Healthier WASHINGTON

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FAQs

Medicaid Transformation through Accountable Communities of Health: Initiative 1

*UPDATED 07/31/17: See questions marked as "**New**"*

For questions about terms, refer to the **Demonstration Glossary**.

Transformation project planning

1. What is the Project Plan?

ACHs are required to submit project plans that describe the work ACHs and their partnering providers will do under the Medicaid Transformation Demonstration (Demonstration). Project plans will contain one section focused on organization, and a second section focused on projects. Plans must be developed in collaboration with community partners, be responsive to community-specific needs, and advance the objectives of the Demonstration. To be eligible to receive Medicaid transformation incentive payments, ACH project plans must receive approval. ACHs will submit completed project plans by November 16, 2017.

2. What is the Project Toolkit?

The Project Toolkit provides details about projects that are eligible for funding under Initiative 1 of the Demonstration. Initiative 1, Transformation through Accountable Communities of Health, focuses on health improvement projects that transform the Medicaid delivery system to serve the whole person, and use resources more wisely. The Project Toolkit was developed with state and regional health priorities in mind, including input from cross-sector experts and stakeholders. The Project Toolkit outlines evidence-based approaches, milestones, progress measures, timelines, and outcome metrics. The final toolkit was released in June 2017, following federal approval.

3. Can ACHs incorporate elements from one project into another and earn incentives for both projects?

Yes, ACHs are strongly encouraged to coordinate the portfolio of projects they submit to leverage resources and align objectives across projects. ACHs are only eligible to receive funding for projects that are formally submitted, approved, and implemented as part of a Project Plan. ACHs will earn performance-based funding based on progress and outcome measures that are tracked at a project level.

4. When will the independent assessor's Project Plan scoring methodology be released publicly, and will ACHs have an opportunity to discuss their assessment if there are concerns?

HCA anticipates releasing the Project Plan scoring process and methodology in late summer 2017. Scored applications will be available in January or February 2018. While there will not be a formal appeals process, HCA will work with ACHs to address questions or concerns regarding their submissions and scores.

5. What happens if an ACH does not submit plans for the Demonstration's required projects?

ACHs are required to select and implement Project 2A - Bi-Directional Integration of Physical and Behavioral Health through Care Transformation, as well as Project 3A - Addressing the Opioid Use Public Health Crisis. They are required to include at least two additional projects of their choice. ACHs that do not include the required projects in their project plans will not receive a passing score.

6. Are the evidence-based approaches that are identified under each project required or recommended?

One or more evidence-based approaches are identified to serve as a menu of interventions for each project. ACHs have multiple pathways they may pursue, which include:

- Selecting one evidence-based approach for the entire project
- Combining evidence-based approaches for the entire project
- Applying different evidence-based approaches for different target populations/geographies for the project

For Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation, ACHs must implement two approaches as described in the Project Toolkit.

7. Is there a required approach to accomplishing Project 2B: Community-based Care Coordination? Is the project itself required?

Pathways HUB was selected as the designated model under Project 2B: Community-based Care Coordination. The selection was based on feedback from the original project idea solicitation. It was recommended as an evidence-based model that had shown success in other states. In order to balance the focus on a single approach, Project 2B was made optional.

If appropriate, alternative approaches to care coordination may be undertaken by ACHs as a component of other projects in their portfolios.

8. Can ACHs implement multiple evidence-based approaches within a project?

Yes. To effectively drive systems improvement in a region, ACHs have multiple options, which include implementing multiple evidence-based approaches within a project, or different evidence-based approaches with different target

populations within a project. Generally, a Project Plan will be scored based on the strength of the proposed approach and its potential for advancing the project's outcome metrics and overall Demonstration goals.

9. Is the community paramedicine model just a framework that needs to be used, or is that specific model required?

Community paramedicine is one of the evidence-based diversion frameworks highlighted in Projects 2D and 3D. While ACHs are not required to implement a specific community paramedicine framework, HCA has provided resources on existing frameworks, models, and evidence-based practices from the University of California, Davis, the Community Paramedic Program, Health Resources and Services Administration, and the Rural Health Information Hub.

10. Can HCA provide guidance on the number of providers that should be involved in project implementation?

During the project selection and planning phase, ACHs will determine how many and what types of providers and other stakeholders will be needed for successful project implementation. ACHs should consider the size of the target population, the type of clinical models of care, the capacity of ACH providers to adopt new models of care, and staffing ratios based on evidence and best practices. At a minimum, HCA expects ACHs to include providers that serve a significant portion of the Medicaid population, and represent a broad spectrum of care and related social services that are critical to improving how care is delivered and paid for.

11. Does HCA expect ACHs to submit a Project Plan that is specific to the Demonstration, or is the expectation that the Project Plan describes community needs, projects, and priorities that are broader than the Demonstration?

There is Demonstration-specific content related to projects and targets, but the ACH's community needs, priorities, and existing efforts are an important part of the Project Plan. The first part of the Project Plan will require ACHs to describe the regional context and vision, including the Theory of Action. This gives each ACH the opportunity to identify community needs, and explore alignment between the Demonstration and the broader vision and efforts to address regional priorities. The second part of the Project Plan requires ACHs to narrow the focus to Demonstration-specific requirements related to the Project Toolkit and Medicaid transformation strategies.

12. How will the Practice Transformation Support Hub support providers who are involved in Demonstration projects?

The Practice Transformation Support Hub (Hub) is a program of Healthier Washington. It is managed by the Washington State Department of Health. The Hub delivers tools, technical assistance, training and on-site coaching and support to providers in small to medium-sized physical and behavioral health provider practices. The Hub's goals are to help physical and behavioral health practices 1) focus on whole-person care by achieving bi-directional physical and behavioral health integration, 2) move from volume-based payments to value-based care, and 3) improve population health by building connections to community resources. The Hub provides tools, training, and hands-on technical assistance to support providers in coordinating care, promoting community linkages, and transitioning to value-based payment models.

New: 13. What opportunities will ACHs have after DY1 to adjust projects and what are the implications for future funding?

In accordance with Section V of the DSRIP Planning Protocol, HCA will consider modifications to an ACH's Project Plan on a case-by-case basis no more than twice a year. Modifications to an ACH's approach to interventions within a project may be required due to unique circumstances or developments outside of an ACH's control. However, modifications to decrease scope of a project may result in a decrease in the valuation of potential earnable funds. HCA does not anticipate permitting modifications that would lower expectations for performance due to greater than expected difficulty in meeting project milestones. In the rare case that removal of a planned project intervention is required, such modification may result in forfeiture of funding for that project, at HCA discretion. Unearned funds as a result of a decrease in the scope of a project will be directed to the Reinvestment pool and earned in accordance with the DSRIP Funding and Mechanics Protocol.

New: 14. The Project Plan template requires a list of participating organizations. Must this list be final for the November 16 submission? If not, is there a mechanism to propose updates to the list?

The project plan requires a list of identified providers. As stated in the supplement workbook, this can be a preliminary list and is subject to further refinement through the end of Demonstration Year 2. The initial list will be used to register provides within the Financial Executor's portal, but there will be a process to register additional partnering providers over time.

New: 15. What level of detail should ACHs provide in their Project Plans regarding sub-contracted providers? Should ACHs include sub-contracted providers in their list of partnering providers?

ACHs should include in their project plan supplemental workbook a list of all partnering providers who have or are expected to enter into a direct agreement with the ACH to participate in the Demonstration. This list essentially represents the starter list for the ACHs direct partnering providers who will potentially earn DSRIP incentive payments disbursed by the Financial Executor. Sub-contracted entities supporting partnering providers are not required to enter into a direct agreement with the ACH. That being said, the narrative portion of the project plan template asks ACHs to describe engagement with partnering providers and the additional context regarding sub-contracting expectations and rationale could be beneficial within the narrative.

New: 16. When will HCA release information about ACH implementation plans for 2018?

HCA anticipates releasing further information and requirements for implementation plans in late 2017.

Accountable Community of Health governance

17. Will HCA require ACH board meetings to be open to the public?

Yes, HCA requires that all decision-making body (board) meetings be public when decisions related to the Delivery System Reform Incentive Payment (DSRIP) program are made. Such decisions include project selection, project design and implementation, partner selection, and approval of incentive fund allocation. ACH board meetings may have closed executive sessions when non-Demonstration decisions are made, or to address sensitive issues such as personnel (e.g., hiring, compensation) and contract negotiations.

18. Can the requirement that ACHs include representation from local public health jurisdictions in its decision-making body be fulfilled by someone who oversees the public health agency or represents another local agency (e.g., criminal justice)?

HCA does not intend to prescribe the specific composition of ACH decision-making bodies beyond the minimum composition and participation expectations provided in the Special Terms and Conditions (STC). The expectations provided by the state are intended to reflect the goals of balanced participation and diverse perspectives among decision-making body members. It is up to the ACH to determine the membership that will meet the intent for balanced participation and diverse perspectives.

New: 19. How should ACHs be thinking about sustainability for projects and the ACH entity beyond the Demonstration period?

ACHs must describe how projects can be sustained beyond the Demonstration period in their Phase II certification submissions and Project Plan applications. HCA envisions that the projects successfully implemented in each region will ultimately become part of standard care practices and the Medicaid program overall. ACH sustainability plans may optionally describe whether the ACH will play a role in sustaining projects over the long-term even though they will no longer have a role in administering project design and incentive payments.

Funds flow and value-based payment

20. What information is available related to DSRIP funds flow?

Information available as of early May 2017 on DSRIP funds flow has been summarized in a "Funds Flow 101" webinar. The bulk of this information is drawn from a working draft Funding and Mechanics Protocol. The final Funding and Mechanics Protocol was approved by the Centers for Medicare and Medicaid Services (CMS) in June 2017. All content in the "Funds Flow 101" webinar, related FAQs, and this document are subject to change pending final program design decisions.

21. Is HCA establishing any timelines for when incentive dollars must be distributed after they are earned by an ACH?

ACHs may decide the timing for disbursing funds. HCA expects that, because incentive funds support partnering providers in carrying out the work of the Demonstration, that they should be disbursed within a reasonable time frame.

In order to ensure consistent management of and accounting for the distribution of earned *DSRIP* incentive funds, the state has selected, through a procurement process, a financial executor. The financial executor will be responsible for the distribution of funds to ACHs and their *partnering providers*. (See definition of financial executor, below.)

22. Are there requirements regarding incentive funds distribution to providers and community partners, or is this at the discretion of the ACHs? Do the ACHs have discretion to decide the amount of funds dedicated to administrative overhead?

Decisions regarding DSRIP funds allocation must comply with the STCs and protocols of the Demonstration. Each ACH board or decision-making body will determine a funding distribution approach and timing for funds earned by its region. There are no specific requirements related to distribution among partnering providers, which include providers and community-based organizations. Similarly, there will be no specific guidance related to the level of funding directed to ACHs to support their operations. On a semi-annual basis, ACHs will report actual fund distribution. DSRIP funding distribution decisions will be made public.

23. When will HCA provide information on the total number of Medicaid beneficiaries residing within each ACH region?

The number of Medicaid beneficiaries residing within an ACH boundary is a factor for project incentive funding allocation. Final population count for the purposes of project incentive funding calculations will be based on HCA's client-by-month file as of November 2017. Relative Medicaid client count estimates can be found in the "Funds Flow 101" webinar. These were based on the 2016 Medicaid eligibility report.

24. Who are the members of the Medicaid Value-based Payment (MVP) Action Team and what is its role in the Demonstration?

The MVP Action Team is made up of state, regional, and local stakeholders and tribal government partners representing MCOs, hospitals, clinics, Indian health care providers, community-based organizations, public health providers, and others. HCA has posted the MVP Action Team roster on its website.

HCA formed the MVP Action Team in April 2017 to support the Demonstration. The group serves as a learning collaborative for MCOs, providers and ACHs as they implement value-based strategies. The MVP Action Team charter on is posted on HCA's website.

25. Will HCA release a survey about value-based purchasing? If so, how is this different from the request for information (RFI) released in 2016? How will the MVP Action Team ensure participation from providers?

Yes, HCA will conduct two annual value-based purchasing (VBP) surveys, one for Managed Care Organizations (MCO) and commercial health plans, and another for providers, both of which differ from prior HCA surveys.

- The purpose of the provider survey is to collect information on provider adoption of and readiness for VBP. HCA's primary goal for the provider survey is to track progress toward statewide VBP goals. In order to

ensure responses from a significant number of providers across provider types, the state is exploring ways to reward provider participation in the survey and expects to finalize an approach in the coming weeks.

- The purpose of the MCO and commercial health plan surveys is to collect information on payments to providers made through VBP arrangements statewide, and to collect provider perspectives on barriers and enablers of VBP adoption.
  - The MCO survey will collect information to inform the analysis of VBP attainment statewide, and by region, according to ACH boundaries. HCA's goal for this year's survey is to establish baseline measures of VBP attainment. This will serve two purposes: 1.) to meet the requirement through the state's MCO contract withhold arrangement, and 2.) to assess a region's eligibility for VBP incentives under the Demonstration.

26. What is the ACH's role in overseeing MCO VBP efforts?

By contractual agreement, MCOs must implement VBP arrangements with network providers. The ACHs do not oversee MCO VBP-related efforts. ACHs provide an opportunity to support regional VBP efforts through project design and implementation.

27. What is the financial executor responsible for?

The financial executor is a state-selected vendor that provides management and accounting for Demonstration project incentive funds. The financial executor will be responsible for distributing incentive dollars to ACHs and their partnering providers. DSRIP funds will not flow through ACHs, with the exception of design funds. DSRIP funds will go from HCA to the financial executor, and from the financial executor to partnering providers, based on allocation directions from the ACHs. The financial executor, Public Consulting Group, was selected in May 2017.

28. How do the integration incentives relate to behavioral health organization (BHO) reserve funds? Should these be balanced against each other in considering when to pursue integration?

No. The integration incentives and BHO reserves are not an "either/or" situation. Integration incentives are available to regions in which all counties sign a letter of intent (LOI) by September 15, 2017, and/or implement integrated managed care by January 2019. These funds may be used to support partnering providers as they transition to integrated managed care and related care models.

ACHs and their boards are responsible for making decisions about allocating integration incentive funds, whereas the use of BHO reserve funds lies with the BHOs. BHOs have the authority to spend down their reserves to the minimum required threshold. BHO inpatient and operating reserves may be funded through two sources: Medicaid funds, or state-only funds. Medicaid reserve funds must be spent on Medicaid services. State-only funds must be spent according to the BHO state-only contract. No matter when a region implements physical and behavioral health integration, unused BHO reserve funds will revert to the State General Fund and the federal government, as required by law.

29. **If the integration incentives are earned, do those funds go to the counties or to the ACHs?**

As with other DSRIP funds, integration incentives are dispersed by the financial executor, according to an allocation approach defined by the ACHs. Although counties are key partners in earning integration incentives (for example, for a region to receive Phase 1 integration incentives, all counties must submit binding LOIs), they are not necessarily the recipients of that funding. County governments are one of a number of potential partnering providers that could receive earned integration incentives. Another example of how these funds may be used is to support providers as they interface with integrated managed care entities.

30. **Are ACHs restricted in how they leverage multiple funding streams to support the same project?**

No. ACHs may have funding sources in addition to their DSRIP funds. These funding sources may build on each other, however, investments should not duplicate or supplant other available funding sources.

New: **31. If an ACH region is not pursing mid-adopter status, will it negatively impact the ACHs Project Plan score?**

All regions are required to implement fully integrated managed care by 2020. However, the timing of integration as described in the Project Plan submission will not negatively affect Project Plan scores. ACHs must state the anticipated timing of integration in their Project Plan submissions to support HCA in collecting information on the regional plan for integration.

ACHs that choose to become mid-adopters of fully integrated managed care will have access to additional integration incentive funds. These funds are administered separately from project incentive funds. For more information, visit the Healthier Washington website.

32. **When will ACHs receive additional budgeting technical assistance from the DSRIP support team?**

The DSRIP support team will provide a Project Pool Calculator as funding information becomes available. This calculator will estimate adjustments to DY1 incentive payments based on anticipated Project Plan score, and to DY2-DY5 incentive payments based on anticipated performance on progress and outcome measures. In addition, further versions may include a funds flow template to enable modeling of trade-offs in incentive distribution. These additional features will be incorporated and released as soon as possible after related program design details are finalized within HCA and via negotiations with CMS.

33. **What is the definition of "partnering providers" as it relates to VBP incentives?**

DSRIP funds, including VBP incentives, may be distributed to ACHs and any of their partnering providers. Partnering providers may include organizations such as clinical providers, community-based organizations, county governments, and/or tribal governments and providers. ACH regions may identify relevant partnering providers for VBP incentive fund distribution based on which entities support regional Medicaid populations and transformation

projects. While MCOs are critical project partners, they are only eligible for "challenge pool" VBP incentive funds, not the reinvestment pool or integration incentives provided to the ACH regions.

New: 34. Will HCA require ACHs to sign a contract to receive incentive funds?

Yes, all nine ACHs have a contractual relationship with the HCA for the duration of the demonstration. This was required before any funds were distributed to the ACHs.

New: 35. Will ACHs need to have a formal agreement with partnering providers that do not receive DSRIP funding?

In accordance with STC #29, it is expected that ACHs will establish a formal agreement with partnering providers that commit to participating in transformation projects with the intent of earning DSRIP incentives. This does not mean that every partnering provider that has an agreement with the ACH is guaranteed to earn incentives payments. It is at the discretion of the ACH to determine whether sub-contracted entities supporting partnering providers must enter into a direct agreement with the ACH.

New: 36. What is the timing for distribution of DY1 project incentive funds from HCA to the Financial Executor?

DY 1 project incentive funds are expected to be distributed to the Financial Executor in early 2018, pending completion of the project plan scoring process.

Performance measurement

37. Will the state be held accountable for statewide performance?

Yes. The state will be accountable for a set of statewide measures, with a percent of overall DSRIP funding tied to statewide performance on those measures, per STC #44. Further details on statewide DSRIP accountability can be found in the Funding and Mechanics Protocol.

New: 38. Are ACHs accountable for performance in their region for all statewide accountability metrics?

The ten statewide accountability metrics are those by which CMS will hold the state accountable beginning in demonstration Year 3, based on statewide performance. A percent of overall DSRIP (Initiative 1) funding is tied to statewide performance on those measures, per STC #44. ACHs are accountable for the list of metrics associated with each project they select, some of which overlap with the statewide list. However, a subset of the statewide metrics will be used as the basis for distribution of unearned Project Incentives to ACHs via DSRIP High Performance Incentives.

New: 39. How will ACH-level performance be assessed?

Each ACH's performance will be assessed based on reporting and performance on defined progress and outcome metrics tied to the selected projects. ACHs are accountable for the entire Medicaid population in their region, regardless of which providers participate or the scope of project design; performance on outcome measures will be measured based on the full relevant attributed Medicaid population for the region. ACH performance on metrics designated as "pay-for-performance" (P4P) will be assessed on an annual basis, while "pay-for-reporting" (P4R) will be assessed semi-annually. P4P outcome performance will be assessed using one of two methodologies: 1) gap to goal reduction, or 2) improvement over self. Further development of each method is underway.

40. What will be the baseline year for Demonstration outcome metrics? When will the ACHs receive baseline data for incentive and monitoring measures?

Baseline performance will be assessed using data from DY 1, or calendar year 2017. Regional baseline data, as well as improvement targets for performance metrics, will be produced and distributed in late summer 2018, when the administrative data is fully mature.

The state will provide a series of interim data products to ACHs throughout 2017 to support project selection, planning, and design. These data products will complement regional project planning efforts.

New: 41. Are ACHs accountable for entire list of metrics for a given project? Or is there flexibility in the specific performance metrics within a given project?

If an ACH selects a project, they will be assessed against all performance metrics listed for that project, regardless of the region's specific project design. The "Project Metrics" section for each project in the Project Toolkit outlines the metrics for each project, along with frequency of assessment and whether reporting responsibility lies with ACHs or HCA. While P4R starts in DY1, P4P accountability does not start until DY 3, to account for detailed project implementation planning and start up in DY 2. See the CMS-approved Project Toolkit and Project Metrics Appendix for more details.

New: 42. In the "Project Metrics" table within each project description, what does the term "P4P-State Reported" mean?

"P4P" is shorthand for "Pay for performance." "State-Reported" indicates that the state will compile and analyze the data for the relevant P4P metrics for each ACH, as opposed to that responsibility falling to the ACH. All P4P metrics will be state reported. In contrast, P4R metrics are ACH-Reported as they will be reported by the ACHs, on a semi-annual or annual basis (depending on the metric).

New: 43. Why was the distinction between system wide and project-level metrics removed from the final toolkit?

In earlier versions of the Project Toolkit, some measures were labeled "system wide," indicating that they would apply to all ACHs that selected a project, regardless of target population or selected intervention strategies, while others were labeled "project-level," indicating that they would only be applied if applicable based on the ACH's implementation strategies. Based on further program design and negotiation with CMS, this distinction was removed and the overall list of measures pared down to standardize and simplify the Project Toolkit. Now, each ACH will be held accountable for the single list of measures for each of their selected projects.

ACHs are strongly encouraged to consider their approach to integrating strategies across their projects to ensure that they will be successful across all metrics for their selected projects.

New: 44. It appears the toolkit metrics changed from earlier versions. Why were some metrics excluded from the final toolkit?

The revisions to the Project Toolkit were primarily in response to CMS comments seeking to clarify and simplify how ACH performance will be measured and how that performance will result in Project Incentive payment adjustments. Earlier drafts of the Project Toolkit included several metrics that were intended to be compiled and monitored by the state, but were not linked to Incentive payment adjustments for ACHs. These were previously labeled as P4R metrics, but held no actual reporting requirement for ACHs; these metrics were removed to more clearly identify those measures for which ACHs will be held accountable on a P4R and P4P basis. The state may still compile and consider additional metrics beyond those listed in the Toolkit for demonstration monitoring purposes. In addition, refinements were made to the P4R / P4P transition timing for some metrics and the overall number of metrics for which ACHs will be held accountable was streamlined to optimize the accountability framework. Remaining metrics included are those deemed most appropriate, feasible and reliable to measure regional-level performance; most relevant to the project; and most closely aligned with broader demonstration objectives.

New: 45. How will an ACH earn incentive dollars for metrics that are associated with multiple projects in their approved portfolio of projects?

Previous versions of the DSRIP Planning Protocol included a metric exclusivity element that would have assigned each metric to only one project; that component was removed from the final Protocol based on further consideration to enhance clarity and operational feasibility of the accountability framework. As a result, Project Incentive funds will be adjusted based on ACH performance on each metric for each selected project, regardless of whether the metrics are also associated with other selected projects. In other words, the ACH will be paid for performance and/or reporting on a metric more than once, if it appears under multiple selected projects in its approved Project Plans.

New: 46. Does each metric count for the same Achievement Value? Or, do some metrics have a higher weight associated with the earnable Achievement Values relative to other metrics in the project-specific list than others?

The full details of the Achievement Value methodology are still under development, including metric weighting. As the details of the Achievement Value methodology are further designed, a close look at metric composition within each project will be necessary to ensure balance and appropriate distribution of weighting across metrics, their sub-parts (i.e., age groups), and P4R / P4P designation.

New: 47. Are ACHs in charge of calculating the required performance metrics in the toolkit?

No. ACHs are not responsible for calculating their outcome measure results. The state (HCA, DOH and DSHS) and independent contractors will be responsible for the compilation, production, validation and reporting of the P4P outcome metrics in the Project Toolkit. Further details about the measurement process and metric specifications will

be forthcoming in DY 1. ACHs are accountable for compiling and reporting on all metrics labeled as "ACH-Reported" in the Project Toolkit, including all progress metrics and any identified P4R outcome metrics (i.e., depression screening).

New: 48. Why is there greater flexibility in the metrics for "Project 3B: Reproductive and Maternal/Child Health" compared to the other projects?

The final metrics list in the Project Toolkit includes all three Contraceptive Care access measures (LARC, most & moderately effective methods, and postpartum), but requires improvement in only one of the three to secure an AV for the metrics. This approach is intended to promote contraceptive care as a core strategy in the project, while providing regional flexibility and avoiding the unintended consequence of promoting one method of contraception or target population over another. Further development of the method for setting improvement targets and calculating AV(s) for the contraceptive measures is underway and additional detail forthcoming.

Clinical capacity

49. What are HCA's expectations with regard to clinician engagement? What types of providers and support staff should ACHs be targeting with their engagement efforts?

Engagement of clinicians is critical to the success of Medicaid transformation. Effective transformation project planning and deployment will be informed by clinical expertise and an understanding of clinical provider resource needs and capacity. At a minimum, primary care, behavioral health, and hospital/health system providers must be represented on the ACH decision-making body. On a regular and ongoing basis, HCA also expects ACHs to engage with a diverse set of providers who reflect a broad spectrum of care and different geographies. ACHs may engage providers in a variety of forums, including committees, workgroups, and open meetings. They should call upon local and state clinical provider organizations to support engagement efforts. ACHs must describe and demonstrate clinical engagement to achieve certification and to submit a successful Project Plan. Types of providers and support staff engaged by the ACHs will ultimately depend on the types of projects selected, the size and distribution of each project's target population, the capacity and geographic distribution of providers, the clinical intervention model adopted and used for each project, and evidence/best practices adopted by the ACHs.

Stakeholder engagement

50. How do you become a partnering provider in the Demonstration?

The best way to get involved as a partnering provider is to stay connected to the ACH in your region. There is no required registration process with HCA, although there will be additional steps to finalize agreements and arrange for payments after project plans are developed.

Each ACH is going through a process to engage partners and select projects over the next couple of months. Following the selection process, there will be additional work to design the projects and discuss specific needs and

opportunities for partnering providers to participate. The Project Plan is due on November 16, 2017. This is the formal mechanism for ACHs to initially identify participating partners, budget detail, and projects.

51. Does HCA have expectations and/or requirements for how ACHs and MCOs should work together?

ACHs should engage MCOs in the design and implementation of Demonstration projects and support providers in preparing to participate in VBP arrangements, such as through developing workforce capacity, clinical infrastructure, and evidence-based care models. MCOs are expected to serve in a leadership supportive capacity in every ACH. In addition, MCOs should:

- Implement VBP arrangements with network providers, in alignment with the state's VBP targets, and report on those VBP arrangements in HCA's annual VBP survey of MCOs
- Ensure payment models evolve to sustain new models of care delivery and population health management, during and beyond the five-year Demonstration

Data strategy

52. Will ACHs be required to comply with privacy/security requirements for data sharing with the state?

Yes. A Data Share Agreement (DSA) will be expected for all regions, and data requests will be handled through data request forms under the DSA. Questions related to the DSA should be directed to Karen Jensen, Healthier Washington Data Integration Manager [karen.jensen@hca.wa.gov].

53. Is there a model by which ACHs (or a business associate) can receive member-level, identified data (e.g., Category 4) from HCA?

All client-level data requests will be reviewed on a case-by case basis. Requests should be directed to Karen Jensen, Healthier Washington Data Integration Manager [karen.jensen@hca.wa.gov].

54. Is the Starter Kit of Databooks only going to be a one-time resource? Is HCA considering any potential vehicles for updating/providing this information in the future?

Under the Demonstration, ACHs are expected to take a data-driven assessment of regional health needs to identify disparities in care and significant gaps in care, health, and social outcomes in order to inform project selection, implementation, and design. The effort to collect regional health needs information includes data provided by the state, as well as regional and local-level data collection based on existing assessments (community, hospital), and collaboration with providers, stakeholders, and partners.

In March and April 2017, HCA compiled information from multiple sources to provide ACHs with a starter kit of foundational regional health data. This was developed to provide ACHs with preliminary information to begin their regional health needs analysis. The initial Databooks can be used to help identify potential gaps in care

or variation in outcomes that ACHs can then further investigate to understand their region's greatest health needs and to begin to think through Demonstration project selections.

Although HCA does not plan to update the starter kit of Databooks that were delivered to ACHs in spring 2017, HCA is currently developing a roadmap describing additional data elements that will be available to ACHs to support project selection, planning, and implementation. Questions and specific requests related to the state-provided data products or other forthcoming data deliverables should be submitted to Kirsta Glenn, AIM Director [kirsta.glenn@hca.wa.gov].

55. **Will HCA provide data to ACHs on current care volumes by billing provider, both in terms of unique clients and total claims, with the ability to examine by service type (e.g., emergency department vs. primary care)?**

HCA's data team, Analytics, Interoperability and Measurement (AIM), provided data to ACHs describing care volume, segmented by billing provider and by servicing provider. ACH specific data was provided. This information included both the number of services provided and the number of unique claimants. It was further grouped by major diagnostic and risk groups.

New: 56. What data will HCA be using to measure performance against the P4P measures? Will the data be provided in real-time or less frequently (e.g., 6 month intervals)?

As clarified in the recently released updated Project Toolkit, all Project Incentive P4P measures will be based on data collected by the State and compiled on an annual basis. In contrast, P4R measures (both progress and outcome) will be reported by the ACHs through their semi-annual reports.

57. **How can ACHs submit data requests to HCA and the AIM team?**

HCA's data team, Analytics, Interoperability and Measurement (AIM), is currently working on a few general-purpose data products that will support all ACHs working on project planning this summer. At the same time, AIM will serve as a central point of contact for data requests, and will help coordinate responses. The AIM team will work with ACH data staff to prioritize and coordinate requests. This will be an ongoing, iterative process over the course of the Demonstration. Requests should be submitted to the Karen Jensen, Healthier Washington Data Integration Manager [karen.jensen@hca.wa.gov].

Project 2A: Bi-directional Integration of Physical & Behavioral Health through Care Transformation

New: 58. What is bi-directional integration?

"Bi-directional integration" means integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings.

New: 59. Is there a required approach to accomplishing Project 2A? Is the project itself required?

This project is required. ACHs must implement two approaches to accomplish Project 2A. To achieve bi-directional integration, an ACH must implement at least one approach integrating behavioral health into primary care settings, and at least one approach integrating primary care into behavioral health settings. Although there is no required model, the core principles adopted by the Bree Collaborative (Behavioral Health Integration Report), and the Collaborative Care model should be applied to integration in a behavioral health setting.

New: 60. Why are ACHs required to propose a project that integrates primary care into a behavioral health setting?

People with serious mental illness and/or substance use disorders continue to experience multiple chronic health conditions. These conditions can dramatically reduce life expectancy. This population constitutes one of the highest cost, highest risk groups among Medicaid enrollees. There is emerging evidence supporting the value of providing whole person care in behavioral health settings where these patients already receive care.

For those with complex behavioral health disorders and co-occurring chronic physical health conditions, there are tremendous barriers to accessing effective primary care, and they need services not available in most primary care facilities. Licensed behavioral health providers are equipped to manage whole person integrated care for people whose mental health and/or substance use disorder cannot be stabilized in a primary care setting. The Bree Collaborative recommendations set forth in the Behavioral Health Integration Report presents a continuum of behavioral health system integration which includes behavioral health homes. These are defined by SAMHSA as "a behavioral health agency that serves as a health home for people with mental health and substance use disorders."

New: 61. What is considered a behavioral health setting under Project 2A?

A substitute senate bill, SSB 5779, which passed during the most recent legislative session, provides guidance on what is considered a behavioral health setting. To facilitate bi-directional integration, the legislation directs HCA to complete a review of payment codes available to health plans and providers related to primary care and behavioral health services, and create a matrix listing "all physical health-related codes available for payment when provided in licensed behavioral health agencies."

To align with this legislation, Project 2A proposals must include at least one licensed behavioral health agency as a partner. Licensed behavioral health agencies may be certified to provide mental health and/or SUD treatment services.

New: 62. Is bringing a primary care physician into a behavioral health setting the only approach for integrating primary care services into behavioral health settings?

No, there are different levels of integration in behavioral health settings. For example, SSB 5779 defines "whole-person care in behavioral health" as a health care integration model in which primary care services are integrated into a behavioral health setting either through co-location or community-based care management.

The project toolkit describes three different approaches; each approach reflects different levels of integration in behavioral health settings:

- *Off-site enhanced collaboration* moves beyond simply making referrals to primary care. Instead, providers have regular contact with each other, an agreement for bi-directional information sharing, and use care managers to track physical health outcomes and facilitate provider communication across treatment settings.

- *Co-located enhanced collaboration* where primary care providers and behavioral health providers work in the same location, rely on care managers to facilitate communications, but they use separate treatment planning and records.

- *Co-located integrated* refers to integrated team-based care and provides routine physical health screenings and diagnosis (e.g., blood pressure, weight, BMI) in a behavioral health agency. It includes on-site primary care, either limited or full-scope. Multiple levels of health practitioners (e.g., RN. ARNP, PA, MD) may provide physical health services within their scope of practice.

In addition to following the recommendations set forth by the Bree Collaborative, the core principles of the Collaborative Care model must be applied and implemented in both of the *colocation* approaches.

Approaches based on emerging evidence for integrating primary care into behavioral health settings are further described here:

- SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/integrated-care-models
- Approaches to Integrating Physical Health Services into Behavioral Health Organizations http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf
- HCA Advancing Integrated Care: The Road to 2020: Joe Parks, MD - Best Practices in Integrated Care – A Full Continuum of Integrated Care, Part II
- U.S. Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/