



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-annual report Template
Reporting Period: July 1, 2018 – December 31, 2018

October 17, 2018

Table of contents

Table of contents.....	2
Semi-annual report information and submission instructions.....	3
ACH contact information.....	9
Section 1. Required milestone reporting (VBP Incentives)	10
Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.	10
A. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.....	12
B. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.....	13
C. Milestone: Support providers to develop strategies to move toward value-based care.	13
Section 2. Required milestone reporting (Project Incentives)	15
D. A. Milestone: Support regional transition to integrated managed care (2020 regions only)	15
B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	17
C. Engagement/support of Independent External Evaluator (IEE) activities	19
Section 3: Standard reporting requirements (Project Incentives)	20
A. ACH-level reporting requirements	20
B. ACH organizational updates.....	20
C. Tribal engagement and collaboration.....	22
Integrated managed care status update (early- and mid-adopters only)	23
D. Project implementation status update.....	26
Portfolio-level reporting requirements	29
E. Partnering provider engagement.....	29
A. F. Community engagement and health equity.....	31
G. Budget and funds flow	32
Section 4: Provider roster (Project Incentives)	36
Completion/maintenance of partnering provider roster	36
Section 5: Integrated managed care implementation (Integration Incentives).....	37
Implementation of integrated managed care (mid-adopters only).....	37
Attachments:	
• Semi-annual report workbook	
• Organizational self-assessment of internal controls and risks	

Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation's Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports to report on project implementation and progress milestones. ACHs will complete a standardized semi-annual report template and workbook developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

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

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved Project Plans and corresponding Implementation Plans. HCA and the IA will review semi-annual report submissions.

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

Reporting requirements

The semi-annual report template for this reporting period includes four sections as outlined in the table below. With one exception, the reporting period for this semi-annual report covers July 1, 2018 to December 31, 2018.¹ Sections 1 and 2 instruct ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 4 per the Medicaid Transformation Toolkit. Sections 3 and 4 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Note: Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:

- The ACH as an organization
- The ACH's partnering providers
- The ACH and its partnering providers

Please read each prompt carefully for instructions as to how the ACH should respond.

¹ The reporting period for Value-based Payment (VBP) milestones covers the full calendar year, January 1 through December 31, 2018.

ACH semi-annual report 2		
Section	Reporting period	Sub-section description
Section 1. Required milestone reporting (VBP Incentives)	DY 2, Q1-Q4	Milestone: Inform providers of value-based payment (VBP) readiness tools to assist their move toward value-based care
		Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH
		Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey
		Milestone: Support providers to develop strategies to move toward value-based care
Section 2. Required milestone reporting (Project Incentives)	DY 2, Q3-Q4	Milestone: Support regional transition to integrated managed care (2020 regions only)
		Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)
		Milestone: Engagement/support of Independent External Evaluator (IEE) activities
Section 3. Standard reporting requirements (Project Incentives)	DY 2, Q3-Q4	ACH organizational updates
		Tribal engagement and collaboration
		Integrated managed care status update (early- and mid-adopters only)
		Project implementation status update
		Partnering provider engagement
		Community engagement and health equity
		Budget and funds flow
Section 4. Provider roster (Project Incentives)	DY 2, Q3-Q4	Completion/maintenance of partnering provider roster
Section 5. Integrated managed care implementation (Integration Incentives)	N/A	Milestone: Implementation of integrated managed care (mid-adopters only)

Key terms

The terms below are used in the semi-annual report and should be referenced by the ACH when developing responses.

- 1. Community engagement:** Outreach to and collaboration with organizations or

individuals, including Medicaid beneficiaries, that are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

2. **Health equity:** Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.²
3. **Integrated managed care:**
 - a. **Early-adopter:** Refers to ACH regions implementing integrated managed care prior to January 1, 2019.
 - b. **2020 adopter:** Refers to ACH regions implementing integrated managed care by January 1, 2020.
 - c. **Mid-adopter:** Refers to ACH regions implementing integrated managed care on January 1, 2019.
4. **Key staff position:** Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, and Program Management and Strategy Development.
5. **Partnering provider:** Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
6. **Project areas:** The eight Medicaid Transformation projects that ACHs can implement.
7. **Project Portfolio:** The full set of project areas an ACH has chosen to implement.

Achievement Values

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

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

ACHs can earn AVs by providing evidence of completion of reporting requirements and demonstrating performance on outcome metrics. The amount of incentive funding paid to an ACH will be based on the number of earned AVs out of total possible AVs for a given payment period.

² *Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.*

All possible earned incentives for the second semi-annual report are associated with P4R. The required P4R deliverables and milestones for the second semi-annual reporting period are identified in the table below.

Deliverable/Milestone	One-time / Recurrent	Reporting Period	AVs
Section 1. Required milestone reporting (VBP Incentives)			
<i>Milestone:</i> Inform providers of VBP readiness tools to assist their move toward value-based care	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey	One-time	DY 2, Q1-Q4	1.0
<i>Milestone:</i> Support providers to develop strategies to move toward value-based care	One-time	DY 2, Q1-Q4	1.0
Section 2. Required milestone reporting (Project Incentives)			
<i>Milestone:</i> Support regional transition to integrated managed care (2020 regions only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)	One-time	DY 2, Q3-Q4	1.0
<i>Milestone:</i> Engagement/support of Independent External Evaluator (IEE) activities	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 3. Standard reporting requirements (Project Incentives)			
<i>Deliverable:</i> Complete and timely submission of SAR. <i>Note: All non-milestone, standard reporting requirements are a part of the SAR 1.0 AV.</i>	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 4. Provider roster (Project Incentives)			
<i>Deliverable:</i> Completion/maintenance of partnering provider roster	Recurrent	DY 2, Q3-Q4	1.0 per project in project portfolio
Section 5. Integrated managed care implementation (Integration Incentives)			
<i>Milestone:</i> Implementation of integrated managed care (mid-adopters only)	One-time	N/A	N/A

Semi-annual report submission instructions

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

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

ACHs must submit their semi-annual reports through the WA CPAS, which can be found at <https://cpaswa.mslc.com/>.

ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled “Semi-Annual Report 2 – January 31, 2019.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → Semi-Annual Report 2 – January 31, 2019.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

File format

ACHs must respond to all items in the Microsoft Word semi-annual report template and the Microsoft Excel semi-annual report workbook based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where Applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

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

- *Main Report or Full PDF:* ACH Name.SAR2 Report. 1.31.19
- *Excel Workbook:* ACH Name. SAR2 Workbook. 1.31.19
- *Attachments:* ACH Name.SAR2 Attachment X. 1.31.19

Note that all submitted materials will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).³

³ <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

ACH semi-annual Report 2 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report template and workbook for reporting period 2 to ACHs	HCA	August 2018
2.	Submit semi-annual reports	ACHs	Jan 31, 2019
3.	Conduct assessment of reports	IA	Feb 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2019
7.	Issue findings to HCA for approval	IA	End of Q2

Contact information

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

ACH contact information

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

ACH name:	Pierce County Accountable Community of Health
Primary contact name	Alisha Fehrenbacher
Phone number	(253) 302-5508
E-mail address	alisha@piercecountyach.org
Secondary contact name	Meg Taylor
Phone number	(253) 302-5508
E-mail address	meg@piercecountyach.org

Section 1. Required milestone reporting (VBP Incentives)

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 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where Applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- A. 1. **Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not Applicable.”

ACH response:

Not Applicable

3. In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
Providers with low VBP knowledge	The ACH held direct advisory sessions with partners and partner groups. The ACH shared best practices and subject-matter expertise with providers during cross-sector meetings. The ACH implemented a learning collaborative in 2018 focused primarily	June – December 2018	Action plan templates were provided to all clinical partners to identify areas of focus and challenges requiring support. A 1-day in-person seminar on contracting with MCOs was

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
	on SUD and BH providers as they were preparing for IMC. The structure of the meetings --and the building of relationships with partners and MCOs in the same room -- will be the foundation for continued work over the next year as we move beyond billing to a deeper understanding of contracting, shared quality metrics, and measurement of QI in support of VBP transition.		presented by Adam Falcone of Feldsman & Tucker.
Small providers	The ACH convened face-to-face monthly meetings and monthly webinars between ACH staff, subject matter experts, and providers. Topics to date have included: legal advice on MCO contracting, billing expertise (the life of a claim and process of billing electronically) and achieving a common understanding of quality measures.	June – December 2018	The IMC Learning Network, which brought together providers and MCOs to discuss issues and begin collaborating on developing parameters for contracting, pricing, and processes related to VBP transition.
Behavioral health providers	<p>The ACH communicated actively with BH providers on our virtual shared community platform – the WA Portal. There are currently 160 partners registered on the virtual community , where they have access to tools, assessments, announcements, and a learning community.</p> <p>The ACH also supported all SUD and BH providers who wish to receive IMC transition support funding as they completed the required implementation plan. As part of this support, the ACH’s Strategic Improvement (SI) team worked collaboratively with providers to identify gaps and challenges.</p>	June – December 2018	<p>Qualis Billing and IT Readiness Assessments.</p> <p>The Implementation Plan Toolkit, which is designed to help providers understand the regional transformation strategy, how their work will fit into and support it, and to prepare for successful implementation.</p> <p>ACH Improvement Advisors and SI leadership met directly with providers to assess challenges and get technical assistance with financial analysis and QI planning for 2019.</p>

4. Attestation: The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not Applicable.”

ACH response:

Not Applicable

Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

B.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
2 BH providers 5 staff Various ACH staff	The ACH sponsored providers and staff to attend a site-visit to North Central ACH for a presentation from their providers on lessons learned from their experience with the early transition to managed care payments.	The ACH provided a \$25 stipend for each BH staff member.
50 BH Providers, including senior leaders.	The ACH sponsored a daylong workshop: <i>Understanding how to contract with MCOs</i> . An expert presenter was contracted to conduct the workshop.	The ACH provided \$10,000 for speaker, time from 3 Improvement Advisors to help facilitate the event, and lunch for all participants. An ACH partner provided the venue as an in-kind contribution.
140+ BH Providers, including clinicians, senior leaders, billing staff, and managers.	The ACH worked with MCO partners to present an MCO Symposium: <i>Understanding how billing and coding will work in the new IMC system.</i>	The virtual IMC Learning Network on the WA Resources Portal was used to promote the event. The ACH’s Improvement Advisors spent time reaching out one-to-one

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
		to regional providers to encourage participation.

Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

- C. 1. In the table below, list three examples of the ACH’s efforts to support completion of the state’s 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
The ACH discussed the survey at all board committees and councils during monthly meetings, including sharing results of the prior years’ survey, reflecting on what the results mean for the region, and encouraging ongoing participation in the process.	No	No
The ACH posted a link to the survey on the ACH Learning Network, which includes over 160 regional partners.	No	No
The ACH discussed the importance of completing the survey during webinars with providers in attendance and in other meetings.	No	No

D.

Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities

Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if Applicable)	Key milestones achieved
<p>Providers with low VBP readiness or significant barriers.</p> <p><i>Regional Examples: HopeSparks, Pediatrics NW.</i></p>	<p>These partners need support thinking about how to partner for bi-directional integration and strategically position themselves for VBP.</p>	<p>The ACH assigned an Improvement Advisor to help these partners with the identified needs.</p> <p>The ACH awarded Catalyst funding to help get integration work started before the 2019 implementation plan.</p>	<p>The partners will receive coaching from the ACH advisor throughout 2019 to support change management and quality improvement in preparation for the VBP transition.</p>	<p>Established a connection with the UW AIMS Center to support Pediatric Behavioral Health integration at Pediatrics NW.</p>
<p>Small providers with 25 FTEs or fewer.</p> <p><i>Regional Examples: Prosperity Wellness (SUD provider).</i></p>	<p>These partners need general education on VBP, help with EMR implementation and billing technology, help developing operational processes to support VBP models, and help developing a sustainable financial transition plan.</p>	<p>The ACH, via the IMC Learning Network, helped provide a peer forum for partners to learn from each other while going through the IMC payment transition.</p> <p>The ACH provided 1:1 coaching to partners. The ACH convened 3 meetings and provided in-house technical assistance to a group of small BH providers.</p> <p>The ACH convened BH providers to identify barriers and challenges with MCOs in the transition, and took those concerns to the Integration Oversight Board for consideration.</p>	<p>With ACH support, these partners have developed Action Plans on the Qualis Billing and IT Toolkit. Plans are documented in the transition plan template.</p> <p>The ACH has and will continue to advocate with MCOs to improve efficiency of the VBP transition for small providers.</p>	<p>Providers were recruited to join the ACH learning network, creating a support structure for small providers undergoing the transition.</p> <p>A group of Providers formed a consortium to jointly implement a new EMR that will support the transition work.</p>

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if Applicable)	Key milestones achieved
Behavioral health providers. <i>Regional Examples: Comprehensive Life Resources (CLR).</i>	These partners need support partnering with primary care organizations to provide bi-directional integration.	<p>The ACH incentivized primary care partners to work with these BH providers through the contracting process.</p> <p>The ACH facilitated meetings between these providers and primary care partners, which were ready to start by Jan 2019.</p> <p>The ACH convened the <i>Whole Person Care Collaborative Guide Team</i> to design a 12-month learning initiative for care teams transitioning to bi-directional care.</p>	<p>The ACH’s binding Letters of Agreement with primary care organizations now require partnership with a BH provider.</p> <p>Participation in the <i>Whole Person Care Collaborative</i> is also required by both the primary care and BH teams, ensuring continued work on integration with key partners at the table.</p>	<p>Initial partnership meetings between CLR and other key partners, such as CHC and Planned Parenthood, have been convened, with next steps identified.</p> <p>CLR staff, along with those of key partners, are represented in <i>Guide Team</i> meetings.</p>

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No

- a. If the ACH checked “No” in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not Applicable.”

ACH response:

- 2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No

- a. If the ACH checked “No” in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not Applicable.”

ACH response:

- 3. Has the region made progress during the reporting period to establish an early warning system (EWS)?
 - a. If yes, describe the region’s plan to establish an EWS Workgroup, including:
 - b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to IMC and identify transition-related issues for resolution?

ACH response:

- 4. Describe the region’s efforts to establish a communications workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response:

Describe the region’s efforts to establish a provider readiness/technical assistance (TA) workgroup, including:

- iv. Which organization will lead the workgroup

- v. Estimated date for establishing the workgroup
- vi. An estimate of the number and type of workgroup participants

ACH response:

5. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response:

6. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response:

7. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response:

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond “Not Applicable.”

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity and describe the entity’s qualifications. Include a description of the HUB lead entity’s organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the lead entity and the ACH.

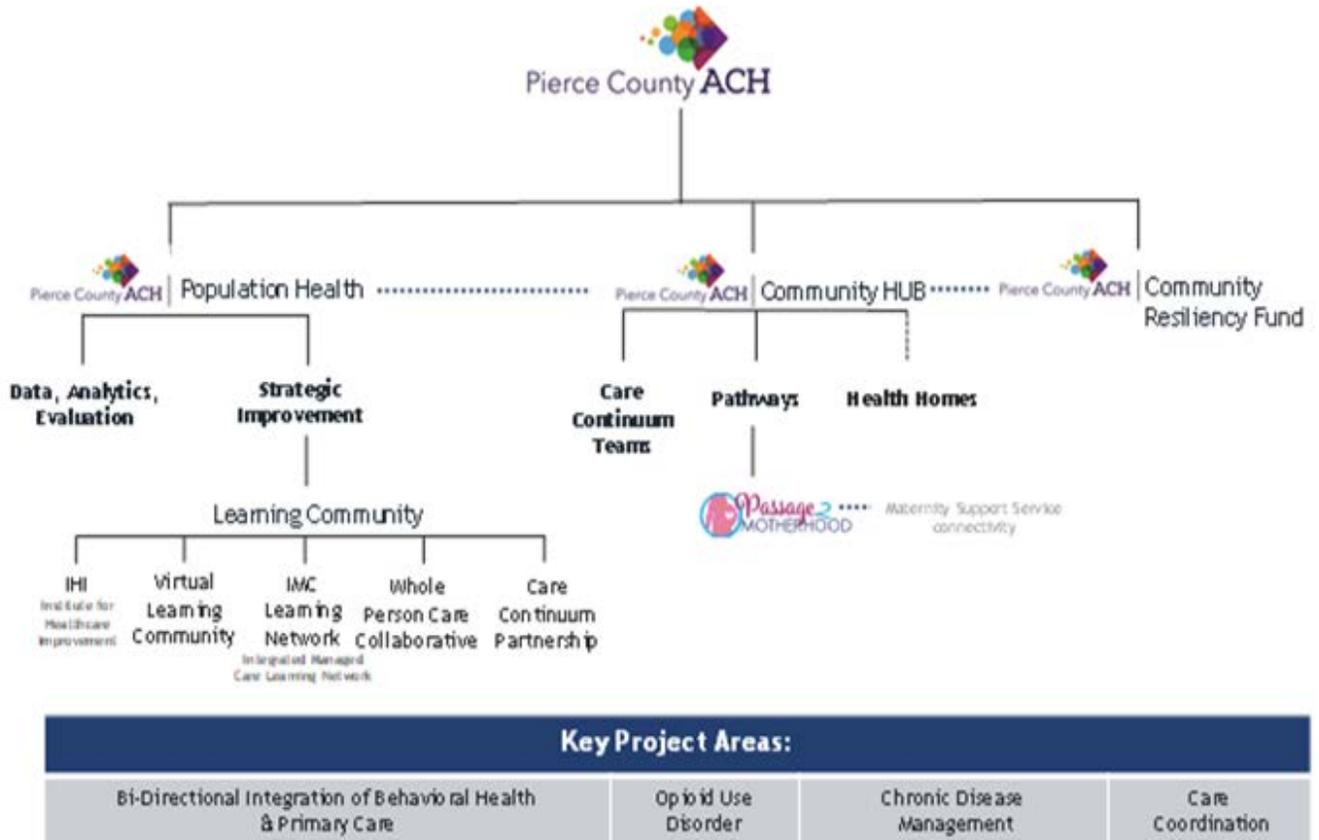
ACH response:

Overview of HUB Structure. Pierce County ACH is the lead entity for the Community HUB within Pierce County. The HUB is currently established as a service line and department within the ACH, which allows it to operate in close alignment with the ACH’s overall community transformation strategy and with other ACH functions including data & evaluation, strategic improvement, and the community resiliency fund. From its position as a key ACH service, the HUB operates a range of community programs designed to further our community transformation efforts.

HUB Staffing. The Community HUB operates under the oversight of the Pierce County ACH Chief Operating Officer/CFO, with the following dedicated HUB staff support:

- Clinical Director – Community HUB. *Provides overall clinical leadership for the HUB.*
- Pathways clinical manager. *Provides clinical oversight for the Pathways program.*
- Pathways program manager. *Manages operations for the Pathways program.*
- Finance and business operations manager. *Manages the HUB’s finances & resources.*
- Customer service representative. *Oversees HUB community engagement outreach and coordination of enrollment in the various HUB programs.*

Figure. Pierce County ACH Organizational Structure, Including the Community HUB



Advantages of HUB Structure. Pierce County ACH leadership and staff have deep experience establishing and operating a community HUB model. Pierce County ACH’s CEO has operated a successful HUB utilizing the Pathways model, and the HUB team has significant experience in care coordination within and across multiple settings, including hospitals, provider practices, FQHCs, and community-based behavioral health and social services. By aligning our community HUB within the ACH structure, we leverage this existing experience and ensure that it operates as an integral part of our comprehensive regional strategy.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response:

Certification Plans. Pierce County ACH will complete HUB certification. We are currently in the process of finalizing Level 1 Certification documentation and anticipate that all documentation required for Level 1 Certification will be submitted to PCHI, The Pathways Community HUB Institute, on or before February 1, 2019.

Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff and referring or other entities.

ACH response:

Oversight. The ACH has a HIPAA Security Officer role that was established and appointed by the ACH Executive Leadership Team, and an appointed system access administrator who oversees data access for all ACH partners.

Data Ownership. The ACH owns the rights to all data that supports the HUB. Data ownership rights are clearly detailed in the contract between the ACH, our Care Coordination Agencies (CCAs), and our data vendor (Care Coordination Solutions, or CCS).

Data Storage & Access Controls. All clinical and administrative Protected Health Information and Personally Identifiable Information is stored in an Amazon Web Services cloud storage environment that is hosted by Care Coordination Services (CCS), a vendor under contract with the ACH. Under the purview of the system access administrator, ACH Pathways program staff have direct access to the data stored in CCS in support of the Hub activities, including reporting necessary to support operation of HUB programs. Contracted Community Health Workers and their supervisors supporting the Pathways program are provided access to the care coordination module of CCS, but do not have access to the underlying data warehouse. CCS access utilizes multi-factor access controls for all users.

Data Security. The ACH has successfully completed a HIPAA Security Audit and has partnered with the HIPAA security auditor to develop numerous information security policies during the remediation process, with a focus on access control policies. The ACH has also formally adopted Washington State government data categorization definitions and has data policies in place to govern use of each category of data. The ACH IT team utilizes multiple tools and processes to identify malicious activity and deploys training modules and communications to staff to mitigate the threat of identified issues.

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, 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:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - 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.

Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- If the ACH checked “No” in item C.1, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked “Yes,” to item C.1 respond “Not Applicable.”

ACH response:

Not Applicable

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

- Attestations:** In accordance with the Medicaid Transformation’s Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. 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: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes,” to all items respond “Not Applicable.”

ACH response:

Not Applicable

Attestation: The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

- a. If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked “Yes,” to item A.3 respond “Not Applicable.”

ACH response:

Not Applicable

3. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

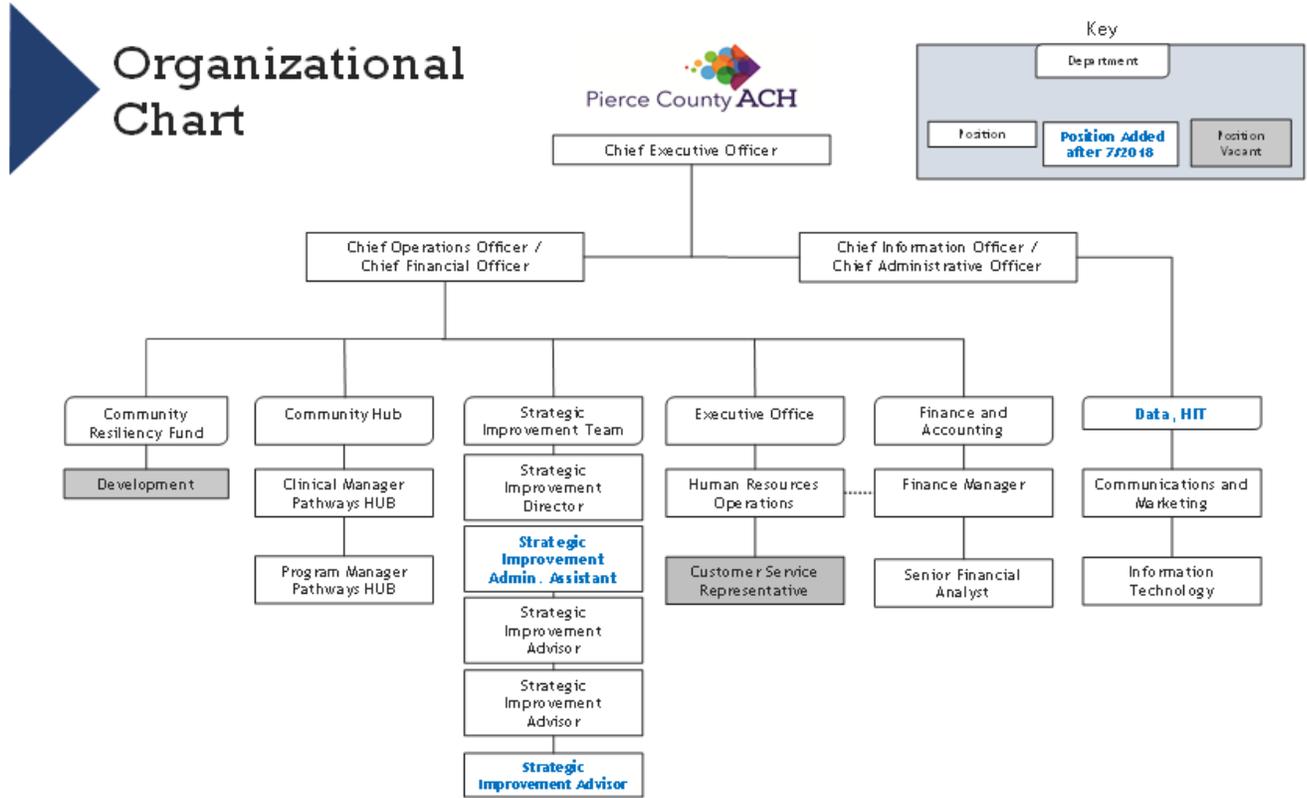
	Yes	No
Changes to key staff positions during reporting period	X	

If the ACH checked “Yes” in item A.4 above:

Summary of Key Changes. The ACH has added several new positions during the reporting period; their place in the organizational chart is summarized in the figure below. Key changes include the following:

- **Strategic Improvement Team (SIT) Staff.** Additional staff were hired to support the SIT, including an additional Advisor and an Administrative Assistant.
- **Data & HIT Manager.** An additional Data Manager position was added to support the ACH’s Chief Information Officer.

Pierce County ACH Organization Chart
 New Positions Created in this Reporting Period are in **BLUE**



B.

Tribal engagement and collaboration

- Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).⁴

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
X	

- If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not Applicable.”

ACH response:

⁴ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

Not Applicable

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not Applicable.”

ACH response:

Not Applicable

Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

C.

ACH response:

The ACH has done substantial work during the most recent reporting period in support of integrated managed care transition in our region. Key activities are summarized below:

Summary of key ACH Activities to Assist Integrated Managed Care Transitions

JULY	Helped disseminate NCACH Early Adopter Learnings to partners. Sponsored IMC Learning network webinar. Held Integration Oversight Board meeting. Continued promoting IMC Learning Network Team on ACH virtual learning community page.
AUGUST	Contracted Position with Strength Workshop (Feldsman/Tucker presenter on IMC) Initiated & posted Q/A on Early Warning System provider log on IMC Learning Network Team folder. Held event for IMC Learning Network: IHI Culture, Community, Action. Held Integration Oversight Board meeting. Sponsored LIFE QI and IMC Learning Network webinars. Launched online QI management tool. Met with NetSmart BH Providers to support joint implementation of a common EHR.
SEPTEMBER	Sponsored MCO/Provider Meet and Greet Event. Held Integration Oversight Board Meeting. Ran IMC LN Webinar and Convened IMC In-Person meeting. Met with NetSmart BH Providers to support joint implementation of a common EHR.
OCTOBER	Held IMC LN Webinar. Put on two-day MCO/ ASO Symposium. Held Integration Oversight Board meeting. Held IMC LN in person meeting. Developed SERI Contingency plan with MCO's, ASO, Providers, and HCA. Released invitation to complete funding application for BH providers.
NOVEMBER	Held IMC Learning Network in-person meeting. Held Joint MCO-BH Provider-ACH meeting. Prepared proposal to HCA to use the July 1, 2018 SERI Guide. Convened MCOs for BH Providers to work with each MCO individually on sustainability funding plan.
DECEMBER	Held IMC Learning Network in-person meeting. Held IMC Learning Network webinar. Awarded IMC sustainability funds to BH provider applicants.

2. Describe how the ACH has prioritized, and will continue to prioritize, incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response:

Connection to & Alignment with Regional Efforts. The ACH works in close alignment with the larger regional effort to advance integration. The ACH is a participating member of the *Pierce County Integration and Oversight Board*, whose membership includes County Council members, County Executive, ACH, HCA, and the provider community. The Board’s collective responsibilities are summarized in the sidebar (right).

Prioritization within the ACH. The ACH has prioritized integration incentives to behavioral Health Providers through its *Waiver and Investments Committee* and *Board of Trustees*. Together, these bodies have identified and supported a range of strategic approaches to incentivize and support the transition.

Direct Technical Assistance. The ACH offers assistance to providers through our Strategic Improvement Team (SIT), and via expert consultants brought in by the ACH. The team brings change management expertise and direct support to assist providers in completing the Qualis Behavioral Health Agency Self-Assessment, and in developing an Action Plan for transition utilizing the Qualis toolkit.

Financial Incentives. The ACH offered IMC Transition Support incentives to BH partners who were actively participating in the IMC Learning Network and submitted a work plan for their integration work to the ACH. As part of receiving these incentives, partners are also required to periodically complete a MeHAF assessment.

Access to the IMC Learning Network. As part of the overall IMC project plan, Pierce County ACH developed a structured learning and support initiative that convenes all major stakeholders, including

POWERS OF THE BOARD, HCA, AND PIERCE COUNTY ACH.

In consultation with the PIERCE COUNTY ACH, the Board and HCA shall collaborate on Pierce County’s implementation of Integrated Managed Care, and shall include responsibility for:

Alignment and standardization of MCO contracting, administrative functions, IT, data sharing, and other processes to their respective providers to minimize administrative burden at the provider level to achieve outcomes;

Monitoring implementation of Integrated Managed Care in the regional service area, including design of an early warning system to monitor ongoing success to achieve better outcomes and make, adjustments to the delivery system as necessary;

Developing regional coordination processes for capital infrastructure requests, local capacity building, and other community investments;

Identifying, using, and building on measures and data consistent with, but not limited to, RCW 70.320.030 and 41.05.690, for tracking and maintaining regional accountability for delivery system performance;

Convening appropriate task forces to provide clinical, data sharing, and other needed expertise, or may confer with and rely on the expertise of provider groups and the PIERCE COUNTY ACH; and

Preserving, financing, and enhancing the crisis and justice-related systems through an administrative service organization or other local organization approved by the Board.

Behavioral Health and SUD providers, MCOs, Pierce County, HCA, Optum, and Beacon. The group has met regularly to share best practices, bring subject matter experts to the table, and work through issues and solutions. A smaller IMC *Stakeholder Workgroup*, comprised of the MCOs, selected Behavioral Health providers, Pierce County Behavioral Health, and the ACH Strategic Improvement Team, have partnered to develop agendas, review and approve metrics to be tracked for the Early Warning System (EWS), and identify and escalate issues and challenges to the Pierce County Oversight Board.

Data Support. The ACH and its data partner, CORE (The Center for Outcomes Research & Education), collect data and compute measures which are shared regularly with the group to support continued integration work and its Early Warning System (EWS) functions.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response:

Decision Making Process. The ACH has a defined governance structure for the allocation of integration incentives. The *Waiver and Investment Committee* runs the allocation process, which operates using the same Funds Flow Guiding Principles and decision criteria the ACH employs to oversee allocation of project funds.

Distribution of Incentives. In 2018, the Board of Trustees approved allocation of half of the integration funds for distribution at the direction of the Pierce County Oversight Board. The remaining funds will be allocated by the Waiver and Investment Committee in 2019 to assist Medicaid providers as they work through the first six months of transition to the IMC model.

Accountability Mechanisms. Recipients of incentives are required to submit work plans for integration that include commitments to serve Medicaid members, participate in shared learning community, and be a part of the ACH's regional transformation strategy. The ACH and its data partner, CORE, are collaborating to create a semi-annual reporting system that will include tracking required P4R metrics and ensuring progress on workplan activities for partners who receive integration incentives. Results will be monitored by ACH leadership. In addition, CORE is developing quarterly dashboard-style reports via available sources such as the All Payer Claims Database that allow the ACH to monitor certain regional trends without placing additional reporting burden on providers.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues **after** the transition to integrated managed care?

ACH response:

IMC Learning Network. The ACH will continue to support the IMC Learning Network through the transition period. Weekly meetings of this group will continue until March, when the

meeting cadence is expected to transition to monthly. At these meetings, partners will continue to share challenges and best practices with one another as the region moves together toward a more integrated system of care.

Management of EWS. The ACH has taken the lead role in managing the Early Warning System (EWS) for the region, working to monitor and resolves issues that occur in real time. The EWS group is meeting over the phone three times a week during January to identify and solve issues around authorizations, crisis services and coding. Ongoing meeting cadence will be determined based on emergent needs as the transition continues into 2019.

Agreements & Supports with Providers. The ACH has binding agreements with most of the behavioral health and SUD providers in the region, and will continue to meet with each partner directly as they settle into the managed care payment system and focus more broadly on clinical integration, quality improvement, and partnership across sectors. As part of these supports, our improvement advisors provide direct technical assistance, which includes expertise around practice management, population health and data analysis, and assistance in bringing together partners to collaborate on interventions.

5. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

Please refer to the attached workbook for this item.

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.⁵

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
- If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.

1. Provide the ACH’s current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting period.

Required attachment: Current implementation plan that reflects progress

⁵ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

made during reporting period.

Please refer to the attached IP workbook for this item. (Attachment 1)

- c. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) during the reporting period.

ACH response:

ACHIEVEMENTS:

Direct Partnership with Local Governmental Agencies. The ACH has entered into direct partnerships with key local government agencies, including the Tacoma Pierce County Health Department and the Pierce County Office of the Executive. These partnerships place the ACH in a position of strong alignment with regional population health and health transformation efforts, ensuring that our work meets all waiver-specific requirements while also remaining in service to a larger, overarching regional vision around health and health equity for Pierce County.

IMC Implementation Lead. Pierce County ACH has agreed to take the lead role in implementing Integrated Managed Care (IMC) in Pierce County by the identified start date. In this role, Pierce county will use its governing structure to oversee distribution of integration incentive funds, operate and support the IMC Learning Network, manage the EWS, provide direct technical assistance to providers working to implement integrated care, and facilitate alignment between integrating providers and MCOs in support of the move toward value-based payment. Pierce County ACH will also leverage its data and analytic assets, including its partnership with CORE, to help inform and create a strong, data driven regional integration strategy, track progress against key integration milestones, and feed data into the IMC Learning Network so all partners can benefit collectively from it as part of continuous regional improvement efforts.

Community HUB Launch. The ACH launched and continues to support the Community HUB in Pierce County. This HUB will act as a centralized community asset to support necessary functions for a community strategy that integrates work across the entire health continuum, including physical and behavioral health, community-based organizations working to address patient's social needs, and more. The HUB provides a data architecture for better care coordination across sectors, an integrative structure to support more efficient allocation of care management and reduce the duplication of such services, and a common connection point around which community partners can work to strategically align their efforts. The HUB will host an array of programmatic interventions designed to address specific community needs, including the Pathways program, complex care coordination via the Care Continuum Teams program, and the region's Health Homes work. The Pathways program has launched through the Community HUB and had already enrolled over 250 clients by the end of the reporting period. Additional programs, such as the HET program, will launch in 2019. By operating the Pathways program, Care Continuum teams, and Health Homes out of a centralized community HUB, we will be able to align and support these efforts across complex and historically underserved populations to create a comprehensive and integrated approach that supports at-risk community members across the entire health continuum.

RISKS:

Threats to a Successful Launch of IMC. There has been some uncertainty that Pierce County providers and Managed Care Organizations would be able to successfully launch Integrated

Managed Care in 2019. This uncertainty has stemmed primarily from the departure of the former BHO in Pierce County, as well as multiple dependencies on state partners whose work has complex interconnections to the Pierce efforts.

Mediation Strategies: To mediate these risks, Pierce County ACH has assumed management of the EWS to better enable us to identify issues as they arise and bring partners together to resolve the issues quickly. In addition, we have continued to support the IMC Learning Network, which provides both regular touchpoints among partners where risks can be raised to the attention of partners and a strong forum for the application of collective wisdom toward mitigating those risks.

Threats to the Community HUB: A second key risk in our region is that our ability to maintain support for the HUB strategy is dependent on showing its success, but it takes time to fully complete a rigorous empirical evaluation of its impact with strong enough evidence behind it to ensure partners will buy in for a sustainable financial model.

Mediation Strategies: The ACH continues to work with MCO partners to develop potential funding models for the Pathways model, and to ask partners to specify in advance the outcomes they would need to see to commit to those funding models. At the same time, we have engaged Providence CORE to perform an independent scientific evaluation of the Pathways pilot population and have shared that plan with our MCO partners to ensure its methods will meet their standards of evidence and that it will produce the outcomes of greatest importance to their decision to help sustain the program. Although the evaluation plan will take several years, it does include the reporting of interim or intermediary outcome measures that will help sustain the commitment of partners to the model along the way. Additionally, we are piloting other projects with complex care teams embedded in partner organizations in order to test outcomes and impact to cost curve, an effort that will help us establish an empirical basis for shared-savings-type financial models.

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

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

- d. **Did the ACH make, adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?**

Place an “X” in the appropriate box.

Yes	No
	X

If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not Applicable.”

ACH response:

Not Applicable

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy	Objectives	Brief description of outcome
<p>Pierce County ACH participated in numerous cross-ACH meetings, including but not limited to:</p> <ul style="list-style-type: none"> ▪ HCA Learning Symposium. ▪ ACH Executive Director Meetings. ▪ ACH Executive peer meetings. ▪ Community-based Shared Learnings across ACHs. ▪ Shared learning based on individual ACHs expertise and experience. 	<p>Share information and best practices across ACHs.</p> <p>Identify opportunities for collaboration.</p> <p>Explore opportunities for joint ACH contracting.</p> <p>Surface common challenges to HCA, MCOs, other agencies.</p> <p>Support learnings at Pierce County ACH with other ACHs (I.e. Community HUB, strategic improvement, population health strategy, community resiliency fund).</p>	<p>ACHs met to discuss common challenges and mitigation strategies, including but not limited to the following:</p> <ul style="list-style-type: none"> ▪ Data and evaluation. ▪ Coordination with MCOs. ▪ Financing for community health workers (CHWs) to support the MTP. ▪ Collaboration on Partner training (reference following strategy). ▪ Sharing learnings and expertise cross ACH.
<p>Pierce County ACH began exploring a range of potential joint contracting opportunities with other ACHs on a project-specific basis. The initial</p>	<p>Bring valuable health equity training to ACH Boards of Trustees, committees, and community partners.</p>	<p>Pierce County ACH is exploring options to partner with other ACHs to jointly contract with ohn a. powell, Director of the Haas Institute for a Fair and Inclusive</p>

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy	Objectives	Brief description of outcome
exploration has focused on a shared approach to equity trainings for all ACHs.	Avoid duplication of effort across ACHs to find respected health equity leader/trainer. Pool funds to jointly contract and gain better leverage together.	Society. The contractor will conduct health equity trainings for the Board of Trustees, Committees, and Transformation Partners, and facilitate monthly ACH full-day work sessions.
The ACH requested that HCA share a list of all organizations registered in the FE portal statewide.	Identify providers and organizations participating in more than one ACH. Enable ACHs to proactively coordinate on partner requirements and expectations.	Pierce County ACH has already identified Practice Partners that are also active in adjacent ACHs. We have shared information and will continue to share information across the regions. Pierce County ACH is using this information to coordinate with its ACH colleagues to ensure alignment of project and reporting requirements in order to minimize the burden on partners.

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not Applicable.”

ACH response:

Building Tribal Partnerships. Pierce County ACH has engaged Medicaid providers and community partners serving over 95% of its Medicaid members across the region. We are currently working to deepen our relationship with the Puyallup Tribal Nation and are in process to secure a contract covering their Medicaid lives. We expect this contract to be completed by the end of the first quarter 2019.

Reaching out to Other Providers & Partners. In addition to working to strengthen connections with the Puyallup Tribe, we have also conducted individual outreach to any providers or organizations not already engaged with the ACH’s efforts. We have worked hard to ensure that these providers and potential partners are aware of opportunities to participate in our IMC Learning Network, Provider Meetings, and Council Meetings.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support

for IMC, etc.

ACH response:

MCOs in Key Partnership Roles. Managed Care Organizations (MCOs) have been critical partners to the ACH from day one. We have worked from the beginning to ensure MCOs are a part of our governance process, board, board committees, councils, workgroups, and project scoring teams, and are an integral element of our IMC Learning Network.

Ensuring Alignment of Interests. We have met consistently with MCO partners to identify their key concerns and areas of interest, and to ensure those interests are represented in our portfolio of work. We have asked MCO partners to specify what a successful ACH effort would look like to them and to commit to measures that would demonstrate that success to their satisfaction; those measures have been embedded throughout our evaluation plans to ensure that we will be able to demonstrate the ways our work benefits MCO partners over time.

Ongoing MCO Collaboration. We continue to broaden and deepen our collaboration with the MCOs on training, education and data sharing for Providers as part of our Integrated Managed Care strategy and continue to work together with our MCO partners to ensure Providers are receiving the support they need. Pierce County ACH is also managing the Early Warning System for the region; this role has deepened our partnerships with MCOs, providers, community organizations and county government to ensure support and compliance with HCA requirements.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not Applicable.”

ACH response:

Not Applicable

3. Provide three examples of the ACH's community engagement⁶ and health equity⁷ activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

ACH response:

Disseminating & Using Community Survey Results. The ACH sponsored a community survey as parts of its work to assess community needs and develop a data-driven strategy. The survey was led by volunteers from our Community Advisory Council and members of the CHW Collaborative of Pierce County. Once results were obtained, the ACH communicated survey results throughout its network of partners and the community at large via the Provider Integration Panel, the Regional Health Improvement Program Council, the Board of Trustees, and the ACH's Data & Learning Team. The survey identified, a number of key priorities, for community members, including healthy, affordable food, good insurance, good communication with doctors, and feeling safe in their own home. Survey results will continue to inform program development and practice across our portfolio of work going forward.

Community Conference for Equitable Population Health. The ACH sponsored *IHI Culture. Community. Action.*, a daylong conference for all partners, MCOs, and community members to learn about IHI's model for equitable population health and how that model will be imbued within Pierce County's health equity work. The agenda included a panel on the role of data in generating better health equity strategies, a health equity activity led by our partners from the Tacoma Pierce County Health Department, and stories and sharing from CHWs working with our Pathways pilot program focused on high-risk pregnant women. Over 100 attendees from across the region participated in the event, and feedback made it clear that the community is primed to move forward with a population health strategy that genuinely holds equity at its center.

Equity Tools for Partners. The ACH has adopted IHI's Health Equity Organizational Assessment Tool as a requirement for partnering organizations. Partners who sign contracts with the ACH also sign a three-year binding letter of agreement to implement transformation activities, including an agreement to conduct equity assessments and take actions to improve equity within their respective organizations.

G. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

⁶ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

⁷ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

2. **Earned Project Incentives**

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response:

Significant investments have been made to build infrastructure to support our partners in their transformation planning and implementation efforts. Investments include:

Community HUB. Pierce County ACH has developed a Community HUB that is the cornerstone of its strategy to support, scale, and spread comprehensive community-clinical care coordination, transitions, and diversion. The Community HUB connects partners from across the continuum and provides a "care traffic control" methodology, built on an evidence-based infrastructure, to provide whole-person care while supporting providers and community-based partners transitioning from fee-for service to value-based payment models.

The Community HUB offers a variety of services to assist ACH partners in transformation. It utilizes the national *Pathways* care coordination model, along with multi-disciplinary complex care teams, to link Health Homes, First Steps Maternity Support Services, clinical comprehensive case management, and care coordination across the health continuum (including clinical providers, managed care organizations, and community partners) to ensure support for community-wide care plans that generate and protect whole-person health. The HUB also sponsors training for the Community Health Worker (CHW) and care coordinator workforce in partnership with Washington State Department of Health, Pathways Community Hub Institute, and Care Coordination Systems (CCS).

With the Community HUB as its centerpiece strategy, Pierce County ACH will continue to work closely with managed care organizations, providers and community-based organizations to ensure robust community-based care plans for whole-person health and support providers and community-based partners to improve their care delivery and supports.

Strategic Improvement Team (SI Team) and IHI. Throughout 2018, Pierce County ACH has developed and deployed a *Strategic Improvement Team* that includes a *Director of Strategic Improvement* and three *Improvement Advisors* grounded in the IHI Model for Improvement. The SI Team provides targeted technical assistance to ACH partners, including in-person and web-based trainings, facilitation, change management, and transformation development. Pierce County ACH's Improvement Advisors support providers individually and through partnership teams, wherein groups of providers seek collaborative technical assistance. The SI Team also collaborates with Managed Care Organizations (MCOs) to ensure leveraged connectivity and alignment with MCOs technical support opportunities.

In addition to making its own Improvement Advisors available, Pierce County ACH has sponsored two cohorts equaling eight (8) individuals from partnering providers and community-based organizations to attend an intensive 10-month Improvement Advisor Training at the *Institute for Healthcare Improvement (IHI)*. This training embeds improvement “champions” within the partner organizations to build the capacity for change management and QI in the community.

Strategic Partnership with the Institute for Healthcare Improvement (IHI). Pierce County ACH has committed to a strategic partnership with IHI. The partnership is led by Pierce County ACH’s executives in concert with Dr. John Whittington, a founder of the Triple Aim and Laura Brennan, MSW, faculty for IHI’s 100 Million Healthier Lives. As part of this partnership, Pierce County ACH is able to:

- Have IHI directly support providers and community partners in transformation efforts;
- Adopt tools & resources from IHI that can be made available to all partners;
- Anchor its Strategic Improvement Team’s work in IHI’s model for improvement; and
- Sponsor representatives from partner organizations to receive intensive IHI training.

Creating Shared Regional Data Capacity. Transformational work is fueled by strong data, monitoring, and evaluation that can demonstrate its impact and ensure its long-term viability, but not all partners have in-house data capacity. Pierce County ACH is leading several efforts to help coordinate this need across partners.

Tracking Key Indicators & Using Them to Drive Change. First, we have worked with our partners to create a set of shared goals and work plans to track transformation progress and will work with our data and analytic partners to provide regional tracking of progress so all partners have access to data that shows how the ACH region is doing. Data from these tracking efforts will also be used to support process evaluation of our work, allowing us to leverage evidence of early impact in order to feed continuous, rapid-cycle improvement efforts across our partners.

Building a Population Health Data Platform. Second, we are actively seeking opportunities to build a regional population health data platform that aggregates and connects key population health data from a diverse array of sources, including clinical, public health, social services, public safety, and other social determinants data, and makes that data available for shared community planning, monitoring, and impact evaluation work. We anticipate that this data will support efforts across our portfolio, including our programmatic work via the community HUB as well as targeting and evaluating our community investments via the Resiliency Fund.

Putting Data into Action. Finally, we convene a *Data & Evaluation Workgroup* tasked with curating this and other available data, extracting meaning from it, and feeding it into our governance structure so that the appropriate workgroups and partner organizations can leverage it to help make the right decisions to support our regional transformation strategy.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response:

Pierce County ACH established the *Community Resiliency Fund*, soon to be rebranded as “One Pierce”, as a vehicle for planning and making collective investments to improve health and health equity in our community, then capturing and reinvesting the shared value created by those investments to sustain and spread change. The ACH created the fund initially from its own budget of 10% of earned incentive funds. We are now working to attract a diverse portfolio of partners that share the ACH/CRF mission, including but not limited to:

- Non-profit hospital community benefit dollars,
- Community development financing,
- Earned incentives,
- ACH partner contributions,
- Reinvestment of shared savings,
- Dedicated revenues,
- Pay for Success Contracts,
- Opportunity Zones,
- Dedicated taxes and fees,
- Private investors,
- Crowdfunding, and
- Existing wellness trusts.

Investments from the fund are intended to be made along two paths, each of which is designed to complement and enhance the other:

Path 1 – Supporting Direct Services: CRF funds will be used to preserve or spread critical programs or services that promote strong community-clinical linkages, including the Medicaid Transformation projects and strategies being developed and supported by the ACH.

Path 2 – Aligned Upstream Investments: CRF funds will be directed toward one or more “big problems” or “social determinants of health” challenges that are hampering the effectiveness of the community’s portfolio of services or represent necessary advancements for the community to achieve its health equity goals. Funds could be targeted to reduce barriers for, or complement and accelerate the impact of, existing programs and services.

Core principles established by the independent CRF formation Board are:

- *Working Smartly Upstream.* Continue to support crisis systems while also working to direct resources toward prevention and diversion efforts.
- *Making Data-Informed Investments.* Use data to make sure our investments are smartly targeted at the points of maximum leverage for optimizing community health and equity outcomes.
- *Leveraging Community Wisdom.* Authentically engage with our communities to ensure local wisdom and diverse perspectives are represented in our decision-making and investment processes.
- *Equity-Focused.* Keep health equity as the North Star of our work. Make decisions that have a clear path to ensuring our impact will be equitably shared by all.
- *Choosing Investments that Build.* Ensure that each investment we make has a plan for generating shared savings across systems, and that the value created can be quantified and re-invested.

Section 4: Provider roster (Project Incentives)

Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-

A. based approaches or promising practices and strategies).⁸

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.
 - b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
 - c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response:

We have not encountered any barriers to tracking site-level participation from our partners, and do not anticipate any challenges in achieving site-level partner reporting during the remainder of the demonstration period. Our mechanism to track participation include:

Partner Tracking. All partner agreements require the organizations to document their detailed internal work plans, which include specific information about clinic or site-level activities. For those partners doing deep behavioral health integration work, the ACH also requires

⁸ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

participation in our Whole Person Care Collaborative, which the ACH runs with advice and assistance from UW’s AIMS Center. This collaborative has representatives from the care teams at the sites where the transformation work is being piloted, providing further insight into the activities being implemented at each site.

Strategic Improvement Team Monitoring. The ACH has strategic improvement advisors assigned to each partner organization, and those teams also monitor and record project activities at the clinic sites. These activities are tracked as part of our partner reporting system, ensuring us an updated summary of key activities at each site.

Section 5: Integrated managed care implementation (Integration Incentives)

Implementation of integrated managed care (mid-adopters only)

- A. 1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not Applicable.”

ACH response:

Not Applicable

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Pierce County Accountable Community of Health

ACH Earned Incentives and Expenditures

July 1, 2018 - December 31, 2018

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period ²	
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$6,407,970
2B: Community-Based Care Coordination	\$4,405,480
2C: Transitional Care	
2D: Diversion Interventions	
3A: Addressing the Opioid Use Public Health Crisis	\$800,996
3B: Reproductive and Maternal/Child Health	
3C: Access to Oral Health Services	
3D: Chronic Disease Prevention and Control	\$1,601,993
Behavioral Health Integration Incentives	
Value-Based Payment (VBP) Incentives	
IHCP-Specific Projects	
High Performance Pool	
Total Funds Earned	\$13,216,440

Funds Distributed by ACH During Reporting Period, by Use Category ³	
Administration	\$1,400,000
Community Health Fund	\$1,500,000
Health Systems and Community Capacity Building	\$4,347,203
Integration Incentives	
Project Management	
Provider Engagement, Participation and Implementation	\$3,686,000
Provider Performance and Quality Incentives	
Reserve / Contingency Fund	
Shared Domain 1 Incentives	\$3,333,375
Total	\$14,266,578

Funds Distributed by ACH During Reporting Period, by Use Category ³	
ACH	\$6,900,000
Non-Traditional Provider	\$148,000
Traditional Medicaid Provider	\$3,885,203
Tribal Provider (Tribe)	
Tribal Provider (UIHP)	
Shared Domain 1 Provider	\$3,333,375
Total Funds Distributed During Reporting Period	\$14,266,578

Total Funds Earned During Reporting Period	\$13,216,440
Total Funds Distributed During Reporting Period	\$14,266,578
Total Funds Left Available for Distribution During Reporting Period	-\$1,050,138

¹ Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on January 4, 2019 to accompany the second Semi-Annual Report submission for the reporting period July 1 to December 31, 2018.

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

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

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