Medicaid Transformation
Accountable Communities of Health
Semi-annual Reporting Guidance

SAR 8.0

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

Updated Template Release Date: September 8, 2021
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## 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>Primary contact name</th>
<th>Phone number</th>
<th>E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Schapman</td>
<td>509-293-8596</td>
<td><a href="mailto:john@ncach.org">john@ncach.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary contact name</th>
<th>Phone number</th>
<th>E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline Tillier</td>
<td>509-293-8648</td>
<td><a href="mailto:caroline@ncach.org">caroline@ncach.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>x</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>x</td>
<td></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>x</td>
<td></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>x</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td>x</td>
<td></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/nfesjalde5m1ye6aobhioou5xre0eh26">template</a> or a similar format) that addresses internal controls, including financial audits.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>x</td>
<td></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>x</td>
<td></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.

**NCACH Response:** See attach NCACH.SAR8.0 Attachment A.1.31.21

**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.

**NCACH Response:** During this reporting period, NCACH transferred $250,000 from the Financial Executor Portal into the NCACH account at Cashmere Valley Bank. NCACH discontinued its hosting agreement at Chelan-Douglas Health District starting January 1, 2022. The funds were transferred into NCACH’s account to allow for the organization to have operating funds for the first quarter of 2022 while the Chelan-Douglas Health District closed its books and transferred any remaining balance over to NCACH’s new account. NCACH did not have any payments to partners outside of the FE portal, and NCACH is following the direction received by Meyers and Stauffer from SAR 5.0 that no reporting was required for expenditure of Design funds used for COVID-19.

**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

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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](https://www.hca.wa.gov/assets/program/payment-reconciliation-form-sar-8.xlsx)
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><strong>Actual</strong></td>
<td><strong>Projected</strong></td>
</tr>
<tr>
<td>In 2018, a contract with Feldesman Tucker Leifer Fidell LLP provided technical</td>
<td>$35,275</td>
</tr>
<tr>
<td>assistance and review of contracts for behavioral healthcare providers who did not</td>
<td>$35,275</td>
</tr>
<tr>
<td>have contracting experience with Managed Care Organizations (MCOs).</td>
<td></td>
</tr>
<tr>
<td>Through 2019, a contract with Xpio provided IT technical support to behavioral</td>
<td>$23,146.66</td>
</tr>
<tr>
<td>health providers who needed assistance in making adjustments to their medical</td>
<td>$23,147</td>
</tr>
<tr>
<td>record systems to bill MCOs for services provided. Prior to integration in January</td>
<td></td>
</tr>
<tr>
<td>2018, approximately $200,000 was spent on behavioral healthcare providers for</td>
<td></td>
</tr>
<tr>
<td>technical assistance support by Xpio.</td>
<td></td>
</tr>
<tr>
<td>A contract with the UW AIMS center provided assistance on how to emphasize the</td>
<td>$41,346</td>
</tr>
<tr>
<td>behavioral health component of bi-directional integration. This contract was</td>
<td>$41,346</td>
</tr>
<tr>
<td>through 2018 but could be extended in the future (and would include additional</td>
<td></td>
</tr>
<tr>
<td>costs.)</td>
<td></td>
</tr>
<tr>
<td>Integration incentive payments for partners: Stage 1 funding through the Whole</td>
<td>$557,500</td>
</tr>
<tr>
<td>Person Care Collaborative (WPCC) helped behavioral health organizations develop a</td>
<td>$557,500</td>
</tr>
<tr>
<td>change plan. The change plans provide a road map for partnering providers to address</td>
<td></td>
</tr>
<tr>
<td>bi-directional integration and contribute to all 6 Medicaid Transformation Projects</td>
<td></td>
</tr>
<tr>
<td>selected by NCACH. This funding includes a Learning and Action Network, where</td>
<td></td>
</tr>
<tr>
<td>providers received assistance in developing their change plans.</td>
<td></td>
</tr>
<tr>
<td>Integration incentive payments for partners: Stage 2 Funding is for behavioral</td>
<td>$1,519,608</td>
</tr>
<tr>
<td>care providers who are participating in the Whole Person Care Learning Community</td>
<td>$1,897,500</td>
</tr>
<tr>
<td>from 2019-2021 and after completing deliverables outlined for Learning Community</td>
<td></td>
</tr>
<tr>
<td>members. This funding supports the continued progression of tactics outlined in the</td>
<td></td>
</tr>
<tr>
<td>behavioral healthcare providers' change plans.</td>
<td></td>
</tr>
<tr>
<td>Payments for consultants and ongoing TA support: This allocation includes project</td>
<td>$468,404</td>
</tr>
<tr>
<td>management costs for consultants who support the WPCC, helping both behavioral</td>
<td>$780,000</td>
</tr>
<tr>
<td>healthcare providers and physical health.</td>
<td></td>
</tr>
</tbody>
</table>
providers move closer to bi-directional integration as well as whole person care. The projected cost accounts for what would be the behavioral healthcare providers’ share of this work if split evenly across organizations. However, the contractor is paid directly from NCACH.

| Total          | $2,295,632.66 (updated since SAR 7.0) | $3,334,768 (updated since SAR 7.0) |

Integrated Managed Care funding is also being utilized to support outpatient providers’ clinical process improvement efforts to address whole person health, as well as partnerships with community behavioral health providers to collectively achieve the goals of bi-directional integration. The above chart demonstrates the funding that behavioral health providers received or costs incurred as part of this work. NCACH is also working on partnerships with the Colville Confederated Tribes, which includes funding to support behavioral health efforts.
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.

13. Partnering provider roster.

The roster should reflect all partnering providers that are participating in project implementation efforts through the ACH under Medicaid Transformation.\(^3\) 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.

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\(^3\) 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.4

**NCACH Response:** NCACH’s broader goal is to promote continuous learning and improvement for all funded partners. There have been no modifications to our overarching Quality Improvement Strategy (QIS), and the following are some of the quality improvement efforts and findings from July to December of 2021.

*Whole Person Care Collaborative:* We continued to encourage partners to apply their QI skills to identify and address root causes when it comes to managing chronic diseases, building pathways for patients to access care, and delivering integrated whole person care. Providers continued to participate in monthly Quality Improvement (QI) affinity group calls which included open discussions as well as focused topics (e.g. risk stratification or recruitment and retention). At monthly WPCC meetings, peer presentations showcased the quality improvement work of partners. For example, two behavioral health partners shared out at the September meeting (watch starting at 17:57) and two outpatient clinics affiliated with hospitals shared out at the October meeting (watch starting at 12:55). Finally, NCACH and partners hosted a Population Health Learning & Action Network (PHLAN) Celebration and Harvest Learning Session which formally concluded the 15-month PHLAN. The session brought everyone together to recognize the hard work and accomplishments from this improvement journey, including a review of improvement data for the cohort (A1C Control, depression screenings, and self-selected measures.)

*Transitional Care and Diversion Intervention Workgroup:* The two workgroup meetings during this reporting period focused on inviting input from partners into NCACH’s future plans. Part of the conversations centered on the value of this workgroup and potential adjustments in 2022. Participants shared reflections about what worked in these meetings and what should be replicated (people sharing what they were doing, metrics, and feedback) and what additional support they might need in 2022 to support transformational work in hospitals (filling gaps in behavioral health supports, including transportation). Funded partner focus in 2022 has been around cross sector collaboration. Each partner that received funding was required to partner with agencies or departments outside of their service type. In the Quarter 3 report, one partner reported that communication about who is responsible for taking care of patient needs was an area of continual improvement. Two hospital partners who were getting referral projects in place with other entities also reported it was more difficult to get agreement and meetings scheduled when working outside of their organization. All three agencies recognize success outcomes when those collaborations occur, but also recognize it takes more capacity to cultivate

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4 Reporting requirements for the quality improvement strategy updates will be fulfilled by COVID-19 context in the “Narrative Responses” section

Semi-annual reporting guidance

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those partnership on the front end and continual communication about how workflows are supporting patient care and improvements across agencies.

**Opioid Workgroup:** During the reporting period, NCACH convened our final Opioid Workgroup meeting to keep partners connected and learn about ongoing opioid-related efforts. This meeting focused on sharing NCACH’s shift from an opioid project focus to a broader recovery lens (which includes all substance use disorders), milestones related to the training of recovery coaches and Narcan distribution, and successes and challenges across our region. A recording from this meeting can be [accessed here](#).

**Community-Based Care Coordination:** NCACH convened and facilitated two meetings with partners in the Region 6 Health Home network. Both of these meetings focused on exploring opportunities for improvement. The August meeting focused on eligibility and outreach, while the October meeting focused on regional strategies to actively move toward more coherence and integration of data and platforms. Partners receiving funds for broader (non-Health Home) community-based care coordination continued to submit quarterly reports. These reports are designed to reflect on milestones and successes, barriers and challenges, as well as lessons learned and next steps. These types of reporting questions support a continuous learning and improvement mindset, and NCACH staff have provided feedback to each partner and offered to meet one on one to follow up about questions and potential adjustments.

**Coalitions for Health Improvement:** Final reports for partners funded through the 2020 CHI Community Initiatives process (initiatives implemented in 2021) were received early 2022 and will be reviewed by staff. Some of these funded partners shared presentations with their local CHIs to keep coalition members connected to the work of funded partners. During the reporting period, NCACH also spent considerable time with support staff and leadership council members from all three coalitions to explore more strategic ways to invest the funds that were allocated for CHIs in 2021. Conversations about increasing the impact of CHI investments, motivated by feedback from CHI and NCACH Board members gathered through meetings and surveys, centered on (1) the best way to use the CHI funds allocated by the NCACH Board and (2) the best way to set up CHIs for long-term success beyond the Medicaid Transformation. This comes at a time when NCACH is planning for its long-term future and evolving its leadership and governance towards a more distributed leadership framework. Increased alignment with local coalitions and developing mutually beneficial partnerships is an important goal.

### 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.).

**NCACH Response:**

NCACH continues to listen to and support partners as well as remain flexible in contracting so partners have time and resources to respond to the most pressing needs created by the COVID-19 pandemic. As NCACH ramped up its social media presence in
2021, COVID-19 related posts from our local public health and health care partners were shared via our Facebook, Twitter, and Instagram.

NCACH continues to support the distribution of cell phones to Foundational Community Support (FCS) providers in partnership with the Health Care Authority and Amerigroup. To date, FCS partners in our region have only requested 14 phones. Because Greater Columbia ACH ran out of allocated cell phones, NCACH coordinated to send them 11 phones originally allocated for our region. HCA encouraged ACHs to coordinate where there were needs and gaps.

Local projects that we continue to support due to COVID-19 in our region are the regional telehealth assessment in partnership with Washington State University and Ingenium Consulting as well as COVID-19 EMS health checks in partnership with Okanogan County EMS providers and Okanogan County Public Health (OCPH).

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.

NCACH Response: The regular surges in COVID-19 continue to place strain on both our healthcare and public health partners. Specific to clinical partners involved in our Whole Person Care Collaborative, the workforce shortages caused by providers and staff being out due to COVID-19 and/or potential exposure have caused most agencies to shift their staffing to focus on basic services and made it difficult to participate in process improvement efforts. The vaccine mandate has added to our region’s staffing shortages. This is less evident among our physical health providers, but a number of our regional community behavioral health providers were hit significantly with the loss of staff due to the mandate, which put some providers that were already unable to meet our region’s needs into greater capacity issues. To support behavioral health providers, NCACH did engage in the House Bill 1504 Behavioral Health internship program. The goal is to support agencies in bringing on interns who struggle to afford the cost of supervision due to the loss of income from those preceptors not seeing patients. Currently, NCACH plans to engage with 4 behavioral health organizations to provide internships across our region when we receive a signed contract with the Health Care Authority.

EMS partners who have traditionally partnered in community paramedicine efforts have made slower progress or have halted those efforts due to taking leadership roles in both testing and vaccine administration in our region. The positive component of the EMS partnership is that providers have learned to collaborate better with public health; one EMS provider (Lake Chelan Health) is also engaging in the COVID Care Connect process through DOH.

Overall, NCACH has continued to engage with clinical partners during the pandemic as able while allowing them flexibility to address their urgent needs. The shift for clinical partners to focus on COVID has allowed NCACH to engage with community-based organizations to support care coordination and other health-related efforts since those organizations continue to operate at a consistent level during the pandemic and therefore had more certainty with how they could engage in transformation work.
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.

**NCACH Response:** Not applicable

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 decisions regarding priority ACH investments and projects, strategic planning results, community/partner engagement, sustainability planning TA or coordination, etc.

**NCACH Response:** In July of 2021, the NCACH Board approved three pillars of NCACH’s future state. These were attached in the previous SAR 7.0 report and also included here [NCACH.SAR8.0 Attachment B 1.31.22]. Since then, NCACH has started working on developing an accessible, sustainable, community-tested version of these three pillars. NCACH’s Strategy Workgroup spent time evaluating models across the country with similar goals as the three pillars. That process helped us identify key lessons we wanted to learn from across the country and helped give us tangible examples of how this work could be done in North Central.

In order to operationalize these pillars, we have focused on exploring pillar #3: (Building through an inclusive process of Distributed Leadership). NCACH invited agencies who have been practicing distributed decision-making to present to our Board in December, including the Georgia Health Policy Institute and Trenton Health. The focus of this session was to learn how similar entities have built a regional portfolio that is anchored in shared measurement and was formed through an inclusive decision-making process. NCACH recognizes the need to have a portfolio that is informed by the needs of all residents. This portfolio and the network built from the process will also help us quickly engage the community in deciding how any future waiver work would be folded into this body of work.

To initiate the process of pillar #2, (Anchoring in shared measurement), NCACH created and posted a position for a Director of Community Data. The position is currently posted and NCACH is actively recruiting applicants. This staff person will act as a neutral convener and bring partners together to develop the governance and infrastructure to support a shared data and measurement infrastructure for our region. The goal is to help regional partners identify the most appropriate agencies to steward different components of a shared data utility (including qualitative and quantitative data analysis).

In preparation for 2022, NCACH finalized plans for our bridge year with 5 key priorities that will help set ourselves for future work in 2023 and beyond while helping us continue to achieve the goals of the Medicaid Transformation Project extension year. Specifically, our 5 key priorities are as follows:
(1) Develop a culture of equity and increase community resilience
(2) Promote coordinated whole system responses to whole person health needs
(3) Improve health outcomes for people struggling with behavioral health needs
(4) Ensure that policy solutions effectively support our region’s needs and the health of our residents
(5) Help partners respond to demand for services by increasing capacity

More details on our 2022 goals can be found by reviewing [NCACH.SAR8.0 Attachment C.1.31.22]. NCACH is working to operationalize these goals in 2022.

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.

**NCACH Response:**

**Reflections on Changes and Improvements:**

In addition to improvements mentioned in section 14, NCACH conducted two Ripple Effects Mapping sessions in Quarter 3 of 2021. The report released at the end of 2021 found that NCACH partners are generally positive about the impact support that NCACH is having on their work. Specifically, participants indicated that funding (and the support it allowed) from NCACH has resulted in high levels of collaboration among partners. This, in turn, has expanded the service each is able to offer. Key to the success of this expanded service has been quality standards and accountability measures that incentivize the whole person approach. Support from NCACH has successfully and, by several accounts, permanently shifted the partners’ mindsets toward providing whole person care. While several individuals said they fear the end of the five-year grant cycle will end the work, some believe the momentum achieved during the granting period will be durable enough to allow the work to continue.

**Reflections on Lessons Learned:**

NCACH recognizes that we should have done a better job at the front end of the Medicaid Transformation Project in bringing in our community-based organization partners and engaging our coalitions to address whole person health and health equity. As we started our work, we were primarily focused on clinical process improvement; although that aided us in building our partnerships with clinical partners, it also caused a number of our community partners to disengage due to not understanding their role in the work. This is evident in a report from the Population Health Innovation Lab released in January 2021 that demonstrated that 3 of the top 4 sector types represented in our region were healthcare focused. This report is part of the Aligning Systems for Health (AS4H) initiative and is testing a cross-sector alignment theory of change.

The AS4H report also found that North Central ACH has effectively supported and increased collaboration across organizations, sectors, and tribal partners. These results were based on 76 survey respondents, and 86% somewhat or strongly agreed that NCACH had increased collaboration, while 90% somewhat or strongly agreed that NCACH had effectively provided support for collaboration.
However, the depth of that collaboration has been less clear. A majority of partners said that collaborative linkages with other community agencies “somewhat increased” (41%) or “neither increased or decreased” (35%) as part of their engagement with NCACH. Even fewer respondents saw increases in referral linkages and data exchange. This shows that while conversations have occurred, actual partnership to complete the work still need to be fostered.

Another reflection is that we could have been more effective at engaging our tribal partners and individuals with lived experience at the start of the MTP. Our initial philosophy was to have partners and the community join the projects and workgroups that NCACH chose and developed. As a result, our primary partners were those who could easily identify with the work and had the capacity to dedicate staff. We have learned that it is most important to go to partners, learn what the needs are, and figure out the best way we can support them in filling those gaps instead of inviting them into a predefined table.

Finally, NCACH is currently in the process of strengthening our value by bringing partners together to identify and address a regional portfolio to advance whole person health and health equity. Though these themes have come across in projects through the Medicaid Transformation Project, it has caused some partners to view us more as a clinical project management organization. Going forward, NCACH will ensure that partners understand our broader scope and ways they can assist in being part of improving health in our region (funded or not). This is especially true for non-clinical partners. Based on AS4H survey results, NCACH scored a 1.68 out of 5 on communicating the value of the ACH’s work to potential funders/investors. A score of 1.68 means that we are right between Not doing this (score of 1) and doing this a little (score of 2) NCACH also consistently scored in the low 2s (out of 5) for measures of engagement with the broader community.

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?

**NCACH Response:** Chelan, Douglas, and Grant counties transitioned to integrated managed care on January 1, 2018. Okanogan County transitioned to integrated managed care on January 1, 2019. Since the transition, there have been no significant issues that have arisen specific to Integrated Managed Care. We continue to work closely with our behavioral health agencies on process improvement, specifically around behavioral health integration.

The primary issue that behavioral providers are experiencing in our region that has been exacerbated during this reporting period is a shortage of workforce to provide the level of behavioral health services needed in our region. This is partly due to COVID surge as well as the vaccine mandate.
This is especially true in substance use disorder (SUD) organizations as evidenced by a workforce gap analysis NCACH conducted prior to COVID-19. During that time, NCACH worked to build out a workforce apprenticeship program with local and state partners, but that program was delayed due to COVID-19, and then ultimately the program was discontinued since there are now statewide efforts to focus on behavioral health internships, which the committed partners also wanted to focus on.

During this reporting period, NCACH received funds from the HB 1504 legislation to increase opportunities for behavioral health internships in the North Central region. A process was developed based on the pilot initiated by Greater Columbia ACH. This pilot is on hold as we are waiting for a contract from the Health Care Authority. We currently have 4 providers with 9 interns waiting to engage.

In addition to the behavioral health internships, NCACH built out a Recovery Coach Network to help address workforce shortages in the SUD field. As of December 31, 2021, NCACH has sponsored one 5-day training with 14 participants, Recovery Coach Academy Certification trainings, one ethical considerations training of 25 coaches (focusing on recovery coach ethics) and one Emergency Department Recovery Coach training with 25 participants (focusing on coaching in an emergency room setting). We have over 100 individuals in our region trained to date by the end of this year. This network will employ recovery coaches to provide direct peer support to individuals with SUD primarily focusing on social determinants of health, allowing substance use disorder professionals the ability to focus on clinical treatment. The Recovery Coach Network is spread out evenly in our four-county region and, out of our 100-plus coaches, we have 19 trained coaches who are now employed in our region in a combination of clinical and community-based organizations.

Finally, NCACH continues to serve as a liaison or a single point of contact for our behavioral health providers if they need it. The primary venue for providers to voice their concern is our Whole Person Care Collaborative, consisting of physical and behavioral health providers who meet regularly and provide opportunities for collaboration through monthly meetings and learning activities. This forum for collaboration has allowed NCACH to help providers identify, gather, and discuss issues they are having across the region as well as voice those collective concerns to the Health Care Authority based on provider input. The NCACH practice facilitators reach out to organizations individually to ensure we continue to stay connected and give them a space to express issues that NCACH can possibly address.

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?

NCACH Response: NCACH organized an interlocal leadership group in partnership with Beacon Health Options to bring regional key stakeholders together to discuss major behavioral health issues in Chelan, Douglas, Grant, and Okanogan counties. While this
leadership group showed promise, COVID-19 disrupted the availability of participants, and the group became stagnant. In an effort to continue the vision of the group, we began planning a behavioral health stakeholder series of meetings. These meeting, to begin in February 2022, will be open to those entities that were included in the original interlocal leadership group as well community members with lived experience, family members with lived experience or anyone with an interest in the behavioral health system in general. We have hired a consultant to help facilitate these meetings.

In addition, the Emergency Department (ED) Pathways group, created and led by individuals outside of NCACH, has requested NCACH assistance with process mapping to better understand the gaps in the system that may contribute to youth ED admission for suicidality.

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

**NCACH Response:** The lack of key performance indicators for clinical integration continues to be a challenge. Even Washington State HCA struggled to clearly define success at the beginning and provide goal posts. HCA and ACHs knew that financial integration would come first, while clinical integration would likely take many years to achieve. This will still take additional partnership from HCA, ACHs, and MCOs to better define this so we have a clearer understanding of how to measure success across the state.

While our WPCC partners have historically completed the MeHAF assessment since it was tied for reporting requirements, it mostly validated what they already knew. When the HCA decided to change the assessment tool, the NCACH decided not to ask providers to complete the MeHAF. The WPCC has worked with primary care organizations to develop workflows and measure PHQ-9 screening and follow-up. Behavioral health organizations have also developed systems to conduct metabolic and Hgb A1c screenings and connect with primary care providers. While we understand that clinical integration is occurring, having a consistent and standardized way to measure success has proven to be more challenging. Our hope and understanding is the rollout of the new Integrated Care Assessment in 2022 will help collect and track data that better helps us measure how our region and state are performing on clinical integration.

### 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. ACH support or engagement may include, but is not limited to:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Identification of partnering provider candidates for key informant interviews.

• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.

• Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

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.

**NCACH Response:** As outlined in the 2020 VBP survey, the top 3 barriers identified for NCACH were (1) “Insufficient patient volume by payer to take on clinical risk,” (2) “Lack of trusted partnerships and collaboration with payers,” and (3 - there was a three-way tie in responses) “Lack of interoperable data systems,” “Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data),” and “Lack of timely cost data to assist with financial management.” These barriers fall outside the role of the NCACH, nor can we assist with risk-based contracting.

This outlines that for small rural areas with smaller patient counts and profit margins, the ability to take on risk remains to be a primary driver. This is also driven by the fact that the current model for Value Based Payment adoption really promotes the MCOs to seek contracts in larger regions. That, in conjunction with reimbursement rates for behavioral health providers, makes it difficult to achieve VBP contracting in our region.

Regarding NCACH engagement with providers, our organization continued to do this in 2021 with our Whole Person Care Collaborative. Each provider is still required to submit quarterly reports associated with their change plan, and NCACH routinely meets with these providers to identify areas of quality improvement specifically focused on how their practice is transformation care. This individual technical assistance is provided to support providers that are able and ready to make change and work with their quality and clinical staff directly on what workflows they can look at changing to support quality and value.

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.
NCACH Response: NCACH has been working with providers around quality and contracting via two main venues in 2021. This is through our Whole Person Care Collaborative as well as our partnership in the Health Care Authority Community Health Access and Rural Transformation (CHART) model. Below is a quick summary of each:

WPCC Work: By creating a population health learning and action network, we were able to assist organizations – involved in primary care and behavioral health – with developing systems to capture data for quality metrics, review the data and then determine next steps. By using the model for improvement, organizations were able to use the data to inform their PDSAs and overall improvement work. This is important to VBP because contracts under these arrangements have dollars that are tied to quality metrics. For a provider to access that funding, they need to have a strong understanding of how to interpret those metrics and develop improvement projects to move the metrics for better patient outcomes.

CHART Details: The NCACH region is also participating in the Health Care Authority CHART Model. Throughout 2021, NCACH and its providers have been in communication with HCA staff on the application process and how this work will be rolled out in 2022 and beyond. Currently, four health systems in our region plan to participate and 2022 will be focused on educating our region on this work and determining if other hospitals would like to participate. This work is initially focused on how we can move acute care to a Medicare capitated rate. However, the final goal is that it will expand to be multi-payer (including Medicaid and commercial insurance) as well as include outpatient services. 2022 will be a planning year in preparation of this work ahead.

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.

NCACH Response: Every year, a majority of clinical partners NCACH works with have completed the survey as part of the Medicaid Transformation Project. Every fall, NCACH sends a personalized email to each partner to complete the survey. The survey is also mentioned at a monthly Whole Person Care Collaborative meeting and a follow-up email is sent closer to the deadline to ensure partners are able to complete the survey. If partners have any issues completing, NCACH always works with HCA to support gathering that partner’s details.

Although no financial incentive is given to providers to complete the Washington State Value-Based Purchasing Survey, NCACH continues to have success in getting surveys completed due to the strong relationships NCACH has with our partners. Due to that success, NCACH has not changed its tactics year to year.
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.

**NCACH Response:** As noted in the 2020 survey, just under half of the providers felt that VBP progression and contracts should be limited until the pandemic is over (48 of 97 respondents). A majority of the providers (57 of 97 respondents) felt there should be a pause in the expansion of VBP and focus on sustaining access to and improving the availability of provision of telehealth services. With the continuation of the pandemic, VBP continues to be a struggle for providers to focus on this current point. However, each year, NCACH shares VBP survey data to inform providers about the results of the survey and open conversations for continual improvement. NCACH plans to host meetings with MCOs and clinical partners to gain a shared understanding of VBP and its definitions, build relationships, and better identify the gaps/barriers for clinical partners to progress in their VBP journey.

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

**Documentation**

**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.

5 [https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121](https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf#page=121)
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.

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.

**NCACH Response:** While NCACH collected MeHAF data in 2017-2020, we did not use this data to drive improvement. The Whole Person Care Collaborative used a change plan that included bidirectional integration. While the improvement principles of the MeHAF were included in the change plan, NCACH chose to use monthly reports based on the work of the change plan to assess integration process. These reports were evaluated for completeness by both a practice facilitator and collaborative manager. As well, each month the practice facilitator would connect directly with the clinics to discuss the reports and action items for continual improvement. This ensured that partners were continually progressing along with their practice transformation plans.

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

**NCACH Response:** Not applicable

Optional: The ACH may submit P4R metric information

**NCACH Response:** NCACH is not submitting the P4R metric information
### Table 1: Incentive Funds earned

<table>
<thead>
<tr>
<th>Project</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A</td>
<td>$</td>
<td>$ 119,720.00</td>
<td>$ 119,720.00</td>
</tr>
<tr>
<td>2B</td>
<td>$</td>
<td>$ 82,307.00</td>
<td>$ 82,307.00</td>
</tr>
<tr>
<td>2C</td>
<td>$</td>
<td>$ 48,636.00</td>
<td>$ 48,636.00</td>
</tr>
<tr>
<td>2D</td>
<td>$</td>
<td>$ 48,636.00</td>
<td>$ 48,636.00</td>
</tr>
<tr>
<td>3A</td>
<td>$</td>
<td>$ 14,965.00</td>
<td>$ 14,965.00</td>
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<tr>
<td>3D</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>VBP</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Bonus pool/High Performance Pool</td>
<td>$</td>
<td>$ 29,930.00</td>
<td>$ 29,930.00</td>
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<tr>
<td><strong>Total</strong></td>
<td>$</td>
<td>$ 344,194.00</td>
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### Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>Interest accrued</td>
<td>$</td>
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</table>

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

<table>
<thead>
<tr>
<th>Use category</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$ 10,536.00</td>
<td>$ 298,639.77</td>
<td>$ 309,175.77</td>
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<tr>
<td>Community health fund</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Health systems and community capacity building</td>
<td>$ 306,194.02</td>
<td>$ 285,132.03</td>
<td>$ 591,326.05</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Project management</td>
<td>$ 95,591.44</td>
<td>$ 123,165.89</td>
<td>$ 218,757.33</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$ 325,610.01</td>
<td>$ 369,608.33</td>
<td>$ 695,218.34</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$ 563,636.67</td>
<td>$ 180,303.33</td>
<td>$ 743,940.00</td>
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<tr>
<td>Reserve/contingency fund</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 1,301,568.14</td>
<td>$ 1,256,849.35</td>
<td>$ 2,558,417.49</td>
</tr>
</tbody>
</table>

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.