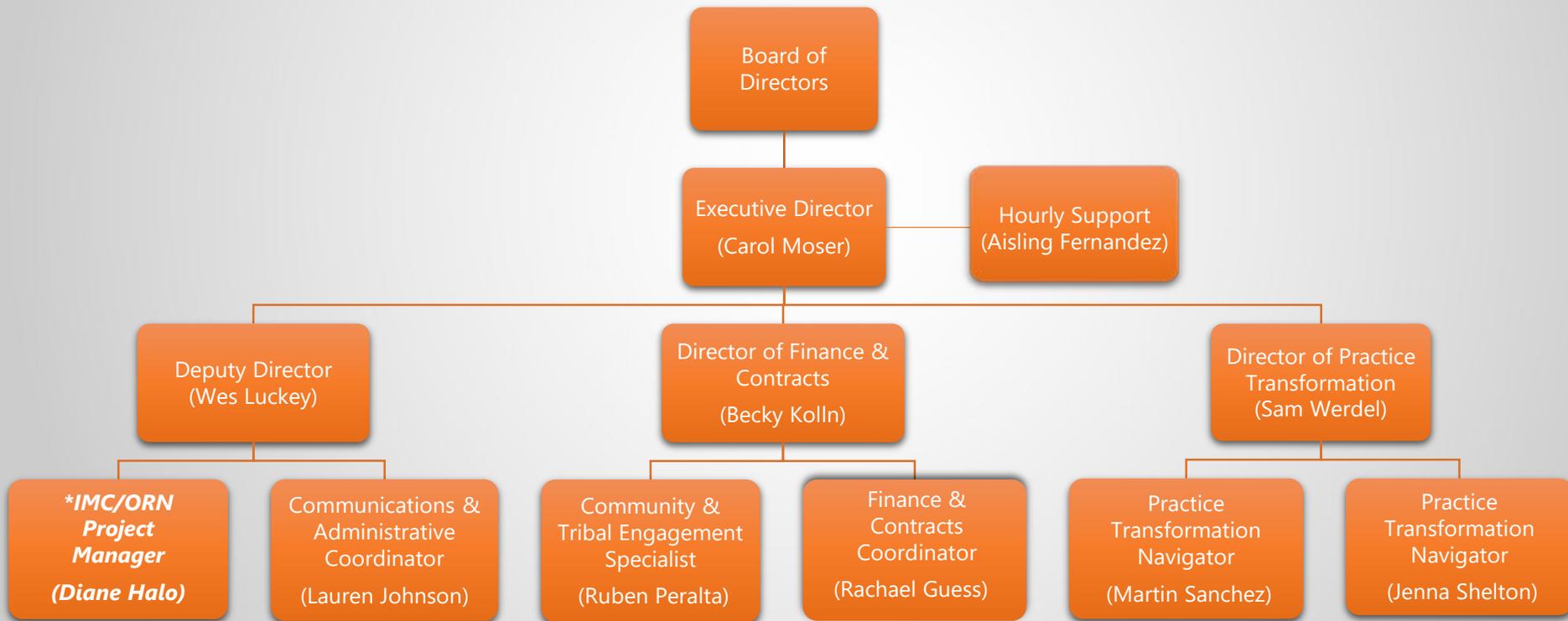
⁸ <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics>

Submit P4R metric information.

GCACH Response:

See attached file:

GCACH.SAR3.Attachment11.7.31.19



Introducing the



from the

What is Circles of Care? A program that supports American Indian/Alaska Native children with severe emotional disturbances and their families within their home community.

How to Setup Circles of Care? Healthcare and community partners team up with Health Commons Project to organize and digitally connect services to a community-wide care coordination system, called the IT Commons Network.

4 step process for setting up Circles of Care

STEP 1 IDENTIFY TARGET POPULATION



Medical

Non-elderly Disabled
Advancing Illness
Frail Elderly
Major Complex Conditions
Multiple Chronic Conditions
Children with Complex Needs



Behavioral

Substance Use
Serious Mental Illness
Cognitive Decline
Chronic Toxic Stress

Children with Severe Emotional Disturbances



Social

Housing Insecurity
Social Isolation
Low Socioeconomic
Community Deprivation



Example: A child with severe emotional disturbances

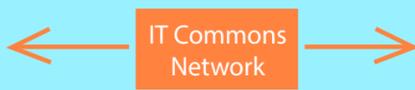
STEP 2 ORGANIZE, CONNECT, AND PILOT TEST INTEGRATED SERVICE

Example of Circles of Care for Children with Severe Emotional Disturbances and their Families



Child Welfare Service

Provider-to-Provider Communication



Reporting and Tracking



Behavioral Health Service for Children and their Families

STEP 3 LAUNCH THE PERSONALIZED, DIGITALLY INTEGRATED SERVICE

Example of Circles of Care for Children with Severe Emotional Disturbances and their Families



Community-Based Service for Children and their Families



Enroll



Collect Information



Develop Care Plan



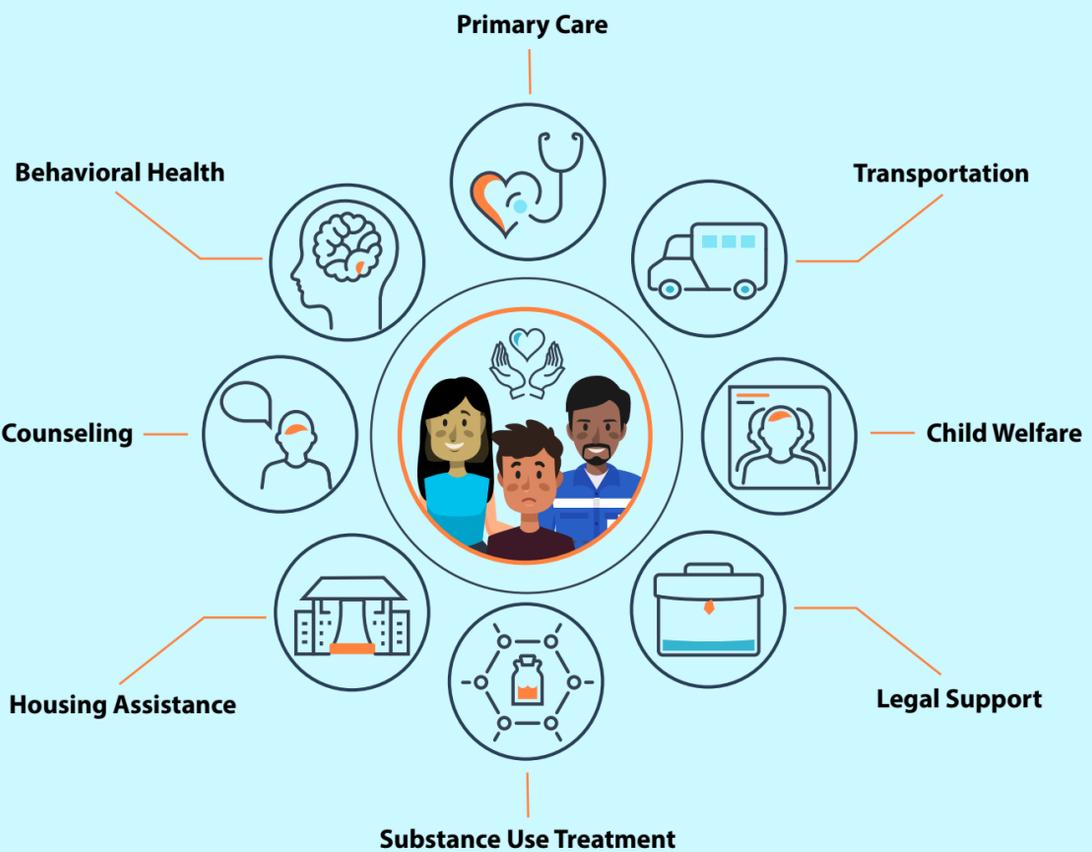
Take Action Together



Ongoing Support

STEP 4 FULLY INTEGRATE ADDITIONAL SERVICES, MEASURE AND SUSTAIN

Example of Circles of Care for Children with Severe Emotional Disturbances and their Families



At scale, the **Circles of Care** model is designed to improve the mental health and wellness of children, youth and families.



August 23, 2019

Dear Ms. Moser:

Thank you for the submission of Greater Columbia ACH'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@mslc.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.mslc.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 1: ACH Organizational Updates

Question 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.

1. ***Independent Assessor Question:*** The Finance and Contracts Coordinator position is highlighted and bolded; however, the position title and person listed are the same as in the organizational chart submitted with the SAR 2.0 report. Please confirm if there has been a change.

GCACH Response:

There has been no change to this position. The Finance and Contracts Coordinator position was filled in December 2018. The bold highlight will be removed from the organizational chart.

Question 10 – Budget/funds flow: 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.

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.)

2. **Independent Assessor Question:** GCACH indicates in its response to Question 11 that funds are being provided to the Yakama Nation Behavioral Health Services and their Circle of Care Program. However, minimal funds are listed as having been distributed to tribal providers. Please confirm if these funds were distributed during this reporting period.

GCACH Response:

The GCACH had set aside \$150 thousand funding for the Dental Health Aide Therapist program. This money came from a grant that GCACH was awarded through the Yakima Valley Community Foundation. This now money has been redirected to the Circles of Care Program. Please see page 10 of the Semi-Annual Report 3.0. The Board of Directors set aside these funds in 2017 for the specific purpose of supporting the Yakama Nation. These funds came directly out of a GCACH bank account rather than through the Financial Executor Portal.

Question 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. 1) Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used, 2) ACHs may use the table or an alternative format as long as the required information is captured, 3) Description of use should be a brief line item (not narrative).

3. **Independent Assessor Question:** GCACH projects use of over \$6 million in 2019; however, actuals as of the time of the report are only \$192,997. This appears to be due to IMC payer distributions having not been made. Please confirm that it is correct that IMC providers have not yet received distributions, and those are scheduled in the last half of the year.

GCACH Response:



Budget for Phase II Integration Incentive Funding	\$	%
Integration incentives for 17 BH organizations	\$ 4,211,631	69%
Scholarships for BH Internships and CHW Workforce Development	\$ 490,000	8%
Health Commons for Opioid Networks (Yakima, Kittitas, SE WA, Pullman)	\$ 360,000	6%
Opioid Resource Network-Kittitas SE WA Pullman (Yakima funded through state grant, BFN funded through extra DSRIP)	\$ 900,000	15%
Learning Community	\$ 100,000	2%
Administrative fee	\$ 48,719	1%
Total	\$ 6,110,350	100%

In May 2019, GCACH Board approved the PCMH Cohort 2, which were all of the behavioral organizations that proceeded through Integrated Managed Care. Contracts for Cohort 2 were signed in June 2019, and payments for Practice Transformation Milestones began distribution in July 2019. These Milestone payments will follow a quarterly reporting cadence similar to Cohort 1.

The \$4.21 million incentive payments earned for integrated managed care Milestones are intended to be used to assist providers and the region with the process of transitioning to fully integrated managed care.

The balance of Phase II funding will also support the behavioral health organizations through scholarships, digital referral networks, the establishments of Opioid Referral Networks and Learning Collaboratives.

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.

- Independent Assessor Question:** A minimum requirement of Implementation Plans is to include Toolkit Milestones. GCACH has deleted tasks for milestones related to continuous quality improvement in favor of moving those to the Quality Strategy. Please submit an updated Implementation Plan that does not have tasks for these milestones deleted.

GCACH Response:

GCACH has removed the strike-throughs to the milestones related to continuous quality improvement sections of the Implementation Plan. Please see updated GCACH Implementation Plan.

5. **Independent Assessor Question:** The Work Step Status column compared to the Work Step Status Legend coding used is unclear in various instances. For example, in Project 3D, Stage2, Steps 3-5, the Work Step Status is listed as On Schedule, then DY3, Q1 is shaded in green to indicate Deliverable Met, followed by Gray Shading which is Delayed, Remains In Progress. Other times this same shading is indicated, but with a Complete Status (see Project 3D, Step 1 under "Implement a Disease/ Population-specific..."). Please review status across all steps to confirm progress indicated is correct, and if so, please provide context for the status listed compared to the legend.

GCACH Response:

The Work Step Status column has been revised to align with the shading in the IP Work Step Status Legend. The Timing columns have been corrected.

Question 16 – Partnering provider roster: 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.

6. **Independent Assessor Question:** Column G is not completed as Y/N for all listed partnering providers. Please complete and resubmit, or provide a narrative rationale if there is a reason there is no response.

GCACH Response:

Column G of the provider roster has been completed.

7. **Independent Assessor Question:** For all partnering providers listed as actively implementing in support of a project, there is an end date of DY3, Q4 listed across all projects. Please provide detail as to why all of these partnering providers are listed as ending at that time.



GCACH Response:

The provider roster has been updated to reflect contract start dates and actual implementation and completion dates.



Greater Columbia Accountable Community of Health

ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period ²		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	8,656,455.00
2B: Community-Based Care Coordination	\$	-
2C: Transitional Care	\$	3,516,685.00
2D: Diversion Interventions	\$	-
3A: Addressing the Opioid Use Public Health Crisis	\$	1,082,056.00
3B: Reproductive and Maternal/Child Health	\$	-
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	2,164,114.00
Integration Incentives	\$	6,110,350.00
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus pool/High Performance Pool	\$	-
Total Funds Earned	\$	21,829,660.00

Funds Distributed by ACH During Reporting Period, by Use Category ³		
Administration	\$	877,500.00
Community Health Fund	\$	1,395,201.87
Health Systems and Community Capacity Building	\$	1,198,937.92
Integration Incentives	\$	1,427,916.89
Project Management	\$	603,500.00
Provider Engagement, Participation and Implementation	\$	4,311,534.00
Provider Performance and Quality Incentives	\$	340,662.00
Reserve / Contingency Fund		
Shared Domain 1 Incentives	\$	2,557,318.00
Total	\$	12,712,570.68

Funds Distributed by ACH During Reporting Period, by Use Category ³		
ACH	\$	1,549,000.00
Non-Traditional Provider	\$	3,291,466.70
Traditional Medicaid Provider	\$	5,314,785.98
Tribal Provider (Tribe)	\$	-
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	2,557,318.00
Total Funds Distributed During Reporting Period	\$	12,712,570.68

Total Funds Earned During Reporting Period	\$	21,829,660.00
Total Funds Distributed During Reporting Period	\$	12,712,570.68

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on July 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019.

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

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

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

