Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 8.0

Reporting Period:
July 1, 2021 – December 31, 2021
DY5 Q3-Q4

Template Release Date: August 10, 2021
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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the 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).

Achievement values

The amount of incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given reporting period.

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

Table 1. Potential P4R Achievement Values (AVs) by ACH by Milestone for Semi-annual Reporting Period July 1 – December 31, 2021

<table>
<thead>
<tr>
<th>Number of Projects in ACH Portfolio</th>
<th>BHT</th>
<th>CPAA</th>
<th>EH</th>
<th>GCACH</th>
<th>HH</th>
<th>NC</th>
<th>NS</th>
<th>OCH</th>
<th>SWACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of semi-annual report</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion/maintenance of partnering provider roster</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Engagement/support of Independent External Evaluator (IEE) activities</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Report on quality improvement plan (Replaced by COVID-19 Response)</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Completion of all P4R metrics (Project 2A, 3A only) (Replaced by COVID-19 Response)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total AVs Available</td>
<td>18</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>34</td>
<td>26</td>
<td>18</td>
</tr>
</tbody>
</table>
Table 2. Potential P4R AVs for Project Incentives, July 1 – December 31, 2021

<table>
<thead>
<tr>
<th>ACH</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>3A</th>
<th>3B</th>
<th>3C</th>
<th>3D</th>
<th>Total Potential AVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Together</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Elevate Health</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
<td>5</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>HealthierHere</td>
<td>5</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>North Central ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>North Sound ACH</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>SWACH</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18</td>
</tr>
</tbody>
</table>

**Reporting requirements**

The semi-annual report for this period (July 1 – December 31, 2021) includes three sections as outlined in the table below.

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (July 1 – December 31, 2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Section 1. ACH organizational updates</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Section 2. Project implementation status update</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
There is no set template for the semi-annual report. All required elements are to be 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.

While ACHs have flexibility in how to develop the report, the main report should be navigable for reviewers and ready to publish to HCA’s webpage. See instructions for how to format the report below.

File format

ACHs are to submit all required elements as a single searchable PDF, with the exception of the Implementation work plan, the partnering provider roster, and the P4R metrics, which are to be submitted as separate Microsoft Excel files or PDFs. Below are examples of the file naming conventions ACHs should use:

- **Main Report or Full PDF**: ACH Name.SAR8 Report.01.31.22
- **Implementation work plan**: ACH Name.SAR8 Implementation work plan. 01.31.22
- **Partnering provider roster**: ACH Name.SAR8 provider roster. 01.31.22
- **P4R metrics**: ACH Name.SAR8 P4R metrics.01.31.22

Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s [Medicaid Transformation resources webpage].

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Semi-annual reporting guidance

Reporting period: July 1, 2021 – December 31, 2021
Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA no later than January 31, 2022 at 3:00p.m. PST.

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

ACHs must submit 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 8.”

The folder path in the ACH’s directory is:


See WA CPAS User Guide available in each ACH’s directory on the CPAS website for further detail on document submission.
**Semi-annual report submission and assessment timeline**

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1 – December 31, 2021.

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Responsible party</th>
<th>Anticipated timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Distribute semi-annual report instructions for reporting period July 1 – December 31, 2021 to ACHs</td>
<td>IA</td>
<td>August 2021</td>
</tr>
<tr>
<td>2.</td>
<td>Submit semi-annual report</td>
<td>ACHs</td>
<td>January 31, 2022</td>
</tr>
<tr>
<td>3.</td>
<td>Conduct assessment of reports</td>
<td>IA</td>
<td>February 1, 2022 – February 24, 2022</td>
</tr>
<tr>
<td>4.</td>
<td>If needed, issue information request to ACHs within 30 calendar days of report due date</td>
<td>IA</td>
<td>February 24 – March 1, 2022</td>
</tr>
<tr>
<td>5.</td>
<td>If needed, respond to information request within 15 calendar days of receipt</td>
<td>ACHs</td>
<td>February 25 – March 11, 2022</td>
</tr>
<tr>
<td>6.</td>
<td>If needed, review additional information within 15 calendar days of receipt</td>
<td>IA</td>
<td>February 25 – March 28, 2022</td>
</tr>
<tr>
<td>7.</td>
<td>Issue findings to HCA for approval</td>
<td>IA</td>
<td>April 2022</td>
</tr>
</tbody>
</table>

**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, also include their information.

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>Greater Columbia Accountable Community of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary contact name</strong></td>
<td>Sharon Brown</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>509-567-5583</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:Sbrown@gcach.org">Sbrown@gcach.org</a></td>
</tr>
<tr>
<td><strong>Secondary contact name</strong></td>
<td>Haydee Hill</td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td>509-851-7912</td>
</tr>
<tr>
<td><strong>E-mail address</strong></td>
<td><a href="mailto:hhill@gcach.org">hhill@gcach.org</a></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>• Primary care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this <a href="https://wahca.box.com/s/nfesialke5m1ye6aohiouy5xemoeh26">template</a> or a similar format) that addresses internal controls, including financial audits.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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.

**Documentation**

The ACH should provide applicable documents 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.

   - Include staff names and titles in the organizational chart. For vacant positions, mark each applicable position as “vacant” on the organizational chart.
   - Provide a narrative explanation of the organizational changes.

   **If applicable, include current organizational chart.**

   **Attachment:** GCACH Organizational Chart (Please see attachment 1 on page 30)

10. **Budget/funds flow.**

    a) **Financial Executor Portal activity for the reporting period.** The Independent Assessor will receive an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. **No action is required by the ACH for this item.**

    b) The ACH is asked to provide additional context to add clarity about the portal activity payments made outside the portal.

       - For payments made outside the portal during the reporting period, populate and submit the payment reconciliation spreadsheet.³

   **Attachment:** GCACH SAR 8 Payment Reconciliation Form SAR 8 (See attachment 2 on page 31-32)

³ The HCA issued reconciliation workbook can be found at the following link: https://www.hca.wa.gov/assets/program/payment-reconciliation-form-sar-8.xlsx

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11. Incentives to support integrated managed care. Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support the region in transition to integrated managed care.

a) List of use and expenditures that reflect a cumulative accounting of all incentives distributed or projected to support the transition to integrated managed care. It is not limited to the reporting period.
   i. ACHs may use the table below or an alternative format as long as the required information is captured.
   ii. Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
   iii. Description of use should be specific but concise.

<table>
<thead>
<tr>
<th>Description of Use</th>
<th>Expenditures ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual (2018-2021)</td>
</tr>
<tr>
<td>Provider Integration Incentives</td>
<td>$12,855,277</td>
</tr>
<tr>
<td>Practice Transformation Staff</td>
<td>$1,008,666</td>
</tr>
<tr>
<td>Telehealth Assistance</td>
<td>$276,660</td>
</tr>
<tr>
<td>Staff Technical Assistance/Admin Support</td>
<td>$14,728</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$14,155,339.89</strong></td>
</tr>
</tbody>
</table>

Use of incentives to assist in the transition to integrated managed care
Section 2. Project implementation status update

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

Attachments

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

12. 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 information to monitor ACH activities and project implementation timelines. Updates to the ACH’s implementation plan were made optional for SARs 5.0, 6.0, and 7.0.

- The ACH must submit an updated implementation plan reflecting current status and progress made since the last submitted update.

Attachment: GCACH.SAR8 Implementation work plan. 01.31.22

13. Partnering provider roster.

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

Instructions:

a) For each partnering provider site identified as participating in transformation activities, the ACH should use the template provided by the IA to indicate:

i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Populate the appropriate project column(s) with Y/N.

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

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

Submit updated partnering provider roster.

Attachment: GCACH.SAR8 provider roster. 01.31.22

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5 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 those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).
**Documentation**

The ACH should provide documentation that addresses the following:

**14. Quality improvement strategy update**

The reporting requirements for the quality improvement strategy updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. The submission of quality improvement strategy updates are considered **optional** for this reporting period but are encouraged to the extent the ACH has an updated quality improvement strategy to keep HCA and the IA apprised of quality improvement activities and findings. If submitting updates, ACHs may determine the format to convey this information.⁶

**Attachment:** GCACH Quality Improvement Strategy SAR 8.0 Update (See attachment 3 on pages 33-59)

**Narrative responses**

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

**15. COVID-19**

a) Provide an update on COVID-19 response and recovery activities. Please describe ACH COVID-19 activities that emerged or evolved during the reporting period (e.g., project management, communication and engagement, coordination of funding, etc.).

**GCACH Response:**

**Community Resiliency Campaign - Practice the Pause:** During this reporting period GCACH continued distribution of the Practice the Pause toolkits and trained a variety of community organizations. The Community Engagement Specialist was a featured speaker at the Washington State Coalition Against Domestic Violence Conference in September, and made in-person and zoom presentations to Columbia Center Rotary, Community Minded Enterprises, Yakima County Leadership Coalition, Benton Franklin Early Learning Alliance, Kennewick School District, United Way, and the Emergency Support Shelter in Longview, WA. A total of 290 community members received training on the phases and common behavioral responses to a natural disaster. They also learned techniques to reframe and cope with anxiety and stress. Toolkits were requested by the Okanogan County Community Coalition, Columbia Basin College, and accessed by an organization in California. The GCACH monthly newsletter provided information and links to the toolkits.

**COVID-19 Vaccination Collaboration:** In late August GCACH partnered with Medical Teams International and the Benton-Franklin Health District (BFHD) to find and coordinate pop-up COVID-19 vaccination clinics in Benton and Franklin Counties. BFHD had created a heat map showing pockets within the counties with low vaccination rates and higher social vulnerability index. As a result, GCACH pursued partnerships within these areas to expand the

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⁶ Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section
reach of the clinics to underrepresented populations. This initiative lowered barriers to vaccinations for populations living or working near the sites. GCACH provided stipends for organizations hosting the clinics, fifty-dollar gift cards for participants getting vaccinated, Spanish translation services, signage, marketing support, and distributed flyers in the neighborhood. Much of the Spanish outreach had to be done in person due to the high number of Spanish speaking individuals living in these communities. Over 25 vaccine clinics and nearly 550 vaccinations were administered at trusted sites including housing authorities, grocery stores, free medical clinics, churches, and food banks. Special outreach to the African American community was led by the GCACH’s Justice, Diversity, Equity, and Inclusion (JEDI) Specialist. GCACH partnered with local churches, Tri-Cities Hispanic Chamber of Commerce, Tri-Cities Diversity Council, Women of Wisdom Tri-Cities, Pacific Northwest National Laboratory, and Heritage University to host, market, and deliver vaccine clinics targeting this population. A total of 33 vaccines were administered. GCACH gift cards in the amount of fifty-dollars were distributed to 30 participants.

b) Describe specific risks/issues that emerged during the reporting period (e.g., workforce, information exchange, access), including any notable impacts to specific providers or communities. Also highlight any mitigation strategies or activities that shifted as a result, if applicable.

**GCACH Response:**

**Workforce:** Many if not all of the participating sites were affected by staffing shortages due to COVID-19. Many staff, ranging from front desk, environmental services to leadership were exposed, got infected, and had to miss work. This impacted service delivery to patients, as well as caused a lack of staff for reporting and quality improvement initiatives. Most sites experienced critical staffing shortages requiring them to pull staff from other departments in order to provide patient care.

**Vaccine mandates and higher wage offers** from other organizations also affected the ability of organizations throughout the GCACH region to recruit and retain their workforce. Some retention strategies we saw employed during this reporting period were offering retention bonuses and, for those sites facing shortages, bonuses for staff picking up extra shifts. To attract potential candidates, recruitment bonuses were offered and some organizations reached out to colleges/universities to recruit, as well as began offering internships and externships.

**Impact to Behavioral Health:** All providers regardless of specialty, have been impacted, however, behavioral health providers have been impacted the most. All throughout the GCACH region, behavioral health providers reported going through severe staffing shortages, especially in rural areas. Tele-health was a big benefit to behavioral health providers as they were able to engage staff members from other sites (for those organizations that have more than once clinical site).

**Care Management for High-Risk Patients:** The COVID-19 pandemic has had a major impact on care management. Many sites throughout the GCACH region are experiencing difficulty filling key staff positions that would be part of the care management team for high-risk patients. Additionally, patients are missing appointments, or can't be reached in order to enroll in care management.
**Communication:** Other risks and issues that emerged during the reporting period for COVID-19 were related to communication and funding. We learned that in order to reach the Spanish speaking community, we had to do outreach face to face or by foot, hang flyers in small business in Spanish speaking communities and set up re-occurring radio ads. GCACH’s Community and Tribal Engagement Specialist served as a direct interpreter during pop-up clinics answering questions and concerns of community members. This helped bridge a language gap and was effective in reaching Spanish speaking communities. It also demonstrated the work it takes to offer pop-up clinics and convince this population to get vaccinated; prior to these efforts turnout for this demographic was very low.

Incentives worked to bring people to vaccination sites as a way to mitigate transportation costs or the cost of having to take time off work. The Tri-Cities Hispanic Chamber of Commerce (TCHCC) has been extremely successful in hosting vaccination clinics and has vaccinated hundreds of people in the area through the use of incentives. GCACH collaborated with TCHCC to fund 250 gift cards and assist in marketing efforts by providing signage, social media, and radio.

**Attachment:** New Beginning Mobile Vax Clinic – English/Spanish (See attachment 4 on pages 60-61)

**Mitigation strategies or activities that shifted:** Increase of use and implementation of telemedicine by providers thereby increasing access to those who could not attend an in-person appointment. This led to process changes in the way that Shared Decision Aids were provided to patients, including the utilization patient portals and, for those that could not access the patient portals, shared decision-making tools were mailed out. Care Management utilized telehealth to meet with high-risk patients. Virtual tools like Zoom were also utilized by providers to hold care team meetings. Care Coordination strategies also shifted for those that could not attend appointments in-person. Resources such as 211 online tools were provided to patients and Community Health Workers were also utilized for care coordination for those that could not attend in-person. Community Health Workers would visit patients at their home often and/or would help with the setup of telehealth appointments.

c) Highlight one best practice or “bright spot” that emerged during this reporting period as a result of COVID-19 response and recovery efforts, if applicable.

**GCACH Response:**

One bright spot discovered during the last reporting period was our “ah-ha” in using unique trusted messengers to reach specific populations; specific to our region. We leveraged a relationship with Tri-Cities Hispanic Chamber of Commerce to target the significant Hispanic population in the Benton-Franklin counties and our JEDI Specialist connected with local churches to reach the African American population. Prior to these relationships, GCACH was making individual efforts to target these populations with minimal success. Once we teamed up with these trusted partners, the number for vaccinations went from 20-30 per clinic to over 100
per clinic. This allowed us to successfully reach underrepresented populations and drastically improve our vaccination rates.

Best practices that emerged during this reporting period was flexibility when conducting outreach (especially when narrowing our focus to target a specific community), working outside scheduled office hours, addressing language barriers, being available to answer questions at all times, and staying up-to-date with the latest COVID-19 updates in order to give people confidence in getting vaccinated.

16. Scale and sustain update

a) In SAR 7.0, ACHs reported on activities and/or conversations regarding the sustainability of DSRIP funded infrastructure, activities, and/or evidence-based models. Please describe relevant updates from the reporting period. These could include (but are not limited to) board decision regarding priority ACH investments and projects, strategic planning results, community/partner engagement, sustainability planning TA or coordination, etc.

GCACH Response:

“GCACH convenes regional partners and invests in community solutions to advance population health and health equity.”

GCACH staff and Board held their third annual retreat on September 16, 2021 and adopted this value statement, along with a roadmap, timeline, portfolio of services, and funding model. Health Management Associates (HMA) was contracted in December 2020 to:

- Develop a marketing plan based on a strategic environmental analysis
- Propose a management and operations plan that considered the structure of the business and a risk mitigation strategy
- Develop a financial plan to outline capital needed to launch the recommended expansion of services

The business plan assumed that a new Waiver would be approved by the Centers for Medicaid and Medicare (CMS) in 2023, but would result in a significant decrease in financial support from the Health Care Authority. The funding model was based on internal and external feedback from stakeholders, partners, and staff, and alignment with HCA “Bridge Year” and Waiver priorities. The plan also included risks moving forward, and mitigation strategies to address them.

Risks:

- Lack of enthusiasm from existing partners to invest in future services
- Investment in the infrastructure needed to stand up and close the gaps in funding of the business
- Key stakeholders are in a state of flux given the current environmental conditions and trends
Mitigation Strategies:

- Ongoing outreach and engagement to partners; relationship building with MCOs, Philanthropy, Grant Funders and HCA
- Ongoing evaluation of sustainability strategy by the Executive Director; Continuance of a strong and engaged Board of Directors
- Ensure the plan is flexible

Proposed Roadmap:

- A braided funding model that includes: Fee for Service, Membership, Grants, MCO, Philanthropy, and HCA funding
- Providing services beyond Medicaid funded providers into the commercial insurance market
- Analyzing the investment strategy of DSRIP and operations funding, and implementing a cost accounting structure

The Board approved GCACH’s three major service lines:

- Practice Transformation & Accelerator Programs; funded by contracts with HCA, MCOs, WRHC & commercial insurers
- Training & Professional Development; funded as a fee for service model
- Care Coordination through Collaborative Initiatives; funded through a membership model

2022 will serve as the bridge year to develop these financing models with expected roll-out in 2023. The 2022 budgets for Delivery System Reform Incentive Payments (DSRIP) and GCACH operations built on the roadmap recommendations for sustainability with major investments in GCACH’s major service lines.

Another risk to the organization was finding the right replacement for the Executive Director who had announced her intention to retire by the end of 2021. GCACH was fortunate that they were able to attract the talent and business acumen of State Senator, Sharon Brown, District 8, to accept the position. Important considerations of a new Executive Director were:

- Understanding of the Medicaid Transformation Project (MTP)
- Connections to community, regional, and state leadership and resources
- Policy experience

Ms. Brown’s educational background included a Juris Doctor from the University of New Hampshire School of Law, a Certificate in Dispute Resolution from the Pepperdine School of Law, and a Bachelor of Arts from Drew University, Madison, NJ. She was appointed to the State Senate in 2013, having served on the Kennewick City Council since 2009.

GCACH had met with Senator Brown in December of 2020, and interfaced with her on behavioral health issues and policies. She was the ideal candidate to ensure the sustainability of GCACH and guide their policy agenda.
In addition to the roll-out of the business plan and hiring a new Executive Director, GCACH has:

- Been actively pursuing state and federal grant opportunities
- Launched the first cohort for the Community Health Worker (CHW) Internship and Training Program,
- Continued dissemination and education on the Practice the Pause community resiliency campaign,
- Initiated a fourth practice transformation cohort for emergency medical services,
- Contracted with the HCA to deliver a second round of funding for behavioral health preceptorships,
- Initiated a pilot program for justice, diversity, equity, and inclusion,
- Supported Medical Teams International and the Tri-Cities Hispanic Chamber of Commerce to coordinate and support vaccination clinics in Benton and Franklin Counties
- Introduced the new Executive Director to hundreds of stakeholders, partners and providers
- Continued hosting Learning Collaboratives for practice transformation cohorts, Leadership Council meetings, and trainings for the CHW cohort

b) As a result of MTP, please share your reflections on changes and improvements that have occurred and/or lessons learned over the past five years. Note, this is not expected to be a comprehensive inventory, but a summary of a page or less.

**GCACH Response:**

- Transformation of the healthcare system has been effective using Practice Transformation Navigators to help clinics make workflow, culture, and infrastructure changes within their organizations.
- The Greater Columbia Cares Model (GCCM) has been transformative for providers wanting to engage in whole person care, but transformation requires leadership and dedicated staff for reporting.
- Financial incentives to change clinic practices are essential in order for organizations to justify and convince upper management of the value of the GCCM model.
- It is essential to keep elected officials, especially state Legislators informed and appraised of the activities and progress of practice transformation.
- The Cross ACH Executive Leadership Cohort has been invaluable in achieving statewide goals and driving policy changes.
- ACHs have demonstrated their ability to react quickly to address such issues as the COVID-19 pandemic, social determinants of health, infrastructure needs, personal protective equipment distribution, workforce shortages, and build relationships with Tribal nations.
- Transformation of the healthcare system requires transformation of the payment system.
- Bi-directional integration requires more people in behavioral health occupations, better
wages, and inter-professional training opportunities.

- Providers in the healthcare system need alignment on measures and metrics across payer groups to ease administrative burdens. Reporting on measures and metrics needs to be efficient, with providers receiving feedback in a timely fashion.

- The fee for service model, while providing predictable payments for services, is hindering many provider organizations from including value-added services that would benefit patient outcomes.

- ACHs in the role as a neutral convener have driven healthcare transformation across the state.

- Providers like learning from each other. The Learning Collaboratives have enhanced provider knowledge of best practices, and facilitated agreements and compacts between organizations.

- Team-based care is critical to the success of whole-person health. The addition of a Community Health Worker on the team is the key to addressing the social determinants of health.

- Integration of Social Determinants of Health into patient care requires care coordination which is not covered by MCOs.

- Bi-directional integration requires funding, policy changes, workflow accommodations, infrastructure, culture change, and upper management to ensure that it happens.

- Care coordination requires, at a minimum, local and regional approaches to get all parties working toward the same goals. The Local Health Improvement Networks have served a vital purpose for GCACH in facilitating care coordination efforts and initiatives within their communities.

- It is essential to have a diverse and engaged Board of Directors in order to advance collective action.

- Population Health Management tools such as Collective Medical have been a valuable resource in helping reduce emergency department utilization and re-hospitalizations.

- Funding is required to ensure all provider organizations use certified electronic health record technology.

- Data analysis, in order to be truly helpful, must be at the provider site level. The Healthier WA Dashboard which is aggregated to the ACH level, is not helpful for individual provider sites. Also, because the claims data has to be “cleaned and scrubbed,” it is eighteen months late in being useful. Quarterly data analytics that are not lumped into quarterly rolling averages would provide a more accurate picture for providers.

- A community information exchange, in order to be most helpful would be organized, coordinated and funded by the Health Care Authority who, at a minimum, should be
working with the other state agencies, such as the Department of Health, Department of Corrections, Department of Commerce, Department of Children, Youth and Families, and the Department of Social and Health Services. All of these agencies have created their own client exchange data bases and need to be connected with each other.

17. Regional integrated managed care implementation and stabilization update

a) For all regions, briefly describe any challenges the region continues to experience due to the implementation or stabilization phase of integrated managed care. What steps has the ACH taken during the reporting period, or what steps does the ACH plan to take, to address these challenges?

GCACH Response:

GCACH continues to collaborate between its contracted behavioral health agencies (BHAs), MCOs, Greater Columbia Behavioral Health Administrative Services Organization (GCBH-ASO) and HCA. GCACH has continued to hold monthly provider meetings that include participation from all of these organizations. These meetings provide the BHAs a place to ask questions of HCA and MCOs and to share information between each other. GCACH has worked hard to keep the lines of communication open between all parties. There are ongoing issues with specific data entry templates and the associated labor cost. The MCOs are aware of these issues and continue to work on them.

Lack of VBP contracting with behavioral health and substance abuse providers:
GCACH meets with the MCOs bi-monthly to advocate for VBP contracts and to demonstrate the value of the patient-centered medical home model of care using data gathered from the quarterly reports required of the providers. A success during this reporting period was a VBP contract between Merit Resource Services and Coordinated Care in November. Merit was able to demonstrate that the use of Collective Medical, an emergency department notification system, and appropriate screenings for behavioral health are resulting in better patient outcomes and reducing costs. The use of these tools is part of incentive milestones for GCACH providers.

Delays on MCO Claim Payments: Claims being paid late by MCOs has been an issue since the inception of IMC. GCACH has often acted as an intermediary between the BHAs and the MCOs for some of these incidents and has facilitated providers working directly with MCO provider contacts. Payment delays have improved, but some MCOs continue to perform better than others.

Service Encounter Reporting Instructions (SERI) Guide: The ongoing changes being made to the SERI guide continues to create problems for billing the correct codes. Through HCA’s continued support and participation in the roll-out process, this has largely been resolved. Currently, all BHAs have and are following the correct guide.
MCO Reimbursement: The BHAs have stated they have fee-for-service contracts but this has been very difficult for some of our smaller agencies. Slowly, this has improved between the MCOs and individual BHA providers. Connecting the individual BHA with the right contact person in the MCO has helped facilitate resolution in many instances. GCACH continues to advocate for VBP contract for our BH providers.

Challenges with submitting authorization or pre-authorization for services: There have been ongoing challenges with submitting authorizations or pre-authorizations for a variety of services, sometimes resulting in denials and delays in patient care. This recurrent topic is being worked out through general discussions with the MCOs, BHA providers, and HCA but may continue to be an ongoing issue. The provider meetings have created a useful venue for BHAs to discuss this with the MCOs.

Processes for reporting claims, pre-authorizations, and payments requiring four different MCO platforms: There has been confusion on "leakage" language in one particular MCO contract; i.e., the payment recoupment process and explanation of the amount. Confusion also, regarding a contractual claw back being deducted for PACT teams for some BH provider. GCACH has facilitated meetings between the HCA and the BH providers to address these issues, and to better understand how to resolve the barriers.

b) For all regions, what steps has the ACH taken, or what steps does the ACH plan to take, to support coordination with local, regional and statewide partners to design and implement strategies to address gaps and barriers impacting the health system in response to integrated managed care implementation and/or the stabilization phase of integration post implementation?

Provider Meetings: GCACH continues to convene monthly provider meetings to discuss, address and many times, resolve issues affecting the local behavioral health agencies and their relationships with other organizations. These meetings have included regional and state partners, such as the MCOs and HCA. This meeting venue continues to support a coordinated response across many delivery system players.

Ties with the Behavioral Health ASO: The GCACH and the BH-ASO have strengthened their relationship. GCACH is invited and regularly attends their monthly Executive Committee meetings which have been very informative and often lead to further collaborations with GCBH-ASO. GCACH is also able to share information with regard to practice transformation and other GCACH initiatives. Through these activities, GCACH has forged closer ties with this regional service provider.

Collective Medical: The Collective Medical platform provides software for provider organizations and integrates hospital admission, discharge and transfer (ADT) data into provider workflows. The Collective Medical platform informs providers about patients who have visited the emergency department through a messaging system. Managing patients that have experienced high emergency department or inpatient utilization has been a priority for the
GCACH practice transformation process. GCACH provides incentives to providers to use this platform and to follow-up with patients. The implementation of this software has resulted from GCACH’s relationship with the MCOs who are subsidizing the related software costs. Prior to IMC, there were significant knowledge gaps on the part of the behavioral agencies about their clients presenting to the emergency departments for behavioral health issues.

**Opioid Resource Networks:** GCACH contracted with two Opioid Resource Networks (ORNs) that provide a bridge between behavioral health and primary care providers. For organizations who may not have Medication-Assisted Treatment (MAT) waivered providers or the capacity to take on a large base of patients that have opioid use disorder, the ORN is available to provide these resources. Practice Transformation Navigators look for opportunities to connect primary care providers to their local ORN for treatment and wraparound services.

c) For all regions, what challenges or opportunities has the ACH identified during the reporting period tied to clinical integration measurement and assessment?

**GCACH Response:**

**Integration Assessments:** All providers contracted with GCACH have a milestone related to conducting integration assessments. Providers are incented to use the Patient-Centered Medical Home (PCMH-A) and the Maine Health Access Foundation (MeHAF) assessments. These assessments are lengthy, time-consuming for providers and clinical staff, questions can be interpreted differently depending on who answers the assessment, and they do not adequately assess provider level of integration. GCACH Navigators provide assistance in filling out the assessments, and generally meet with the Quality Improvement Team at each site to get input from a cross section of the organization. These challenges are not unique to GCACH as discovered in an exercise that Artemis Consulting conducted for all ACHs.

Typically, when a Behavioral Health organization takes the MeHAF, they interpret the questions as if the clinic were behavioral health integrated into a primary care and if the organization is not integrated on-site they score themselves lower. GCACH’s process is to have each organization complete the survey and then GCACH schedules a follow up meeting with the organization’s QI team as well as other staff members that need to be present to review the assessment in detail. Behavioral Health organizations typically score themselves at the lowest level, with a 1-2, on their initial assessment if they are not fully co-located with primary care. This misinterpretation stems from a focus on primary care and not behavioral health; for example, using evidence-based practices to treat patients. Although these organizations have evidence-based processes in place - even to the point of obtaining consent for release of patient information and sending it securely to the primary care along with a follow up call - they are scoring themselves a 1 or 2 when they should be scoring at the highest. If there is not a trained facilitator to administer these assessments, scores could and would be greatly misconstrued.

Quality Behavioral Health (QBH), a BH provider located in Clarkston, was given the opportunity to participate in the Integration Assessment Pilot Project led by HealthierHere. The purpose of
the project was to identify an assessment tool that could be implemented statewide, measure integration progress more accurately, and give providers a better understanding of where they stood on their integration journey. QBH participated in this three-month pilot using a complementary set of tools, the Continuum Based Framework for Behavioral Health Integration into Primary Care, and Continuum Based Framework for General Health Integration into Behavioral Health. As a result of this pilot program, the assessment is now being called Washington Integrated Care Assessment (WA-ICA).

All ACHs have agreed to fund the implementation of the WA-ICA that will launch in July 2022 for primary care and behavioral health providers that have experience in completing the MeHAF. Additionally, GCACH has replaced the MeHAF requirement in its contracts for 2022 with the WA-ICA.

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.

<table>
<thead>
<tr>
<th>18. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders’ and partners’ successes and challenges with Medicaid Transformation project implementation.</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Identification of partnering provider candidates for key informant interviews.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
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</tr>
</tbody>
</table>

If the ACH checked “No” in item above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.
Section 3. Value-based Payment

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 5, Q4.

*Note: The reporting period for VBP milestones cover the full calendar year (January 1 through December 31, 2021).*

**Narrative responses**

19. Identification of barriers impeding the move toward value-based care

a) Providers reported the following top three barriers in the 2020 Paying for Value survey: “misaligned incentives and/or contract requirements,” “lack of timely cost data to assist with financial management,” and “Lack of interoperable data systems.” Describe whether these align with your region’s experience or if you are experiencing other more impactful barriers regarding implementation of value-based care. Also, describe methods the ACH continues to use to identify providers struggling to implement practice transformation and move toward value-based care.

**GCACH Response:**

According to the 2020 VBP survey results, thirty-six providers in the GCACH region responded. The largest group of responses, twenty-eight, came from behavioral health providers. Twenty-nine providers reported working directly with GCACH. The greatest barrier they cited to participating in VBP was “misaligned incentives and/or contract requirements.” This barrier was overcome for the first time in GCACHs region in November 2021 when Coordinated Care developed a VBP contract with Merit Resources. Merit argued that there were better assessment tools to screen for substance abuse and post-traumatic stress disorder, so Coordinated Care agreed to different screening tools under a VBP arrangement.

Another barrier cited in the survey was “Insufficient patient volume by payer to take on clinical risk.” This barrier has been acknowledged by both providers and the managed care organizations, especially for our smaller behavioral health organizations that do not have large Medicaid member volumes although Medicaid might be the largest volume payer in their practice. By their own admission, MCOs focus on the larger clinics that can provide care to a higher volume of Medicaid members. Behavioral health providers are struggling with fee-for-service contracts.

While many cited “Lack of interoperable data systems,” all providers contracted with GCACH received funding to upgrade their electronic health records systems. All but two providers are now using the Office of the National Coordinator for Health Information Technology certified electronic medical records systems.

Practice Transformation Navigators provide technical assistance for each provider site, ensuring that quality metrics are being met, and ensuring progress towards the Patient-Centered Medical Home (PCMH) model of care. The Navigators and the Quality Improvement (QI) teams work...
together to develop the Practice Transformation Improvement or plan) which details how the organization can achieve success for each milestone in their contract. The Navigators also use data from the QI teams’ quarterly reports to show how the implementation of different work flows, evidence-based practices, and population health management tools can help the site achieve better outcomes for their patients.

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

   a) Describe how the ACH has helped providers overcome barriers to VBP adoption; indicate if the scope or intensity of support has been different for small providers (25 FTEs or fewer), or behavioral health providers.

   **GCACH Response:**

   GCACH’s technical assistance for Practice Transformation process improvement and EMR data retrieval resulted in Coordinated Care offering the first VBP contract to a BH provider in the GCACH region! The BH organization contributes the success of this contract to having aligned contractual agreement around metrics and deliverables between the MCO and the GCACH milestones. As a result, the BH organization was prepared on the data preparation and how to relate it to the performance of the deliverables.

   GCACH built the Greater Columbia Cares Model (GCCM) to help our sites progress in Practice Transformation to align metrics that are contractual deliverables between HCA and MCOs as well as contractual deliverables between the MCOs and the provider organizations. Key aspects of the GCCM that move our sites into alignment with MCO and HCA metrics are:

   - Milestones around empanelment and comparison to MCO rosters, identifying patients that are current and those that need to be established.
   - Milestones for self-management support, shared decision-making tools, risk stratification and identification of high-risk patients that drive better patient outcomes, patient satisfaction and patient/family involvement in their care.
   - Technical assistance for implementation of social determinants of health screening tool, identification of social determinants of health and health literacy processes to educate and inform the practice of current patient resources and deficient resources. Technical assistance to connect partnering providers with additional resources.
   - Technical assistance and facilitation of electronic data software i.e. Collective Medical, Direct Secure Messaging, OneHealth Port (HIE), PDMP. In collaboration with the MCOs to provide sponsorship to our contracted partnering providers for Collective Medical.

   As our sites work through Practice Transformation, GCACH offers onsite and technical assistance to help them with data reporting and to the sites QI teams to identify, enhance, and drive provider requirements that leads to better patient outcomes. GCACH transitioned to also providing virtual technical assistance which our providers appreciate due to its flexibility.
GCACH has modeled their payment incentives loosely after a VBP model to assist our sites in transitioning to this new type of reimbursement. GCACH convenes BH providers, MCOs, and the HCA on a monthly bases with the goal of fostering healthy working relationships between these entities to help create sustainable reimbursement models and VBP contractual agreements.

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

a) Provide an example of the ACH’s efforts to support completion of the state’s 2021 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

**GCACH Response:**

Due to COVID-19, VBP survey efforts dropped off the radar for GCACH, which is ironic because GCACH has been beating the drum for VBP payments for their providers since the MTP program began. According to the HCA, the 2021 VBP Survey yielded 64 responses from providers in 31 counties across Washington; a decrease in response rate from 170 in 2020 and 148 in 2019. The change in respondents from GCACH respondents was 10 less which followed the trend of decreasing responses across the state. The HCA used a different survey notification process and survey instrument which could have impacted the results, and the usual notifications to let ACHs know of the survey responses per ACH was also missing from the VBP process in 2021. The better news from the survey indicated that the percentage of MCO dollars in VBP arrangements increased 4% for the GCACH region. GCACH celebrated the first VBP contract with a behavioral health agency, Merit Resources and Coordinated Care in October 2021.

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

**GCACH Response:**

GCACH reserves the Leadership Council meeting each November to explain the results of the HCA’s VBP survey, and receive direct feedback from the managed care organizations, providers, and stakeholders. This allows a deeper dive by HCA to discuss the survey results from the providers, MCOs, and the commercial/Medicare health plans. GCACH has traditionally used this meeting to engage a panel of MCO representatives to give feedback on the results and report out their efforts on VBP arrangements with the GCACH region, and hear directly back from the providers. However, in 2021, the HCA did not have the survey results back in November and will be making their presentation in January 2022.
The results of the 2020 VBP survey indicated that the barriers to VBP adoption were due to misalignment of contract incentives and requirements, cost of care data, lack of interoperable data systems, and insufficient payment volume by payer to take on risk.

While GCACH cannot control contracts between providers and payers, GCACH prepares providers for VBP contracts by using the Patient-Centered Medical Home (PCMH) model of care, and linking quality measures with milestones. There are currently seventy-seven sites receiving technical assistance on the PCMH model, including forty-three sites that will start a fourth year of practice transformation in 2022. The fourth-year contract offers a $10,000 incentive for sites that achieve PCMH recognition. Practice Transformation Navigators meet monthly to review progress toward PCMH goals, and quarterly reporting from the providers helps the Navigators tailor their support toward achieving whole person care. Each year contract milestones build upon the foundation of quality care and Learning Collaboratives - offered monthly - to expand quality improvement concepts. The end goal is to position providers to be successful under value-based payment arrangements.

GCACH uses every opportunity to demonstrate provider readiness for VBP arrangements to the MCOs whether through the bi-monthly MCO meetings, through the weekly meetings with the HCA, the monthly Board of Directors meetings, or through highlighting the work of provider organizations in the monthly newsletter. The Practice Transformation Navigators also hear from the providers their frustrations with fee-for-service models, and relay this information to HCA and MCO representatives.
Section 4. Pay-for-Reporting (P4R) metrics

22. P4R Metrics

The reporting requirements for the P4R Metrics updates are temporarily replaced with COVID-19 related responses in the “Narrative Responses” section. ACHs may use discretion, and will not be penalized, surrounding the timing and volume of P4R metric data collection during the COVID-19 pandemic. For example, an ACH may choose to delay data collection, make participation optional, or target participation. The submission of P4R Metrics are considered optional for this reporting period but are encouraged. However, it is requested if an ACH continues P4R data collection, including the MeHAF assessments, that the ACH submit a completed P4R report. These reports are helpful in providing utilization numbers and provider engagement totals throughout the state.

MeHAF guidance:

- The state continues to develop future integration assessment surveys and processes to improve on the reporting of behavioral and physical health integration. Until a new assessment is officially implemented it is recommended ACHs avoid engaging new providers in MeHAF assessment.

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster affiliated with Project 2A and 3A.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: How to read metric specification sheets.

- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under “ACH pay for reporting metrics.”

Instructions:

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

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

Format:

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

Attachment: GCACH.SAR8 P4R metrics.01.31.22

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Semi-annual reporting guidance
Reporting period: July 1, 2021 – December 31, 2021 Page 28
Narrative responses:

23. If the ACH is not providing updates on the MeHAF this reporting period, please describe what, if anything, the ACH is doing to assess partnering provider implementation progress at a clinic/site level.

24. If the ACH is providing updates on the MeHAF this reporting period, please provide any additional context if applicable.

Optional: The ACH may submit P4R metric information


Organizational Changes made during reporting period
1. The new position of Justice Diversity Equity and Inclusion Specialist (JEDI) was added to the organization and Office Manager, Damia Safford, transitioned into the role in July 2021.
2. Finance and Contracts Coordinator, Sulamita Savchuk, resigned October 2021
3. Practice Transformation Navigator, Brittany FoxStading, resigned.
4. The Office Manager, Damia Safford, was hired in March 2021.
5. The Deputy Director, Wes Luckey, resigned in May 2021.
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$10,420.26

Brief description: The funds listed above were pulled down from the Financial Executor portal and paid to the ACH, however the funds represent payment activity not captured in the portal. For example, funds may have been disbursed to providers or vendors that were not setup in the portal. This template provides an opportunity for ACHs to clarify payments made outside of the portal.

The Accountable Community of Health (ACH) understands that this workbook will be attached to the Semi Annual Report and serves as the record for payment reconciliation. The ACH certifies that this information is complete and accurate.

**Yes**

**No**

01/31/2022

ACH Signature of Authority*

*Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).
"SAR 8 Payment Reconciliation Workbook" History

Document created by Greater Columbia ACH (activations@gcach.org)  
2022-01-31 - 5:49:49 PM GMT - IP address: 64.146.130.87

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Signature Date: 2022-01-31 - 6:38:54 PM GMT - Time Source: server - IP address: 24.177.15.1

Agreement completed.  
2022-01-31 - 6:38:54 PM GMT
Greater Columbia Accountable Community of Health
(Medicaid Transformation project areas 2A, 2C, 3A, 3D)
Quality Improvement Plan

*Develop continuous quality improvement strategies, measures, and targets to support the selected approaches*

Greater Columbia Accountable Community of Health (GCACH) is using the transformative model of care called the Patient-Centered Medical Home (PCMH) as its framework for quality improvement (QI). Based on the principles of the Chronic Care Model, the PCMH model uses evidence-based guidelines, applies population health management tools, and demonstrates the use of “best practices” to consistently and reliably meet the needs of patients while being accountable for the quality and value of care provided. The PCMH model delivers whole-person care that is team-based and coordinated, based on data, and measured continuously for quality improvement. The PCMH model incorporates evidence-based practices identified in the Healthier Washington Medicaid Transformation Project Toolkit and from the four MTP project areas that GCACH has chosen:

- Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation
- Project 2C: Transitional Care
- Project 3A: Addressing the Opioid Use Public Health Crisis
- Project 3D: Chronic Disease Prevention and Control

Providers that contract with GCACH receive hands-on technical assistance by Practice Transformation Navigators (PTNs). The Director of Practice Transformation has put together an extensive training program using the Agency for Healthcare Research and Quality’s (AHRQ) Primary Care Practice Facilitation Curriculum and the Safety Net Medical Home Initiative PCMH implementation guides. The curriculum is continuously supplemented with the latest resources and evidence-based tools.

PTNs guide clinics through PCMH transformation through assessments, training on population health management tools like registries, risk stratification, and decision tools. They identify barriers, provide resources, assist in implementation and troubleshoot issues.

However, the formation of a QI team is a requirement and Milestone of each partnering provider clinic or hospital. Improvement work invariably involves work across multiple systems and disciplines within a practice. The QI team is the group of individuals within a practice charged with driving quality improvement efforts. One of the first tasks to complete with the QI team is to identify opportunities for the improvement work and associated performance metrics, and it is recommended that the team is comprised of a cross-sector workgroup (clinicians, IT, senior leadership, finance, etc.) from within the organization. As of 12/31/2019, the sixty-two clinic sites contracted with GCACH for Practice Transformation represent over nine-hundred QI team members and providers that serve over seven hundred thousand patients (all-payers) in Greater Columbia ACH’s service area.

PTNs make site visits to each participating clinic at least once a month, and meet with the QI team to review progress, discuss barriers or challenges, and to make adjustments to their workplans. PTNs also
communicate regularly with each QI team to answer questions and to send resources and tools that will help them through the various Milestones.

The PCMH model entails numerous changes to the clinic’s business model, from claims and billing processes, to workflows and scheduling systems, to EHR configurations and organizational culture. PTNs provide resources and guidance to help each clinic, hospital, and practice be successful throughout the Practice Transformation journey, working with the QI teams, or specific departments within the organization. The Practice Transformation Implementation Workplan (PTIW) is a change plan for each site and a living document that integrates the PCMH-A and/or MeHAF assessment results incorporated into a Plan Do Study Act (PDSA) cycle and guides the improvement process. The PTIW is reviewed on a quarterly basis, and is one of the incented Milestones that is reported on.

The PCMH model incorporates regional Learning Collaboratives that bring together the QI teams from hospitals and clinics that are seeking improvement in a focused topic area. Learning Collaborative sessions vary from two hours to two days, depending on content, interest level to providers, and project area. Learning Collaborative sessions occur on a monthly cadence. The sessions often use representatives from exemplar organizations from within the PCMH Cohorts, and other subject matter experts who share best practices, lessons learned, and success stories. Learning through this process has helped Practice Transformation organizations in their implementation of PCMH Change Concepts: please see Figure 1.

![Figure 1: PCMH Change Concepts](image)

Feedback from the providers has indicated that they would rather learn from their peers than bring in subject matter experts from outside the region. How to change the culture of an organization, how to integrate behavioral health and primary care, and how to effectively use nurse case managers for transitional care are examples of site visits for peer learning within the GCACH region.

Participation in the Learning Collaboratives is also a Milestone requirement of Practice Transformation organizations who contract with GCACH. Providers must attest that they have participated in at least four Learning Collaborative sessions during the year to meet that Milestone.
PCMH success stories are also shared in the monthly Community Newsletter that is distributed to over 1,100 individuals associated with GCACH, and reviewed monthly by the GCACH Board of Directors.

Providers work from a guidebook called the Practice Transformation Reporting Workbook that is modeled after the Center for Medicare and Medicaid Innovation’s (CMMI) Comprehensive Primary Care’s (CPC) Implementation and Milestone Reporting Summary Guide. The workbook has been customized to meet the needs of the Medicaid Transformation (MT) program and contains Milestones and reporting measures linked to the MT project areas, to PCMH/Practice Transformation concepts, and to statewide measures (MT Pay-for-Performance). These Milestones are evidence-based and critical to health care delivery transformation. However, the GCACH takes a very collaborative approach and is flexible with PT organizations doing the work. The workbook has been described “descriptive without being too prescriptive” and offers providers flexibility in designing their change programs, allowing them to choose the targets and measures that they want to track and report on within the project areas. In this manner, providers are introduced to a fairly rigorous form of value-based contracting, and their level of attainment and improvement are both rewarded. Patients are also treated more proactively through a planned model of care. Quality is built into the Milestones for which the providers are rewarded. Beginning in July 2019, the PT organizations will begin recording their progress in a web-based portal site (CSI Healthcare Communities portal) to track progress in completing PCMH Milestones. Through this reporting portal, PT organization will upload PT Milestone data on a quarterly basis.

Finally, the process is overseen, monitored and evaluated by the Practice Transformation Workgroup (PTW), a chartered committee selected by the GCACH Board of Directors and comprised of clinical providers and subject matter experts in quality improvement, population health management, complex case management, and workforce development. The PTW meets quarterly to review the results of each Cohort using the Practice Transformation Scoring Report. The Practice Transformation team presents an overview of the progress of each participating provider across the four project areas, indicates barriers to implementation in the prior reporting quarter, and highlights success stories from the PT organizations in their implementation work. The PTW offers guidance and adjustments to the process and this is integrated into changes in the overall Practice Transformation process.

**SAR 4.0 UPDATE:** Provider results are also reviewed by the Board of Directors, and beginning in 2020, CSI Solutions will be producing an aggregate report in the form of a dashboard to enable providers to visualize their progress, and compare their progress with other sites. Each site will be assigned an anonymous ID so their site identity will remain unknown. However, the data will aggregate all eighty-three sites across twelve measures. The twelve dashboard measures are those that will give GCACH staff the greatest insight into how sites progress using population health management tools, approach care coordination, and progress under the quality metrics they are gathering. The twelve dashboard measures are:

- Top Ten Clinical Quality Metrics
- Care Management for High Risk Patients
- Empanelment Rate
- Top Five Risk Stratification Methods
• Care Coordination Options
• Behavioral Health Integration Models
• Medication Management Services
• Follow-up within One Week of ED Discharge
• Follow-up within 72 Hours of Hospital Discharge
• High Referral Community Partners
• Identify Patients Needing Integrated Care
• Behavioral Health Integration Assessment Tools

SAR 6.0 UPDATE: While in-person Navigator visits were curtailed due to the COVID-19 pandemic, GCACH adjusted quickly to on-line Learning Collaboratives, Leadership Council meetings, and visits with Providers. Virtual visits had the advantage of being able to share screens with the provider organizations, helping them with reporting requirements, and bringing up resources that they could use to improve their services.

SAR 8.0 UPDATE: The CSI Dashboard is being used to provide information to the Practice Transformation Workgroup, the provider sites, and to inform GCACH staff where progress or improvement is needed. If milestones are added, deleted, or modified, GCACH works with CSI to keep them current in the portal.

The following quality improvement steps were extracted from the Quality Improvement sections of the Project Area in the Implementation Plan, Semi-Annual Report 2.0 (SAR 2.0) and are common to all four MT project areas:

Step 1: Create an advisory committee of subject matter experts with C-suite representation from large, medium and small practices to guide the transformation project, review the process for PCMH transformation, study the results, and monitor the progress. Engage these leaders to understand, facilitate, and advocate transformation within their organizations, and to become disciples of the PCMH care model. Their responsibilities include:

• Reviewing regional data and helping identify the appropriate selection criteria for providers to receive PCMH technical assistance;
• Selecting providers to engage in the PCMH transformation process;
• Reviewing GCACH provider assessments and identifying regional strengths and weaknesses to better inform the selection of providers and application of change strategies;
• Monitoring PCMH provider performance and making any necessary adjustments in strategy or tactics.
• Reviewing and recommending changes to the Milestones for years two and three of the Transformation program.

STATUS: The Practice Transformation Workgroup (PTW) was chartered in January 2018, and met twice a month from February to October 2018. In April 2018, GCACH staff introduced the PCMH model as the framework that met many of the Medicaid Transformation objectives regarding value-based payments, chronic care management, bi-directional integration, care
coordination, transitional care, and the social determinants of health. In 2019, the meetings moved to a quarterly cadence in order to review the quarterly reports from the participating Provider organizations.

**SAR 4.0 UPDATE:** GCACH has added two additional Cohorts since June 30, 2019. The second Cohort includes the seventeen behavioral health agencies that transitioned to integrated managed care (IMC) in 2018. Upon receipt of the second phase of IMC funding in April 2019, GCACH staff recommended to the Provider Readiness Group and the Budget and Funds Flow Committee that $4.2 million of the $6.1 million be distributed according to the same Practice Transformation revenue sharing model as Cohort 1. While it would not be expected of the behavioral health agencies to achieve all of the Milestones of Cohort 1 for Practice Transformation, it would honor the expectations of the Washington State Health Care Authority to support implementation of a fully integrated physical health and behavioral health managed care system. This recommendation was forwarded by these committees and approved by the Board of Directors.

While the behavioral health agencies were skeptical that Practice Transformation applied to their clinics, they have quickly embraced transformation concepts, and are eagerly making changes within their workflows and practices. Their earlier suspicions about the GCACH have also dissipated as well. GCACH has allowed more flexibility in their integration models, and are seeing innovative partnerships such as integrating mental health and behavioral health services, offering mental health services in a school setting, screening for behavioral health in a dental setting, and offering primary care in a SUD clinic. This has pushed integration approaches to new limits.

GCACH had more difficulty in assembling the third Cohort, in spite of the possible substantial financial incentives. While roughly the same process was used for sending out the Letter of Interest/Current State Assessment application and scoring them upon receipt, fewer providers responded. So the GCACH Board allowed for a “rolling start” through the end of November to allow time for GCACH staff to go back to specific providers to give them more information about the PCMH program. GCACH solicited independent primary care offices with medium to large Medicaid populations, and organizations referred to the GCACH by Practice Transformation organization CEOs during our mid-year check-ins. Most of the independent practices did not seem to understand the 1115 Waiver and were not ready for transformation within their clinics. However, GCACH was able to attract a mix of palliative care agencies, skilled nursing facilities, and additional primary care clinics from larger health systems, again pushing the Practice Transformation process to new frontiers. There are twenty-one clinics in the third Cohort, and they are still finalizing contracts and determining practice sites. With the addition of the second and third Cohorts, GCACH will have eighty-three sites doing Practice Transformation using all or part of the PCMH framework.

**SAR 6.0 UPDATE:** Additionally, GCACH embarked on a major effort to inform the Legislators in our nine-county region of our PCMH efforts. While not directly involved with Greater
Columbia ACH, their advocacy on the behalf of primary care is critical to sustaining these vital services and advancing needed policy changes at the state legislative level.

**SAR 8.0 UPDATE:** The Practice Transformation Workgroup (PTW) has been meeting quarterly since 2020. When workgroup members retire or resign their position, new members are nominated and vetted by staff, and approved by the Board of Directors. GCACH staff seeks out C-suite representation from large, medium and small health systems to fill positions on the PTW.

**Step 2:** Create a standardized method to assess the readiness and willingness of potential participating Providers to undertake Practice Transformation, and the PCMH model. Use the following change concepts to assess Provider readiness: Leadership, Transparency, Collaboration, Adaptive, Value-Driven and Equity. Prioritize Provider list based on independent analysis of adherence to change concepts.

**STATUS:** The Current State Assessment (CSA) tool was initially used by Oregon Health Sciences University (OHSU) to score the provider organization applications in July 2018. OHSU scored the CSAs and made recommendations for high, medium, and low levels of readiness for Practice Transformation. The PTW used the OHSU recommendations and factored in geographic equity across the nine counties to finalize the list of PT organizations. The same process will be used to add future Cohorts to the PCMH program.

**SAR 4.0 UPDATE:** GCACH combined the Letter of Interest and Current State Assessment documents (LOI/CSA) in August 2019 to streamline the application process and remove redundant questions across both documents for the third Cohort. Scoring for the third Cohort was done by OHSU, and the third Cohort is provided the opportunity to earn incentive funding using the same revenue sharing model as Cohort 1.

**SAR 8.0 UPDATE:** GCACH is in process of adding a fourth Cohort of emergency medical service (EMS) providers. The Letter of Interest (LOI) and Current State Assessment (CSA) was modified to attract EMS providers interested in starting or furthering a community paramedic program. GCACH is using the Abbeville County, South Carolina community paramedic program for its curriculum which will prepare first responders how to operate within a patient-centered medical home model of care, learn the skills of population health management, and use data to better manage their patient populations. The LOI and CSA and was sent out to all EMS providers in the GCACH service area on November 23rd, and applications were due January 6th, 2022.

**Step 3:** Develop Milestone reporting measures that align and reinforce the PCMH change concepts and project areas. Incorporate Milestones in Provider contracts. Contracts developed based on a revenue sharing model that rewards completion of the Milestones. Milestones are weighted, and based on work tasks that build capacity in the organization, develop and enhance population health management tools like risk stratification and decision-making tools, EDIE and PreManage, and track clinical quality measures chosen by PCMH organizations. Host
a Learning Collaborative meeting to explain contract, revenue sharing model, and reporting Milestones. Incent attendance for Partnering Providers.

**STATUS:** All contracts with PCMH Cohorts include the revenue sharing model, deliverables, and Implementation Toolkit. The PCMH contract was thoroughly reviewed with all of the PCMH Cohort #1 providers on January 3, 2019 and attendance was required. All contracts were signed by April 14th. (See attached contract, and Practice Transformation Implementation & Reporting Toolkit for more detail.) Example of revenue sharing model for 2019 is shown in Figure 2.

**EXHIBIT “A1”**
TRANSFORMATION INCENTIVE ALLOCATION WEIGHTS AND VALUES-RICHLAND

Greater Columbia Accountable Community of Health
Medicaid Transformation Project
Maximum Available Revenue Sharing for 2019

Partnering Clinic: Catholic Charities Serving Central Washington 2139 Van Giesen St. Richland, WA 99352

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*Figure 2: 2019 Revenue Sharing Model*
**SAR 4.0 UPDATE:** GCACH developed a revenue sharing model that includes incentive funding for a three-year period. Technical assistance will be provided to each site during this timeframe with the expectation that sites will adapt to the Change Concepts and processes for each Milestone. Incentive funding decreases in a step-down fashion from Year One to Year Three, however. Please see Figure 3. Emphasis on the following Milestones in Year Two builds on the processes and evidenced-based practices introduced in Year One: Budgeting, Care Management, Bi-Directional Integration, QI Team, Reporting, PTIW, Attestations, Care Coordination, Training and Mentoring, Learning Collaboratives, and the PCMH-A and MeHAF assessments.

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<td>Care Coordination</td>
<td>$4,433</td>
<td>$4,433</td>
</tr>
<tr>
<td>6A.4 Collaboration</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>6A.1 Attestation (Collective Medical, Direct Secure Messaging, One Health</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>6A.1 Collaboration</td>
<td>$4,433</td>
<td>$4,433</td>
</tr>
<tr>
<td>7A.1 Training/Mentoring</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>8A.1 Patient Centred Medical Home Assessment (PCMH-A)</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>8A.1 Maine Health Access Foundation (MeHAF)</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

*Figure 3; 2020 Revenue Sharing Model*

Additionally, some of the Year One Milestones will be mandatory in Year Two.
The following Milestones are mandatory or new Milestones in contract Year Two:

- Empanelment Status
- Review of Patient Rosters
- Increase target rate to risk stratify 85% of empaneled patients (up from 75% in Year One); provide care management to at least 95% of patients
- Screen for Social Determinants of Health
- Provide a concise narrative describing the approach methodology or tools used to stratify patients
- Record the total number of patients in each risk stratum and the number of patients within the stratum that received care management services
- Conduct a daily (in-person or electronic) team-based huddle
- Quantify the percentage of patients that have been assessed for behavioral health
- Sites will follow-up with patients after one no-show. Follow up can be completed via phone call or mailed letter
- Being trained in medication assisted treatment (MAT) having a MAT referral source will be required
- 10% of patients that have at least three high-risk conditions should receive self-management support
- Providers must identify measures that are tracking patients with three or more high-risk conditions
- Medication Reconciliation will be mandatory
- Engaging pharmacists will be mandatory (i.e. collaborated, integrated, contractual, tele-pharmacy)
- Collaborative Drug Therapy Management is mandatory for contracted or staffed pharmacists
- Clinic sites will report on third next available appointment for the following appointment types: Acute, Adult, Well-Child, and New Patient visits
- Clinics sites will determine what workforce or training is needed to provide patient-centered care (i.e., Community Health Worker, Behavioral Health Peer Specialist, ARNP, etc.)
- Each quarter, the sites will be expected to show an increase in the percentage of patients that received surveys
- Each quarter, the sites will be expected to show an increase in the percentage of patients that received shared decision-making tools
- QI teams must meet internally at least monthly
- Clinical Quality Measures (CQM) must be reviewed on a weekly or monthly cadence
- Practices will be required to create individual practitioner or care team CQM reports
- Monthly meetings with the Practice Transformation Navigator are mandatory
- The use of Collective Medical is mandatory 2020
- The practice must attest to using OneHealthPort by Quarter 2
- Sites will be expected to show an increase of the percentage of patients receiving follow-up calls after an ED visit or hospitalization
• The following Learning Collaboratives will be mandatory in 2020: Billing training, Shared Care Plans, Shared Decision-Making aids, and Self-Management tools

**SAR 6.0 UPDATE:** Except for the combination of some reporting requirements, the revenue sharing model for year three of practice transformation is one-half of the revenue sharing model for year two. Reporting requirements were combined for Care Management, and Training and Learning Collaboratives. This allows for greater flexibility in scoring these sections. The contract language now specifies which milestones exclude certain provider types, e.g., empanelment excludes hospitals, dental clinics and Urgent Care since these provider types do not empanel patients.

**SAR 7.0 UPDATE:** Greater Columbia ACH had an opportunity to participate in a pilot project for testing behavioral health integration into primary care practices using a new framework. The financial and regulatory resources of bringing systematic screening, treatment or referral
and follow-up to the primary care setting are challenging for smaller practices, so the Health Care Authority contracted with Healthier Here to identify and pilot a new assessment.

Healthier Here reached out to several ACHs with rural behavioral health providers, including GCACH, who found a willing provider Quality Behavioral Health to pilot the assessment. It is a continuum-based framework for integrating behavioral health and primary care clinics with the goal to advance behavioral health integration into primary care. While the assessment has not been fully vetted, GCACH is allowing Cohort 2 to test it out across the region in lieu of completing two other assessments that have accomplished the same purpose: the MeHAF, and PCMH-A. The NY assessment covers the same content of these two assessments but is more comprehensive and asks more relevant questions. GCACH believes this will be a good process improvement for our providers, but is testing it all with Cohort 2 Behavioral Health providers for 2021-2022 as shown below.

**AMENDMENT FORM NO. 2**

Pursuant to Section 15, the following changes are hereby incorporated into this Contract:

A. **Description of Change:** Extend the completion date to October 31, 2022 and replace Exhibit "A" Transformation Incentive Allocation Weights and Values Revenue Sharing Model in its entirety with the following:

### Maximum Available Revenue Sharing for 2021-2023 (Program Year 5) Scale and Sustain

**Partnership Provider:**

**Exhibit A: 2021-2022 Revenue Sharing Model**

<table>
<thead>
<tr>
<th>Milestones</th>
<th>2021-2022 Quarterly Maximum Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A.3 Budget Development</td>
<td>$609</td>
</tr>
<tr>
<td>1A.2 Budget Reconciled</td>
<td>0</td>
</tr>
</tbody>
</table>

**Care Management ($4,500 total per quarter):**

- 2A.1 Empowerment
- 2A.1A Risk Stratification/2A.1B Risk Stratification Statistics
- 2A.1C Opportunities for Those at Highest Risk
- 2A.2 Self-Management Support
- 2A.3 Medication Management
- 2A.4 Access and Continuity
- 4A.1 Patient-Centered Interactions
- 4A.2 Shared Decision Making

- 2B.2 Bi-Directional Integration
  - $1,825 | $1,825 | $1,825 | $1,825 | $7,300
- 4A.3 QI Team
  - $1,875 | $1,875 | $1,875 | $1,875 | $7,500

**Reporting**

- 5A.2 Clinical Quality Metrics
  - $3,306 | $3,360 | $3,360 | $3,360 | $13,468
- 5A.3 MICO Hub Reporting (Primary Care and Dental only)
  - $500 | $500 | $500 | $500 | $2,000
- 5A.4 Practice Transformation Implementation (Workplan/PTIP)
  - $1,000 | $1,000 | $1,000 | $1,000 | $4,000
- 5A.5 HRT Assessments (Collective Medical, DSM, One Health Port)
  - $100 | $100 | $100 | $100 | $400

**Care Coordination ($2,217 total per quarter):**

- 6A.1 Selection A (Clinic) Follow-up contact within one week of ED Discharge
  - $2,217 | $2,217 | $2,217 | $2,217 | $8,868
- 6A.1 Selection B (Clinic) Follow-up contact within 72 hours of ED Discharge
- 6A.1 Selection C (Hospital) Identify patients without PCP and make referral
- 6A.1 Selection D (Care Connect Agreements)

**Training & Learning Collaboratives ($7,708 total per quarter):**

- 7A.1 Training/Mentoring
  - $2,708 | $2,708 | $2,708 | $2,708 | $10,952
- 7A.2 Practice Transformation Learning Collaboratives

**Assessments ($1,000 total – earned during the quarter performed):**

- 8A.1 Continuum Model Framework for Integration in Behavioral Health and Primary Care Clusters (Below), can be earned in any quarter
  - $1,000 | $0 | $0 | $0 | $1,000

**Total 2021-2022 Maximum Available Revenue Sharing:**

- $19,739 | $18,130 | $18,130 | $18,130 | $74,398

**SAR 8.0 UPDATE:** A new revenue schedule (included below) for the fourth year of practice transformation was developed that retains the major milestones in 2021, and includes the Washington Integrated Care Assessment (WA-ICA), previously referred to as the continuum-based framework for integration in behavioral health and primary care. ACHs will assist HCA in introducing the WA-ICA to primary care and behavioral health providers that have experience
in completing the MeHAF (or similar integration assessment tools) starting in July 2022. All three GCACH PCMH Cohorts will begin using the standardized tool after receiving training. Included in Cohort 1’s contract is an additional $10,000 should the organization achieve PCMH recognition during the year. Another new assessment, 8A.1, the Justice, Equity, Diversity, and Inclusion assessment is also included for the fourth year of practice transformation. Maximum available revenue earned is $50,000.

Step 4: Develop Learning Collaboratives specific to the needs of PT organizations for successful implementation of the change concepts and evidence-based practices in the four project areas: Bi-Directional Integration, Opioid Crisis, Chronic Disease Management and Transitional Care. Trainings will be identified to support the project areas from the Current State Assessment (CSA) tool, the PCMH-A and MeHAF assessments. Provide in-person assistance through site visits, technical training, or opportunities for the providers to participate in training seminars, webinars, and learning sessions as part of Quality Improvement program. Learning Collaboratives provide learning opportunities on how to achieve Milestones in the contract working in collaboration with PT Navigators, Director of Practice Transformation, and exemplar organizations.

STATUS: A curriculum for the Learning Collaboratives, based on the Milestones and Current State Assessment results has been developed, and monthly Learning Collaborative sessions have been in effect since January 2019. To date the following sessions have covered:
• Reviewing the PCMH contract – January (2.5 hours)
• Reviewing and Developing a Budget – February (2 hours)
• Behavioral Health Integration with Exemplars – March (2.5 hours)
• EMS and Community Paramedicine – April (2.5 hours)
• PDMP, Medication Management, P4R, MAT training – May (2.5 hours)
• Opioid Use Disorder and Trauma Informed Care Summit – June 20-21 (2-day event)

The curriculum for the rest of the year includes:

• Access and Continuity and the CSI Portal – July 19 (2.5 hours)
• Chronic Disease, Self-Management Support, Motivational Interviewing, Transitional Care Management – August 1-2 (2-day event)
• QI Metrics/VBP and technology – September 19 (2.5 hours)
• Exemplar clinics with residency programs – October 19 (2.5 hours)
• Lessons Learned and Success Stories – November 15 (2.5 hours)

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

Each Partnering Provider selected for PCMH receives $14,598 for attending Learning Collaborative sessions based on the evidence-based practices and Change Concepts. Ideally, all members of the PT organization’s Quality Improvement Team attend the in-person sessions held by GCACH, but credit is given for attending learning webinars remotely, or attending other learning webinar or professional development activities. Partnering Providers must attest to their participation in the Learning Collaboratives, Leadership Council meetings, monthly webinars, or other professional development opportunities.

**SAR 4.0 UPDATE:** The curriculum for the Learning Collaboratives in 2020 builds on Year One, and includes:

• Reviewing and Developing a Budget - January
• Crisis Services - February
• The Art of Person-Centered Care - March
• HIPAA Policy Changes - April
• Shared Decision Making and Self-Management Tools – June (Mandatory)
• Shared Care Plans – July (Mandatory)
• EHR breakout session - August
• How to Maximize Medicaid Reimbursements – September (Mandatory)
- Practice Transformation Recognition Dinner, Exemplar Panel - October
- Cultural Sensitivity/ Cultural Competency - December

There is one schedule for all Cohorts, and each site will be incented $14,596 by attending four Learning Collaboratives throughout the year with three sessions that are mandatory. In 2020, the GCACH Marketing Department is teaming with the Practice Transformation Department to provide materials that relate to each topic. For example, GCACH will provide hot/cold packs for the Crisis Services Learning Collaborative session.

**SAR 6.0 UPDATE:** The following curriculum for 2021 Learning Collaboratives is geared at helping providers become ready for PCMH certification, should they decide to take that step.

- Working with Navigators/Reporting - January
- PCMH Certification with NCQA - February
- TeamSTEPs with Dr. Karen Hill - March
- Practice Transformations Successes and Difficulties while starting during COVID - March
- How to Screen for Social Determinants of Health - April
- MCO Rosters to Manage Populations - May
- Self-Management Support - June
- Cultural Competency – Donald Warne, MD, MPH, Director, Indians Into Medicine Program and Associate Dean for Diversity, Equity and Inclusion for the School of Medicine and Health Sciences at the University of North Dakota - July
- Pharmacy & PDMP – August
- Collective Medical Platform – September
- Awards Banquet: Speaker TBD – October

**SAR 7.0 UPDATE:** The Learning Collaborative curriculum above has been helpful in providing opportunities to advocate for Patient-Centered Medical Home (PCMH) to the Health Care Authority (HCA). As a result of our Learning Collaborative in February, representatives from the National Committee on Quality Assurance reached out to HCA to speak with them about PCMH and its value to the state. The Learning Collaborative on Managed Care Organization (MCO) rostering gave GCACH the opportunity to advocate for empaneling patients, and the June Learning Collaborative was attended by the HCA Manager of Quality Measurement & Improvement, Clinical Quality & Care Transformation Division, who encouraged GCACH providers to submit their decision aids on behavioral health to her.

Please see attached Learning Collaborative flyers as an example.

**SAR 8.0 UPDATE:** GCACH provided nine Learning Collaboratives (LC) during 2021. There was only one March LC (PCMH Certification) and no July LC meeting. The September Learning Collaborative was cancelled due to crisis staffing situations due to COVID-19 cases.

**Step 5:** Develop monitoring process through [GCACH online Reporting Platform](#) (CSI Healthcare Communities) using outside IT vendor, develop internal monitoring processes
through PCMH Trackers, Practice Transformation Implementation Workplan (PTIW), Practice Transformation Reporting Workbook, Quarterly Reporting, and One-on-One technical assistance from Practice Transformation (PT) Navigators.

**STATUS:** GCACH developed a reporting workbook to track quarterly PCMH Milestones, and report progress for implementation activities. The reporting workbook tracks achievement through data, narratives, or through a selection of options. The reporting workbook will be transitioned over to an online web-based reporting portal, that will upload PT organization Milestone data to report progress. The PTIW creates the baseline for the Change Concepts, and records monthly site visits.

**SAR 4.0 UPDATE:** All reporting is now accomplished through an online portal co-designed by CSI Solutions and GCACH. This has reduced manual reporting time for providers, and has given the Practice Transformation Team the ability to access provider data more easily and efficiently. A Dashboard consisting of twelve measures will be aggregated across all provider sites for an overall view of the progress of all three Cohorts.

**Step 6:** Monitor Progress of Milestones through [GCACH online reporting portal](#), IMC and PCMH Trackers, Practice Transformation Implementation Workplan, Quarterly Reporting, and site visits from Practice Transformation Team. Contract deliverables include Practice Transformation Change Concepts and Milestones, assessments, clinical quality measures, population health management implementation.

**STATUS:** Quarter 1 Milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included Assessments (MeHAF, PCMH-A, HIT/HIE), year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation has been delayed. (See [Practice Transformation Scoring Report](#) for more detail.) The site went live on June 17, and Quarter 1 reports were pre-loaded by the PT Navigators. PT organizations will be able to view this Q1 data when they begin to enter their Q2 reporting Milestones due July 15. GCACH and CSI conducted online trainings for using the reporting portal on June 26th, and any organization can receive one-on-one technical assistance from GCACH staff.

Additionally, PT Navigators meet with each clinic monthly to track progress toward Change Concepts and goals in the PTIW, and track the progress of each clinic on a monthly basis which is reported out at the monthly Board meetings. If organizations have a deficiency during the reporting period, the Practice Navigator will do a follow up with the clinic to discuss the deficiency. The clinic will then have a 6-day grace period to work with the Practice Navigator to correct the deficiency in order to receive the full value of the point system assigned to that Milestone. The Director of Practice Transformation will reevaluate the deficiency for full, partial or no point payment. Additionally, PT Navigators refer to the PTIW for baseline data, and to record monthly site visits. Milestone progress for each clinic is reported out at the monthly Board meetings through the PCMH or IMC Tracker document. After Quarter 2 reports have been input into the Portal, GCACH will work with CSI on a Reporting Dashboard to capture aggregated data that best represents Cohort progress toward implementing the Milestones.
**SAR 4.0 UPDATE:** Four quarters of metrics are now available electronically through the CSI portal, and all Practice Transformation Cohort providers are entering quarterly data using the platform. The entry of data is much more efficient for both the providers and the Navigators. GCACH is recommending slight improvements to the Milestones. Drop-down menus, and automatic calculations for Milestones requiring numerator and denominator data make monitoring and evaluation more efficient for the Practice Transformation Team, however some erroneous data entry is occurring which is being corrected. The Reporting Dashboard is almost complete with weekly conference calls with CSI to work out the final details. The Dashboard report aggregates the reporting from all sixty-two clinic sites, allowing a quick analysis of twelve metrics as shown in Figure 4. Cohort 3 will be added once they begin quarterly reporting in April 2020.

**SAR 7.0 UPDATE:** All three Cohorts (82 sites) are reporting in the CSI portal. The dashboard is reviewed by the Practice Transformation Workgroup to measure progress and show trends.

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**Figure 6:** GCACH Reporting Dashboard – updated 6.28.21

**Step 7:** Share results with PTW and Providers. Adjust measures and processes as needed to implement Change Concepts by PCMH Cohort, and review with PTW. PT Navigators review progress towards Milestones with Partnering Providers with every site visit.

**STATUS:** Milestones are continuously reviewed for each Partnering Provider by the Practice Transformation Navigators at their monthly site visits to make progress toward transformation efforts. Quarter 1 Milestones were reviewed by the Practice Transformation Workgroup on May 2nd which included year-to-date payments to each Partnering Provider, status on each project area, and a list of barriers if implementation has been delayed.
**SAR 4.0 UPDATE:** Quarter 2 and 3 Milestones were reviewed by the Practice Transformation Workgroup on July 25 and November 7th. All organizations have implemented processes for all four project areas, chosen a model of bi-directional integration, and are working with the Managed Care Organizations to implement population health management tools like EDie, a web-based technology that provides real time information to reduce ED utilization, improve transitions of care and enhance care coordination. Some of the barriers that were identified from reporting in Quarters 2 and 3 included:

- Provider communication within organizations
- Staff turnover, recruiting barriers (more in rural areas)
- Leadership and clinical staff disagreeing on metrics to track/which are more valuable to track based on clinic location or patient population
- Technology implementation planned for later in the year that will allow for risk stratification, patient rostering, population health management
- Electronic Health Record transitions
- 42 CFR Part 2: sharing information from behavioral health (BH) to primary care physician (PCP) or PCP to BH
- Opportunity to enhance billing workflows that will allow for sustainability
- Internal transitions and/or protocols
- Culture change
- MCO sponsorship for Collective Medical
- Staff not working at the ‘top of their license’
- Reworking the reporting to make it more relevant to hospitals.

**SAR 7.0 UPDATE:** GCACH continues to meet with the Practice Transformation Workgroup to review quarterly progress, and obtain feedback on milestones. Figure 6 has been updated to reflect the latest reporting cycle, Quarter 1 of 2021.

**SAR 8.0 UPDATE:** The CSI portal data continues to be a valuable resource to GCACH and providers. The trends during 2020 and 2021 clearly show the impacts of COVID-19 on case management, and follow-up. The top Risk Stratification method, Social Determinants of Health was a notable change from the last reporting period. High-referral Community Partners also showed a change from the last reporting period which mirror the behavioral health trends that the healthcare industry has witnessed during the pandemic.
Step 8: Assess each work step and Provider resources for successful implementation of population health management tools (e.g., staffing for risk stratification, enhancements to EHR, PMP), and how they will improve health systems, community capacity building, and health equity.

STATUS: The Practice Transformation Team meets with each Partnering Provider organization monthly to ensure that they are making progress toward using population health management tools, selecting and reporting quality metrics, and optimizing their EHRs. The Executive Director, Deputy Director, Finance and Contract Director, and the Practice Transformation Director started an initiative in May 2019 to make site visits with hospital and clinic leadership to ensure that transformation efforts, reporting requirements, Milestones, Learning Collaboratives, and implementation of population health management tools were going smoothly, and to determine if any mid-year corrections to the transformation process were needed.

Site visits with the following Partnering Providers have been accomplished:

- Astria Toppenish Hospital, Astria Sunnyside, Astria Yakima
- Kadlec Regional Medical Center/Providence St. Mary’s Hospital
- Virginia Mason Memorial Hospital
- Garfield Hospital
- Pullman Hospital
• Columbia County Health System
• Kittitas Valley Healthcare
• Tri-Cities Community Health
• PMH Medical Center
• Lourdes Health Network
• Yakima Neighborhood Health Services
• Quality Behavioral Health
• Comprehensive Health Care
• Columbia Basin Health Association

These meetings were extremely productive, and Leadership from these organizations reported favorable feedback regarding the Practice Transformation Navigator’s technical assistance in finding resources, re-thinking workflows, and re-evaluating PCMH strategies. They seem pleased with the “descriptive but not prescriptive” nature of the PCMH program as it allows them flexibility to use their revenues to meet local needs, however the lack of structure also creates confusion among some provider organizations. Greater Columbia is using this feedback to make improvements to the reporting platform, to minimize the work in reporting on Milestones, and to get referrals for potential Partnering Providers for future Cohorts.

**SAR 4.0 UPDATE:** While the majority of primary care sites are making steady progress toward PCMH, two primary barriers exist for the behavioral health providers in successfully implementing population health management tools:

- Having an ONC Certified EHR, and
- Access to the Collective Medical Platform

Prior to Integrated Managed Care, behavioral health providers received compensation for services based on a contract with the Greater Columbia Behavioral Health Organization (BHO). Now that the providers are submitting claims to the MCOs for reimbursement, their patient data and claims information has to be collected, stored, and billed through an ONC Certified electronic health records system. Behavioral health providers have been using the incentive funding from the IMC transition to purchase new EHRs, and setting up their EHRs systems. Navigators have assisted fifteen (15) behavioral health organizations transition to new EHRs.

The Collective Medical Platform is an admission, discharge, transfer (ADT) notifications system and a care collaboration platform that unifies a patient’s entire care team. In the Greater Columbia region, the network includes hospitals, primary and behavioral health care providers, health plans, and even one emergency medical system (EMS), an innovation for this system. Each clinic must be sponsored by a Managed Care Organization, unless it is a primary care practice affiliated with a hospital. Each organization must also complete a “Discovery Form” in order to be added to the Collective Medical network. The Discovery Form also requires the upload of a patient eligibility file (patients paneled to the provider organization), which some
organizations have had to produce manually, because they are in the process of switching to an ONC Certified EHR.

In order to facilitate access, GCACH staff and the MCOs came together in the Summer of 2019 to develop a workflow to lay out a process for the provider organizations. However, there are a few organizations not yet connected.

Figure 5 demonstrates the workflow for MCO sponsorship to the Collective Medical Platform.

**MCO Sponsorship to Collective Medical**

1. GCACH will provide list of Cohorts to the MCOs; Clinics within the same organization that cross over cohorts will be identified. (The Commercial Medical Platform is sponsored by Organization and not by individual clinics)
2. GCACH will send list to MCOs of the provider organizations that are in need of CM sponsorship
3. Once MCOs receive list of organizations from GCACH, the MCOs will talk amongst each other and will decide which organizations they will be sponsoring
4. Once sites have been divided amongst the MCOs, they will notify GCACH Practice Transformation Navigators.
5. GCACH Practice Transformation Navigators will send out an email to the organizations informing them that they will be sponsored by an MCO, which will be CC’d on the mail so that the MCO can send discovery and connect with the appropriate organization contact.
6. Once the organization has filled out the discovery form, they will send it back via email to their sponsoring MCO.
7. Once discovery form is back to the MCO, they will pass that along to Collective Medical and that will indicate to Collective Medical that they will be sponsoring that organization.
8. After Collective Medical has received discovery form, they will contact organization to contract and provide Patient File Form that Collective Medical will upload into their system. Commercial Medical and/or the Organization will contact the Practice Navigator to assist with facilitating the completion of the file form.
9. The GCACH Practice Navigator will assist the Organization in developing policies, procedures and processes to ensure the use of the Collective Medical Platform supports milestones completion.
10. The GCACH Practice Navigator will follow up with the organization no less than monthly to ensure the utilization of the Commercial Medical Platform.

**Figure 7; MCO Sponsorship to Collective Medical**

**SAR 7.0 UPDATE:** Utilization of Collective Medical has increased over time, and 95% of providers are using this platform to follow-up on emergency department utilization and hospitalizations. Because of GCACH’s success in implementing this platform, they are facilitating other providers to gain access to Collective Medical. Catholic Charities of Spokane is building a permanent supportive housing complex in Pasco, and has asked GCACH to help them get access to Collective Medical.

**SAR 8.0 UPDATE:** All but two provider sites are using Collective Medical to follow-up on emergency department utilization and hospitalizations. Molina Healthcare has agreed to sponsor Catholic Charities of Spokane on Collective Medical. The majority of sites are using OneHealthPort to get client information and upload patient records.
**Step 9:** Health Care Partners, Primary Care, and Behavioral Health develop and agree on shared care plans, how to exchange information. Training for an implemented shared care plan dependent upon specified evidence-based model, e.g., Transitional Care Model, Community Para-medicine model.

**STATUS:** GCACH contracted with Quad+Aim Partners to develop a community information exchange (CIE) called the Health Commons to electronically connect health and social service providers together to improve patient/client care transitions between agencies. Through a competitive process, the Kittitas County Healthcare Network was chosen to pilot this project as they had an established network of providers identified as “The A Team“ that were trying to develop such a system, and were relying on manual processes to manage patients common to their organizations. The CIE manages digital consents, health record integration and information exchange. Patient Health Information (PHI) is stored on Amazon Microsoft’s secure cloud infrastructure and is under contract to Quad+Aim Partners to ensure proper technology integration as well as quality and consistency of service. The pilot includes Kittitas Valley Fire and Rescue Paramedics, Kittitas Valley Healthcare, and Comprehensive Mental Health, and will add additional partners after successfully demonstrating a live patient experience.

Additionally, GCACH has a Memorandum of Understanding with the Yakama Nation to implement a Health Commons that will connect several programs related to family reunification. The Yakama Nation will be working with Quad+Aim to organize and digitally connect services to a community-wide care coordination system.

Practices are also encouraged to use direct secure messaging. Direct secure messaging is an electronic communication technology, that sends messages and data packets between provider EHRs but also includes secure (HIPAA-compliant) web e-mail to communicate with organizations with no EHR. It is designed typically for the exchange of patient health information but can also convey information relating to a patient’s social service needs.

GCACH is also working with Collective Medical and the Managed Care Organizations to implement EDIE and PreManage. EDIE is a care management tool that provides alerts to emergency department providers regarding patients who visit the emergency department more than five times or have an inpatient admission in a 12-month period. PreManage combines information from participating healthcare partners, including hospitals and emergency departments (EDs), primary care practices, and behavioral health agencies (BHA), and synthesizes the information into brief, actionable information about individual clients. It is a valuable tool for identifying and tracking high-risk, high-utilizing clients and assisting providers with developing strategies to stabilize clients and reduce unnecessary hospital and emergency department (ED) utilization by facilitating real-time alerts and care coordination. In its implementation, the GCACH seeks to find ways to full integrate PreManage into the practice’s EHR, reducing the need for a separate sign-on for accessing data.

**SAR 4.0 UPDATE:** In addition to accessing the Collective Medical platform for providers, GCACH staff is exploring a secure texting platform developed by Karuna Health. Karuna integrates with customers’ electronic medical record systems and lets users schedule
appointments, organize transportation, and repeat messages to patients automatically, such as reminders to take medication.

GCACH is investigating a Community Information Exchange (CIE) called NowPow, and received a demonstration of this product in December. GCACH is also working with the other ACHs to discuss a common strategy in implementing a statewide CIE or, at the least, update electronic community resource directory of social service providers.

The Yakama Nation has a signed contract with Quad+ Aim Partners for the Health Commons project, a community health information exchange focused care management of high risk individuals with co-occurring disorders and social service needs. This work is projected to start in January 2020.

**SAR 6.0 UPDATE:** Due to the pandemic, a common Community Information Exchange (CIE) is being implemented by the Department of Health using the CCS platform for those ACHs implementing the Care Coordination project. Greater Columbia has been in conversation with North Central ACH and Better Health Together to examine WIN 2-1-1’s platform for referral management.

**SAR 7.0 UPDATE:** HCA is pursuing a statewide strategy to implement CIEs, and launched a white paper in March 2021 that describes the various modules that are part of a CIE. HCA is forming a CIE committee that will include ACH representatives. The GCACH Executive Director is part of that committee and their first meeting is scheduled for July 9, 2021.
**SAR 8.0 UPDATE:** GCACH continues to participate on the HCA/ACH CIE committee to share information and exchange experiences regarding CIE progress. SiteSavvy, a software and mobile applications developer is currently finishing a resource directory for the GCACH region. SiteSavvy used the WIN 211 data base and filtered it by geographic area to create a uniquely branded directory for GCACH that should be available by the end of January. GCACH is also in discussion with SiteSavvy to develop a strategic plan to address the other components of a CIE. While the resource directory is the first component for GCACH to tackle, GCACH would like to explore options on how to address client data exchange (CDE).

The HCA included $300K in the 2022 Governor’s budget to develop a report on the next steps for a CIE solution that will exchange and receive information from other state exchanges and integrate with the Department of Health's CIE. Once the report is submitted and upon receipt of a letter from the Office of Financial Management accepting the authority’s plan and authorizing the implementation of that plan, $1.9M of the general fund—state appropriation for fiscal year 2023 and $262K of the general fund—federal appropriation is provided solely for community information exchange.

**Step 10:** Scale and Sustain

**STATUS:** GCACH selected a second Cohort in May 2019 (Scale), the seventeen community Behavioral Health organizations that transitioned to Managed Care in January 2019. These organizations will be using the same QI model, PCMH, to transform their practices. While integration with primary care is preferred, the BH agencies will have flexibility in developing their integration models. Integrating with SUD or mental health agencies, schools, dental offices, skilled nursing facilities, emergency departments, fire departments, or other community settings is encouraged.

A third Cohort is planned for October 2019. The third Cohort will be comprised of remaining hospitals that want to incorporate PCMH Change Concepts, additional clinics with large Medicaid populations in Yakima and Benton Counties, and possibly, care coordination and transitional care facilities such as skilled nursing facilities, and palliative care programs. GCACH is using the same process to select the third Cohort; LOI/CSA submission, independent scoring, PTW confirmation, and Board approval. As the composition of the Cohorts evolves, the LOI/CSA is revised to include questions specific to that aspect of the healthcare delivery system.

GCACH has modeled its projected cash flow through 2023 (Sustain), and has committed to fund all three Cohorts through 2022. Funding steps down from approximately $283,598 in year 1, to $149,454 in year 2, to $74,727 in year 3. During this time, each organization will have received technical assistance on evidence-based practices in all four project areas, and training on how to maximize claims reimbursements based on delivering quality care, and how to negotiate a contract with managed care organizations that is value based. Figure 6 shows the Scale and Sustain funding model for all three Practice Transformation Cohorts:
SAR 4.0 UPDATE: As recorded in Step 1, two provider Cohorts have been added to the Practice Transformation program since June 30, 2019 using the same workbook, toolkit and reporting structure as Cohort 1. The revenue sharing or cash flow model is being updated to reflect the timing of incentive payments, and to reflect the most recent financial projections from the Health Care Authority.

Cohort 3 contracts will be signed by the end of January 2020, and their first reporting period will be in April.

SAR 5.0 UPDATE: The third Cohort comprised of eighteen provider organizations was added in January of 2020 that included Skilled Nursing Facilities, Palliative Care, and added more primary care clinics.

SAR 7.0 UPDATE: GCACH added a Community Health Worker Intern Cohort in June 2021. Community Health Workers (CHW) play a critical role in improving the health of communities, by linking diverse and underserved populations to health and social service systems. Eleven organizations responded to the internship funding opportunity with nine CHW’s starting the formal Department of Health CHW training program in July 2021. Training for supervisors of CHW’s occurred on June 22nd and monthly trainings for the Cohort are planned through the end of the program - December 2022. The $50,000 contract with providers requires that the CHW Intern is integrated into the organization’s clinical care processes so that the CHW Intern gains adequate clinical care exposure and training along with a host of other requirements.

SAR 8.0 UPDATE: GCACH worked during 2021 to find alignment between GCACH’s core competencies, “bridge year” activities, HCA expectations for the 2023 Waiver, and provider needs in order to determine what scale and sustain activities would be provided in 2022. Careful monitoring of expected DSRIP payments and grants in 2021, 2022, and 2023 led to a revised cash flow model, and supported a fourth year of practice transformation activities as well as adding an emergency medical services cohort, a second cohort for community health workers, and a second behavioral health preceptorship cohort.
Additionally, GCACH has been following the development of HCA’s Multi-payer Primary Care Transformation Model (PCTM). The PCTM will be a framework that aims to strengthen primary care through multi-payer payment reform and care delivery transformation. In October 2021, insurance payers, representatives from the Washington State Health Care Authority (HCA), Governor Jay Inslee’s office, and the Washington State Medical Association signed a memorandum of understanding (MOU) committing to improve primary care and develop a new payment model in Washington. While the MOU is non-binding, each participating payer is committed to this multi-payer initiative and will “make good faith efforts to implement it, and comply with all components of the MOU for the success of the WA Primary Care Transformation Initiative.” PCTM closely aligns with the Patient-Centered Medical Home model of care, presenting GCACH with the opportunity to transition all provider sites into the HCA’s PCTM, and providing the technical support needed to be successful under a value-based payment contract. GCACH is in close contact with HCA to find opportunities to help launch the PCTM model in 2023 as part of our scale and sustain strategy.
A Component of the Quality Improvement Plan

Patient Centered Medical Home Change Concept: Quality Improvement (QI) Strategy

- A QI strategy is an approach to change and provides a framework and tools for planning, organizing, monitoring, sustaining and scaling based upon data.
- A QI team is sponsored by leadership and focuses on the organization’s strategic priorities. QI teams will adapt to change based upon data and also keep everyone on track.

GCACH Practice Transformation (PT) Resources

- PT Toolkit
- Learning Collaboratives
- Exemplar organizations
- Technical assistance
- Healthcare Communities portal resources
- Practice Transformation Implementation Workplan
- Assessments

GCACH Practice Transformation Toolkit: Milestone 5 – Quality Improvement

- Milestone 5 guides PT organizations to take a systematic, data driven approach to drive quality improvement.
- Organizations will identify measures for quality and utilization that are important to them and their patients. They will use these Clinical Quality Measures (CQM) as guides while they test changes to their practice.
- Milestone 5 also requires that PT organizations create a Quality Improvement team that will be directed toward achieving the GCACH Milestones and working with its Practice Transformation Navigators.

GCACH Practice Transformation Workgroup (PTW) Review

- PTW reviews PT Milestone reporting results on a quarterly basis
- Obstacles to Practice Transformation implementation are assessed
- Possible solutions are identified

PT Milestone Reporting

- PT organizations transmit Milestone reporting deliverables to GCACH
- Uploaded CQMs correspond to MTP Pay-for-Performance measures

Improvement Strategy Translation

- GCACH responds and assimilates findings from PTW review and translates them into PT process changes

Practice Transformation Organizations

- Leadership
- Plan
- Act
- Do
- Study
- Admin.
- Staff

Continuous Improvement

Revised: 7-27-2019
Free · No Insurance Needed · No Appointment Required

COVID-19 VACCINE CLINIC

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Be one of the first 30 people to get vaccinated and receive a $50 gift card! (For 1st or 2nd doses only)

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SABADO 4 DE DICIEMBRE 10AM-2PM
1116 N 20TH AVE, PASCO, WA 99301

SEA UNA DE LAS PRIMERAS 30 PERSONAS EN VACUNARSE Y RECIBIRA UNA TARJETA DE REGALO DE $50 (SOLO PARA LAS PRIMERAS Y SEGUNDAS DOSIS)

J&J, MODERNA, Y PFIZER DISPONIBLES PARA DODAS LAS EDADES PFIZER DISPONIBLE PARA EDADES DE 5 EN ADELANTE OFRECIENDO PRIMERA Y SEGUNDA DOSIS Y REFUERZOS DISPONIBLES

WWW.GCACH.ORG
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### WELCOME & INTRODUCTIONS

**Welcome & Introductions (Dr. Patrick Jones)**

Dr. Patrick Jones of Eastern Washington University facilitated the meeting. The topic for this meeting was Value Based Payments (VBP).

### DISCUSSION ITEMS

**Value Based Payment Overview**

JD Fischer and Mia Nafziger of Health Care Authority (HCA) gave a presentation titled, “2020 Paying for Value survey results”. JD is the VBP Manager at HCA within the policy division. He coordinates purchasing strategy across the agencies (Medicaid and Employee Benefits programs). Mia works with JD and works with projects across VBP and health equity.

JD noted statewide results will be published in the coming weeks.

Their presentation included:

- Who HCA is: purchaser, convener, and innovator
- VBP roadmap with HCA’s vision and goals. Unfortunately, 2019 is the first year where minimum targets were met.
APM Framework: Reminder that when referencing VBP, HCA is using the Health Care Payment Learning & Action Network Alternative Payment Models (APM) framework. This is a refreshed framework that will be implemented into contracts and reporting tools over time. Changes include removal of category 2D (penalties for performance) and addition of the new category 4C (integrated finance and delivery systems, which used to report under 4B).

HCA’s long-term VBP roadmap: 2022-2025. This included continuing the shift from paying for volume to paying for health and value, as well as ensure payment drives higher quality

Thank you for your engagement with GCACH!
services, lower costs, greater health equity, improved access, and improved patient and provider experience.

- HCA’s vision for VBP in 2025:
  - VBP arrangements will be aligned across all public purchasing programs and advance multi-payor primary care models where appropriate. We will leverage HCA’s purchasing power to continually drive the health care system toward improved outcomes, patient and provider experience, and equity while containing costs. JD noted that legislature passed a bill to establish a statewide health cost transparency board. They are hoping this board will be influential in shining a light in health care costs across the state. HCA is tasked with facilitating that work and will be closely tied to that work.
  - VBP arrangements will be rooted in data-driven policy making, requiring HCA to collect and utilize actionable data to:
    - Reinforce accountability among delivery system networks as well as provider and MCO partners.
    - Exercise significant oversight to identify priorities, monitor progress, and improve performance.

- Refreshed foundational principles with new language that include “affordable and accessible care”. There was an addition of new principle that encompasses a robust primary care and other prospective APMs as having payments where providers are getting predictable, steady, constant funding stream allows them to navigate disruption better. They have also done work internally to recognize health equity (principle 4).

- Key priorities for 2022–2025 (in no particular order)
  - Health equity, SDoH, primary care, alignment, accountability and support, access, and affordability. The long-term roadmap lays out the what, why and how for each area and JD encouraged individuals to take a look.

Next, JD and Mia reviewed the Results from the HCA’s Paying for Value survey. HCA issues an annual survey to providers and health plans to track progress to VBP goals and gather information to help us understand information for current and future strategy design. All MCOs and health plans responded.

- Payments by APM category showing statewide VBP accounting for 69%, which is a steady improvement from 2016. He noted the interesting use of these payments across Medicare advantage, all commercial, and Medicaid Managed Care.
• MCO VBP adoption by ACH, which five have exceeded the target. Need to have conversations with MCOs and ACHs about challenges to ensure nothing is being missed.

MCO VBP by Accountable Community of Health

• Health plan surveys enablers and barriers

<table>
<thead>
<tr>
<th>All payers: top four enablers</th>
<th>All payers: top four barriers</th>
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</thead>
<tbody>
<tr>
<td>Interoperable data systems</td>
<td>Lack of interoperable data systems</td>
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<tr>
<td>Aligned incentives/contract requirements</td>
<td>Payment model uncertainty</td>
</tr>
<tr>
<td>Aligned quality measures/definitions</td>
<td>Disparate incentives/contract requirements</td>
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<tr>
<td>Trusted partnerships and collaboration</td>
<td>Disparate quality measures/definitions</td>
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n=9  
n=9  

Thank you for your engagement with GCACH!
VBP within specific provider categories (excluding hospitals). This demonstrates that the focus for APM implementation is really honed in on primary care and behavioral health, which are critical areas for driving improvement.

**VBP within specific provider categories (excluding hospitals)**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Many</th>
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<tbody>
<tr>
<td>Behavioral health providers</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Dentists</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Home and community-based service providers</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Long-term care facilities</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Nurse-midwives</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>OB/GYNs</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Primary care providers (i.e., physicians, advanced practice nurses, physician assistants)</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other specialists</td>
<td>1</td>
<td>3</td>
<td>2</td>
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Impact of COVID-19 on VBP adoption, which has affected organizations in a few ways.

**Has the COVID-19 pandemic affected your organization’s ability or capacity in the following ways?**

- Reduced willingness or ability among providers to engage in new or expanded VBP contracts: 5
- Challenges to the sustaining providers networks: 2
- Negative impacts on quality measure reporting and/or performance: 7

**From your perspective, how should payers, purchasers, and providers adjust their VBP strategies in light of the COVID-19 pandemic?**

- Reduce/limit risk-based payments until the pandemic is over: 3
- Continue expanding VBP models: 5
- Implement prospective APMs: 4
- Pause the expansion of VBP and instead focus on sustaining access and improving the availability and provision of telehealth services: 4

Provider survey results in the GC region including:

- Highest responses from BH providers, outpatient and inpatient clinics/facilities.
- More respondents from GC region compared to last year
- VBP readiness: somewhat ready

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VBP experience: neutral. Comments include appreciation for value instead of volume and putting resources to quality improvement. Challenges include working with multiple payors and different VBP programs, access to timely data, and minimal reward for the level of administrative burden.

**Top enablers and barriers**

<table>
<thead>
<tr>
<th>Top five enablers</th>
<th>Top five barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligned quality measurements and definitions (27)</td>
<td>Mismatched incentives and/or contract requirements (39)</td>
</tr>
<tr>
<td>Trusted partnerships and collaboration with payers (24)</td>
<td>Lack of timely cost data to assist with financial management (17)</td>
</tr>
<tr>
<td>Access to comprehensive data on patient populations (23)</td>
<td>Lack of interoperable data systems (35)</td>
</tr>
<tr>
<td>State-based initiatives (22)</td>
<td>Insufficient patient volume by payer to take on clinical risk (13)</td>
</tr>
<tr>
<td>Aligned incentives and/or contract requirements (22)</td>
<td>Lack of access to comprehensive data on patient populations (29)</td>
</tr>
</tbody>
</table>

Perceived role of HCA/role clarity: somewhat clear/not so clear

Health disparities and equity (showing an increase of collection). She also noted the rise in providers addressing health disparities.

<table>
<thead>
<tr>
<th># of respondents selecting “Yes” to collecting the following data</th>
<th># of respondents selecting “Yes” to assessing performance by the following data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race 142</td>
<td>46</td>
</tr>
<tr>
<td>Ethnicity 135</td>
<td>43</td>
</tr>
<tr>
<td>Language 134</td>
<td>35</td>
</tr>
</tbody>
</table>

- Technical assistance: GCACH results –

**Survey question: What type of technical support has your organization received?**

- Value-based reimbursement: 12
- HIT/HIE planning, implementation, and/or reporting: 6
- Behavioral/physical health integration: 13
- Practice transformation: 6

- Survey question: What type of technical support would be most helpful to your organization?

- Value-based reimbursement: 10
- HIT/HIE planning, implementation, and/or reporting: 3
- Behavioral/physical health integration: 4
- Practice transformation: 6

- Impact of COVID

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**Thank you for your engagement with GCACH!**
Questions/comments include:

- Carol of GCACH highlighted JDs suggestion for the MCOs and ACHs to work together to increase the level of VBP contracts in our region. She recognized the barrier with contracting with smaller providers. What does HCA consider as a volume in order to have that level of population make it affordable for an MCO to go into that contracting arrangement? JD noted there are flexibilities in the APM framework that allow smaller providers to participate—he mentioned 2C payments as an option. He highlighted the role that HCA plays vs. MCOs (i.e. those details need to come from the MCO and health plans in your region).

- Assessing access: JD noted in the roadmap one of the first steps is to come up with ways to measure that access to both provider types and service types. To be determined, but they know it is an important focus. He clarified that the Center for Excellence (COE’s) are only in the employee benefits side, they understand specifically in Medicaid COE’s do not

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have the same volume. They have not gone down the road of implementing COE’s within Medicaid at this time.

- Integrated Managed Care models in 2019 and the impact to percentage of VBP models in the GC region. This data has not been determined but JD intends on doing analysis.

No further comments or questions.

**Provider Panel**

<table>
<thead>
<tr>
<th>Penny Bell</th>
<th>Shane McGuire</th>
<th>Dr. Michael Shannon</th>
<th>Dr. Kevin Martin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director, Ideal Balance</td>
<td>CEO, Columbia County Health System</td>
<td>Endocrinologist and Physician Executive, Physicians of SW Washington</td>
<td>Medical Director, Kittitas Valley Healthcare</td>
</tr>
</tbody>
</table>

Prior to the convening, these professionals were provided with the following questions:

1. What are the barriers to value-based contracting from your perspective?
2. How has practice transformation helped you prepare for value-based payments?
3. How do you pay for care coordination?

Penny Bell from Ideal Balance responded:

1. What are the barriers to value-based contracting from your perspective?
   - Greatest barrier is the lack of engagement or communications from the payors. They have invested a lot of time and energy in preparing for VBP; it feels they are stuck in the preparation phase without knowing the outcome. This is an expensive endeavor and they want to know they will be able to maintain these programs they have implemented to meet requirements for VBP contracting.
   - Another barrier is that Medical monies for Medicaid are different than BH dollars. Under Medicaid medical, the providers are paid the same price for every service no matter where they do it by all payors. With BH, the reimbursement model is extremely variable—Not just by payor but by location. What would that look like?
   - The outcome measures are another barrier. They track so many measures under the ACH. They are meeting the milestones, but again no conversation from payors on what they want to see and what that would look like for VBP contract.

**Thank you for your engagement with GCACH!**
1. She is waiting for the payors to come to her to get ready for VBP contracting. In fact, she is in the process of preparing a proposal to bring to the payors to demonstrate Ideal Balance’s VBP readiness.

2. How has practice transformation helped you prepare for value-based payments?
   - What haven’t they done? GCACH has been unbelievably helpful- education, meetings with professionals (e.g. Adam Falcone), funds for switching to EMR, funds for platforms and quality improvement programs to improve quality of care while also tracking data being collected. It’s the funding, education, and technical assistance. She praised GCACH for “being there” when they need it by answering questions and bringing in resources (via meetings) to provide that education.

3. How do you pay for care coordination?
   - Currently, they bill the payors for the case management (she noted this question is more pertinent for medical providers rather than BH providers such as Ideal Balance). She reiterated that they have prepared and prepared and prepared without knowing what the end result will look like. They have invested a lot of time, money, and energy without any indication of the future from the payors.

Shane McGuire from Columbia County Health System responded:

1. What are the barriers to value-based contracting from your perspective?
   - From a positive perspective: they have been in an ACO (accountable care organization) for the last five years and have been with the ACH since inception. They believe population health addresses very important issues. They’ve embraced it and built the necessary infrastructure with respect to rostering, IT integration, etc.
   - The largest barrier—population, they have a high number of individuals with chronic disease in their area. It is not an attractive population from a risk perspective.
   - Serving multiple counties and referenced Medicare advantage plans. He explained their frustrations with contracting with these plans due to cross county patients visiting. They consume a much larger contractual obligation for those patients to maintain the care for those individuals but are not able to participate with the Medicaid provider.
   - Misaligned incentives—they have contracted with ALTC for numerous projects. They’ve seen evidence that these programs due save money, however in actuality it doesn’t cover the cost of care to provide those services. Thus, resources spent is less than what is reimbursed. They see this in many places. He shared the difficulties with not having a concise reimbursement model (i.e. trading clear reimbursement methods for methods and services we know are better, but actually hurt overall bottom line by doing better care coordination).

2. How has practice transformation helped you prepare for value-based payments?
3. How do you pay for care coordination?

- If they are capable of getting CCM (chronic care managed) visits billed, then they do. To get it billed successful is complex however—requires complex coding, charting, keeping track of time, coders have to parse through complex multi-provider notes in order to get billed correctly. Very challenging. In lines of CHW, do tremendous amount of coordination but no strategy for that reimbursement for that level of coordination.

- Most of the specialties are outside of their organization. They do not have any on site. The majority of cost beneficiary ends up being on the specialist side. He noted it’s been nearly impossible to get them to communicate on any VBP agreement on those patients. Many challenges in the demographic, size and number of patients, they have not been approached by any of the payors to get involved with any VBP contracts. They have looked outside to larger affiliation to participate. He noted the ACO they are a member of, is made up of multiple care providers. However, they still do not see a clear path to how shared savings and contracting can benefit them for the work they are doing.

Dr. Michael Shannon from Physicians of Southwest Washington. It is a population health company based in Olympia. They have a couple Medicare advantage plans, Medicare ACO in three states, and some commercial lines of business. They serve as the hub of an IPA for a couple hundred independent providers, and have a health system minority shareholder as well. His responses to the questions included:

1. What are the barriers to value-based contracting from your perspective?
   a. Long lag time for quality and claims data, it can be months. Certainly, delays ability to inact interventions. It is also source of provider abrasion when they are provided a list of gaps that they have already solved or recognized.
   b. Partial of lack of healthcare IT and interoperability. He noted having few hundred of doctors on 20-30 different EHRs, can either require a lot of IT to create a central switchboard or laborious for manual extraction.
   c. Attribution and alignment. At the Medicare ACO, they can invest a lot in a patient and turns out they see someone else one more visit than us in a different system they are attributed to that system.

2. How has practice transformation helped you prepare for value-based payments?
   a. They designed their provider payment with substantial incentives for hitting key quality metrics and utilization goals. In their Medicaid advantage space and risk contract space they were already used to incentivizing them, they have been comfortable moving along. Over time as guidelines change, they just update those accordingly.

Thank you for your engagement with GCACH!
b. They have a strong central care management team, which relies on central hub to do care management. Their role includes coordination between appointments as well as some remote monitoring and nurse triage.

c. Invested in Innovaccer (healthcare IT tools). They have invested to get reasonable actionable claims, close quality gaps, and approve what’s appropriate, HCC scoring.

3. How do you pay for care coordination?
   a. This is done centrally; providers and contracts rely on them to do that. They are going to be the hub of contract for Medicare advantage and insource the cost. Or if they did a management service deal, where they supported care management in New York, they’d charge per member per month. He noted they sometimes carve out areas where they lack specialized care managers so they will carve out and outsource the necessary professionals.

Dr. Kevin Martin from Kittitas Valley Healthcare began by sharing his time at a healthcare summit in 2009 at Seattle Center that involved 50 representatives of payors, providers, and employers (ranging from state to small). What should a PCMH look like? What should PT accomplish? The morning session was a robust conversation that concluded that a PCMH should offer services that patient needs in one place and that is has to include integrated behavioral health. Later that day, it was focused on how to pay for care coordination or PCMH—a VP for a large payor saying primary care costs them $25 per month and anything that costs a penny more is a nonstarter. Dr. Martin noted that is interested that 11 years later we are still having the same conversation. He responded:

1. What are the barriers to value-based contracting from your perspective?
   a. We tend to talk a lot about to expect PT to result in meaningful outcomes, but we forget in a PCMH model, the meaningful outcomes are the ones that happen to the patient. That is lost in our discussion in economics and efficiencies. PCMH and practice transformation is supposed to result in savings by being more efficient. If we are having to retrain providers to diligently make sure they hit the right check boxes in order to capture efficiencies, we’re done. we have to get past a CPT based coding model. It’s putting a new body on fee-for-service and losing the efficiencies we hope to achieve.

   b. As an organization, he can’t tell his providers that they have to meet the different requirements of five different payors to achieve a quality metric. They have to be able to design their systems and have the payors recognize the value. It has to be the same system for every payor. They have recently severed relationships with one large payor because every quarter they would sit down with senior leadership to outline gaps in care, to which they were told they’d get paid an extra $17k a year to close—failing to recognize that they were spending as much on the room space and expertise as the improvement.

2. How has practice transformation helped you prepare for value-based payments?

Thank you for your engagement with GCACH!
a. Part of the backbone is that the metrics are in a central EHR and it gives access to data so providers can look at the care being given and improve quality. Barrier now is that nobody has paid for it. The support of GCACH with the practice transformation navigators and IT support has really made practice transformation accessible to our system for the first time ever. His predecessor used to co-chair the WA Family Practice Physician’s Workgroup and this organization has had a long focus on practice transformation (since 2004), which hasn’t been obtainable until now.

3. How do you pay for care coordination?
   a. He will let us know when they do. They treat it as a cost of doing business. They have to take care of their patients and make sure they get to where they need to be. They have to make sure that care is available. Care coordination is a challenge and a work in progress.

Questions and comments included:
- Roadmap from HCA has 2021 with 90% of transactions be VBP based and if that is a reasonable goal.
  o Dr. Shannon—they are comfortable based on the natures of the contracts they take.
  o Shane—any methods for VBP is through partnership. It is an indirect value-based agreement that has a shared savings component. He noted there aren’t any payors lined up to sign VBP with Columbia County Health System, and if they do they have the challenge with their serving multiple counties (need service agreements for both areas). This is a huge concern for him.
  o Dr. Martin—if they can get to 90% VBP and it appropriately rewards matters of quality, he believes it is realistic. However, the devil is in the details. HMOs were a great idea but ended up adding to cost not saving money. It has got to capture benefits that we approve for better care if we are going to pay for less care. It’s the provision of unnecessary care and how we pay for it.
  o Penny—at this point, she is just sitting and waiting for payors to come to her but feels they are nowhere near ready. It’s costly to provide less care at high quality, and how are those costs going to be covered. Currently they are not, so they are often providing services for free.
- According to Dr. Martin, Health Commons has supported care coordination and is used routinely at KVH, but highlighted the need for work on role-based access control.
- Long lag in data reporting (feedback loop for patients, payors, and providers) and how it might become shorter.
  o Dr. Martin noted that it is because it grounded in claims-based data. He provides a service, submits a bill, it gets processed, hopefully he gets a check, data goes into repository (payor that took care of the claim) compiles the data, allow adequate time for claims from last quarter to clear. On the other hand, if based
analysis on care that providers are giving in EHR, that would provide access to near real-time data. Challenge is that the payors only want data on their lives, not all lives providers care for. Quite frankly, he is not interested in improving the lives of a given payor, it should be payor agnostic. He is interested in data about the quality of care his providers deliver. This is why he has a quality department so that he can real-time data from his own system as he can’t rely on data the policy is based on.

- Dr. Shannon added the challenge with outdated gap analysis and negative feedback. He highlighted the biggest challenges with getting everything into claims form no matter what is in EHR and explain why, and then closing time gap so providers don’t rework what is already been done.

- Shane learned early on that relying on claims data and ACO data would not be effective—it’s reviewing history that is beyond the time of making effective pivot or changes. They built their own internal analytics team. He also echoes reporting things independently based on the payor rather than an aggregate—why should Medicare beneficiaries have different services than Medicaid and commercial beneficiaries? They really have streamlined practice to provide same level of care across all payor mixes and then have their analytics team deal with frustration of breaking out who needs what piece of data on how they cared for that patient. Lastly, he noted that in a small, rural area—anytime they are aggregated together, they get nonsensical reports that are not relevant or meaningful to them.

No further comments or questions.

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<thead>
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<th>Managed Care Organizations (MCO) Panel</th>
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<td>The Managed Care Organizations (MCO) panel included Amerigroup, Community Health Plan of Washington, Coordinated Care, and Molina Healthcare.</td>
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Prior to the convening, the MCOs were provided the following questions:

1. What is preventing contracting with small rural or BH providers?
2. What do you see the ACH’s role for VBP?
3. How do the MCO reconcile their care coordination vs the state care coordination program? Will the MCOs pay for care coordination?
4. How do PCPs help compensate the BH provider for contributing to their achievement of certain metrics?

Caitlin Safford of Amerigroup responded first. She started by acknowledging the honesty from the provider panel and their status on the VBP. She recognized the frustration with the data lag and shared that most of their metrics they are held to are claims based and not really look at the care of the patient as much as we hope they could (a frustration they have and is a national problem):

1. What is preventing contracting with small rural or BH providers?
• They do not have any problem with contracting with small or BH providers, it is just the manner of that model is variable. The kind of model they may have with a PCP might look different than a BH provider. In particular in the GC region, they are the smallest MCO and they do not have many members. It is not safe from a risk standpoint for smaller providers to take on any risk for such a small population because the incentive varies widely. They are interested in testing how they help providers move along the spectrum of integrated care (what they are looking forward to in 2021 and 2022). What its like to build incentives to both BH provider and PCPs regardless of size. Then, identify how to measure and validate progress; this might be a great entry point for smaller/BH providers to move into some sort of VBP model and build up the skills needed. She recognized those in GC have done a lot of work to get ready and might progress quickly, so it would be a great test case for Amerigroup while trying to build out model of payment.

2. What do you see the ACH’s role for VBP?
• Support providers in building up the skills, and GCACH is one of the best examples of having done this. Not every ACH focuses on practice transformation and GCACH does it in a consistent way/format for all providers. GCACH makes sure the providers are engaged and needs are met. For them, GCACH is a great representation of what the ACHs would help with.
• Going forward one thing they would have liked to see in financial model for the ACHs, is try to figure out how to get providers used to ISO being the ones to contract with health improvement. If VBP agreement with PCP, and given them a little bit of risk or have significant incentives to improve, they are also incentivized to help mitigate those SDoH aspects that might be affecting their patient’s life and care. What does that mean for them to contract with a CBO to help with that, vs. MCO also contracting with the CBO and trying to make the connections between that provider and CBO. Really need to build up that payment infrastructure for the provider to have those payments.

3. How do the MCO reconcile their care coordination vs the state care coordination program? Will the MCOs pay for care coordination?
• One third of their contract with HCA is for care coordination. They have significant requirements within their administration and Medicaid regulation to do care coordination work with their member population. Amerigroup prefers methods to do this through providers as they know they provide better services on the ground than they can ever do. But they like to help supplement with the resources that they have. They have contracted with providers to provide additional funds to do that case management. They are absolutely willing to do that, it just depends on what model of payment, what is foreseen the money will be used for, how it will be billed, is always conversations they have to have. Depending on the care coordination program through the state, they may be able to contribute something else or if there is a centralized entity they can help

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support is always a potentiality. There has been lots of conversations but not a lot of movement as of yet.

4. How do PCPs help compensate the BH provider for contributing to their achievement of certain metrics?
   - This is what they want to test out in their integration model. What they’ve heard from other regions, when BH agency partnered in some sort of co-location or shared services model with PCP, the PCP gets the incentive for improvement but the BH doesn’t get the same recognition or compensation for work provided. They are trying to find an equitable way to make sure finances are flowing to both agencies. This is going to help with parities. Also, the BH infrastructure in our state is severely underfunded so they want to prop up these agencies to ensure they are an equal partner in integration and serving our most needed services. It is important to them to figure out what this looks like, they don’t know how they will implement in a contract and need some providers to test it out. It is something they are interested in finding out as they move providers along continuum of integration.

Erin Hafer of Community Health Plan of Washington responded:

1. What is preventing contracting with small rural or BH providers?
   - CHPW does have contracts with both types across the state and believe it’s about building a relationship between the MCO and provider. It requires flexibility on what that contract looks like. They support a range of models. It doesn’t mean that all providers are going to want to or be able to engage in a full risk arrangement or total cost of care arrangement, it could be pay-for-performance, gap closures, or other innovative models for specific populations. For example, they are exploring a VBP bundle for individuals experiencing homelessness, a small population but thinking about how to creatively work with provider partners to develop a payment mechanism that is going to allow them to effectively outreach and engage with that population and focus on some of the shared outcomes they’d like to see.
   - The approach, they see this is a partnership between provider and MCO. Work together to align incentives and shared goals—identifying quality improvement areas and priority measures. When engaging in that work, they are looking at focus areas providers already have to avoid administrative burden. She recognized the challenges around tools and data, however they continue to work with their providers to provide tools and as close to real-time data to inform partnership and targeted approach.

2. What do you see the ACH’s role for VBP?
   - Doing a really great job with practice transformation efforts. She noted to continue providing tools to support providers with population health management, measurement-based care, and how to advance integrated care

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partnerships. She also added that the ACH to help providers to elevate their value statements, but ultimately contracting would be between MCOs and providers directly.

3. How do the MCO reconcile their care coordination vs the state care coordination program? Will the MCOs pay for care coordination?
   - Similarly, they have many requirements but want to look at how to work with provider partners to enhance programs already in place—this could mean delegation of care coordination of activities or partnering closely with their care coordination teams.

4. How do PCPs help compensate the BH provider for contributing to their achievement of certain metrics?
   - Part of their work has been looking at range of models they could possibly support, bringing partners together to share data (e.g. large volume of shared patients between PCP site and BH agency, can they work to support shared workflows and develop that value statement to grow that shared potential and savings).

Heidi Nelson and Whitney Howard of Molina Healthcare responded:

1. What is preventing contracting with small rural or BH providers?
   - Heidi first highlighted their program’s collaborative approach. They negotiate models, metrics, and other aspects to align with where providers are and their priorities and level of risk. They are very open to working with small/BH providers and have done that. Most are those models with little risk. They just want to be able to help them with the data they are able to provide.

2. What do you see the ACH’s role for VBP?
   - Help providers understand data and be able to take action based on population health goals and strategies in the community. That is where the ACH is and can continue to help providers.
   - Next, she acknowledged the issue tied to the claims-based data. That is not something as the MCOs they can fix. Together figuring out to we can access real-time data, what’s in the community and how to incorporate that into action—that is something the providers, MCOs, and ACHs can try to do together. Making data that is easy to access and as connected as possible.
   - Help us all address connections to CBOs to address SDoH. That is foundational for members to be successful in their lives. The VBP healthcare information we have is just a part of it, helping strengthen those connections to help support members is a huge role the ACH has and should continue to have.

3. How do the MCO reconcile their care coordination vs the state care coordination program? Will the MCOs pay for care coordination?
   - Their program is based on collaborating, so they provide monthly reports that include cost, quality, and member specific information that supports care

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management. They met with providers on a quarterly basis on minimum to use information to take any needed action. They want this information to be used immediately, so they take feedback on how to make reports more actionable. They are not trying to duplicate what providers are already doing.

4. How do PCPs help compensate the BH provider for contributing to their achievement of certain metrics?
   - They have started VBPs with PCPs, they very much support using the information that they have about how members are seeking care to use as a foundation for PCPs to connect within the community to create new and best practices.
   - Whitney acknowledged Penny’s comment about the MCOs do not appear ready to sit down and work on VBPs, and noted that it is under construction. They are trying to accomplish the same collaborative approach and outcome to provide the right tools and reports, and everything necessary to be successful. They’ve made huge progress and continuing that work. She added that what is preventing contracting with small and BH providers, adding the BH providers is the only component they are looking to solve for in terms of making sure they have sufficient access needed. They’ve adopted models the BHO had as starting point, they’ve been into this for two years now and they are trying to build the models to support growth and support ability to do VBP with existing partnerships. They are doing a lot of work internally and wants the community to know there is quite a bit of work going on.

Edie Dibble of Coordinated Care responded:

1. What is preventing contracting with small rural or BH providers?
   - There is nothing preventing contracting, they contract with all types of providers. That is not a barrier. With the VBP side of it, it does limit the provider and payor to enter into a more risk typed agreement as the membership can be much lower. However, they have a full range of VBP from P4P to full risk and are happy to meet with providers on where they are in that spectrum.

2. What do you see the ACH’s role for VBP?
   - Help building relationship, knowledge of VBP (gap closure, practice transformation), continuing with collaboration and communication.

3. How do the MCO reconcile their care coordination vs the state care coordination program? Will the MCOs pay for care coordination?
   - Both providers and payors have different case management programs. It’s about working together on that communication and collaboration, and avoiding duplication of programs. She noted a streamlined partnership and being transparent.

4. How do PCPs help compensate the BH provider for contributing to their achievement of certain metrics?
- They have piloted some BH VBP arrangements in 2020 and learned a lot. It is different from a PH side as it is easier to attribute members and see the cost of care, quality of care, etc. BH is different as patients can see multiple BH providers at the same time. They did find improvements for 2021 program going forward. They do look to community providers to tell them where they are at in that spectrum and share how they would like to move forward. They have some agreements with non-PCP providers they’ve entered into as trials. She described the ability to modify certain reporting as they go. They’ve been creative in meeting provider needs as they’ve done these ad-hoc pilots.

Questions/comments included:
- If we believe that RWJ causality on the logic model on what is behind good care, we know that clinical care is only one part of that. In the upstream factors, the social and economic determinants of health are even larger. Where do the activities to address those social economic determinants of health fall into your organization’s purview?
  - Caitlin from Amerigroup: They are responsible for their members wellbeing (social and emotional). They are doing what they can do to connect more services to their members or support CBOs that serve the Medicaid population (through grants). They are interested in understanding how they can help providers. She mentioned focus around coordinating better with jail and jail transitions (when detainees leave the system and getting reentered into the system).
  - Erin from CHPW added that this is an area where she sees opportunity for VBP. She noted investments that support local resources such as homeless respite, harm reduction, and other key pieces. She sees it as a vehicle to help support the expansion of additional services that support overall wellness.
  - Whitney from Molina: They screen all members for social needs in initial health screening. As members are referred for case management, they are interested in better coordinating with other community-based care coordinators. How can they tie in some of the work that others are doing as well?
  - Patrick asked if this is something for the ACHs to assist with in terms of creating those connections and the MCOs agreed. Caitlin added that they all have their own community-based resources portal along with 211 when helping folks get access to services. There are always more resources to be found and that would be a great place for the ACHs to contribute. The more the MCOs more about the more they can help their members. Patrick highlighted the GCACH’s local health improvement networks and how that may help as MCOs move down that path.
- Question around getting a larger picture of the data from the MCOs since they have broader visibility.
  - Molina noted that the reports shared on a monthly basis include all information at a drill down level except actual payment information. They feel it is important to give providers that picture of all care being delivered. It is something they use...
as a basis with working providers to identify a high cost member and create solutions. It is foundational information used and shared with providers.

- Coordinated Care agreed with Molina with a few exceptions—they’ve had providers reach out for data on patients that aren’t necessarily theirs but are paying some incentive for providers. They do restrict data elements they’d share for members that are not for that provider.

- Note to contact MCO representative for access to providers patient list. This usually involves logging into a portal. For VBP providers, they are provided with a roster of their paneled members only.

- Carol from GCACH noted conversation around care coordination, the clinical community linkages. It is really up to HCA and their contracting with the MCOs to determine what that care coordination effort should look like. She asked HCA for feedback on future contracting after hearing from the ACHs the past couple years on how to address this problem. HCA was no longer on the line to comment. Carol asked the MCOs for comment on the steps needed to improve care coordination for the Medicaid population.

  - Erin from CHPW commented that they’ve had a lot of conversations around this at the joint MCO, HCA, ACH table. It is complicated and she goes back to the review and alignment of requirements from the state’s perspective on what they are requiring related to care coordination of the MCOs for the Medicaid population, whether that is in the MCO contracts or ACH contracts. Doing that review and callout of areas of duplication or alignment continues to seem like a good place to start.

- A question posed by the audience: None of the core measures are designed to measure SDoH as much as we say, until they have dollars attached they won’t have the attention required, including care coordination that is required to address SDoH.

  - Erin from CHPW responded that one of their hopes would have been more present in the demonstration. She noted the work done a part of the Cross Systems Measures Workgroup thinks looking back at the work created would be a good exercise.

Carol of GCACH thanked the participants for the conversation today. She also highlighted the reason behind the demonstration, which is to elevate what works and what doesn’t. We appreciate the relationship with the MCOs as we strive to get these P4P measures that will be delivering dollars to providers, it is becoming more apparent that GCACH needs to work with the MCOs. This is a goal to work with each MCO in 2021 to see how GCACH can do a better job of preparing our providers for VBP contracts. Patrick thanked the speakers for their time and remarks.

No further comments or questions.

**ADJOURNMENT**

*Thank you for your engagement with GCACH!*
Adjournment

Meeting adjourned at 11:25am. Minutes taken by Chelsea Chapman.

Find the meeting recording here: https://youtu.be/lG6N8FkqtKk.

Thank you for your engagement with GCACH!
### Table 1: Incentive Funds earned

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<td>Project 2C</td>
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### Table 2: Interest accrued for funds in FE portal

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### Table 3: Incentive funds distributed, by use category

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Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 26, 2022 to accompany the seventh Semi-Annual Report submission for the reporting period October 1 to December 31, 2021.