MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Healthier Washington Medicaid Transformation

Independent Assessment of Semi-annual Report

Reporting Period January 1, 2018 – June 30, 2018

Findings Report: September 2018

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I. Overview

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the state's Healthier Washington Medicaid Transformation (Medicaid Transformation), Section 1115 Medicaid waiver. The focus of the Independent Assessor's work is on Initiative 1, Transformation through Accountable Communities of Health (ACHs), for which an estimated $1.1 billion of the $1.5 billion federal waiver funds are allocated.

As part of this engagement, Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. This findings report represents Myers and Stauffer's assessment of ACH semi-annual reports for reporting period January 1, 2018 – June 30, 2018.

This findings report is organized as follows:

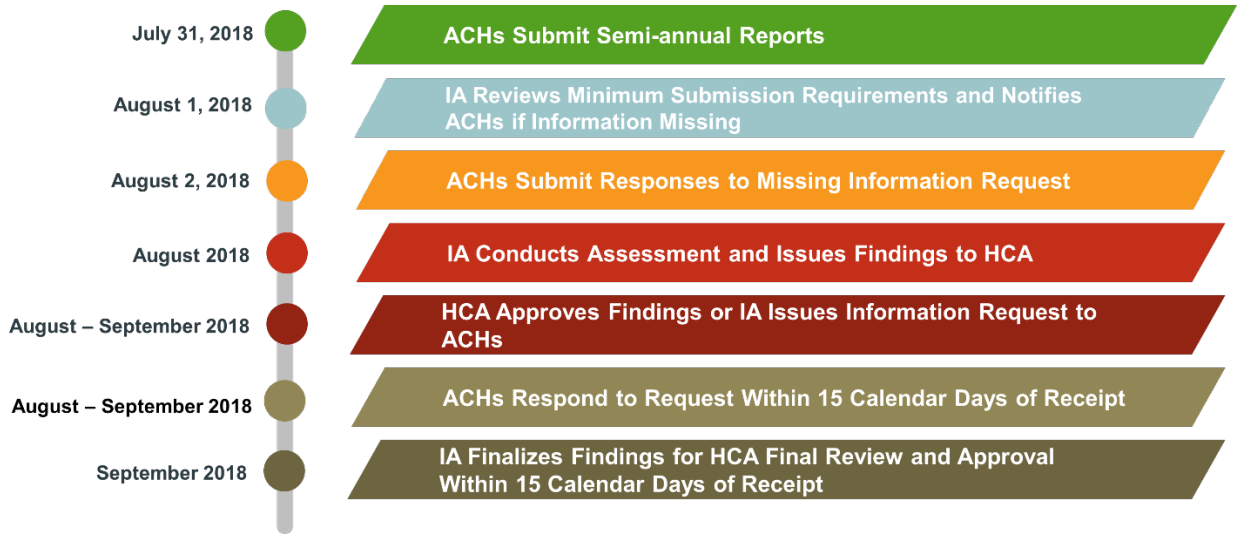
- **Semi-annual Report Assessment Timeline and Process.** Provides the high-level timeline and associates tasks for completion of the assessment. We also provide an overview of the process used by Myers and Stauffer to conduct the assessment.
- **Summary Findings of Completeness and Recommendations for Payment of Incentives**. Lists the Independent Assessor's determination of completeness by sub-section of the report. We also indicate whether payment would be supported based on our determinations of completeness.
- **Key Considerations Across ACHs**. Provides information for HCA review for potential areas of ongoing monitoring of ACHs.
- **Key Considerations by ACH**. Provides examples of strengths and opportunities identified within each ACH's report.

Based on the independent assessment and its own considerations, HCA will use the Delivery System Reform Incentive Payment (DSRIP) Program governance and decision-making group for final determination of incentives earned by each ACH.

II. Semi-annual Report Assessment Timeline and Process

Figure X is the high-level timeline to conduct each step of the independent assessment followed by detailed information of the process.

Figure 1. High-level Semi-annual Report Assessment Timeline: Reporting Period January 1 – June 30, 2018



The Independent Assessor used the following process to conduct the assessment:

- **Minimum Submission Requirements Review**. Upon receipt of each ACH's report, we conducted a high-level review to confirm the ACH submitted responses to all questions. Where missing information was identified, we requested the ACH provide an updated submission.

- **Detailed Assessment**. Primary reviewers conducted detailed assessments of the ACH reports for completeness. We assessed that all sections of the report were addressed and that responses provided detail to confirm progress is being made. Each response to a question within a report sub-section was assessed as complete or incomplete. For any responses marked as incomplete, the entire sub-section was marked as incomplete with the exception of Milestone 3 which requests submission of target populations and evidence-based approaches and strategies at the project level. If, for example, the subsection was complete with the exception that the ACH did not submit an approved evidence-based approach for Project 2A, the response would be marked as incomplete. All other responses for Milestone 3 would be marked complete to assure that the ACH was not penalized in regards to performance incentive funding across all projects for lack of response to one project requirement.

  Where the primary reviewer found a response to be incomplete or requested a second review for confirmation, a secondary reviewer conducted additional assessment.

- **Assessment of Requests for Additional Information**. As a result of the detailed assessment, we developed requests for additional information to the ACHs for responses identified as incomplete. Additionally, we requested information where the response was complete but greater clarity could improve the overall response. This information was requested given the reports are being posted publicly and clarity would support readers' understanding of responses.

III. Summary Findings of Completeness and Recommendations for Payment of Incentives

As a result of the detailed assessment, the Independent Assessor found that six ACHs submitted complete reports. Three ACHs had incomplete items for which we requested additional information. After review of responses to requests for additional information, the Independent Assessor found all ACH reports to be fully responsive and complete.

Table 1 provides an overview of the total earned Achievement Values (AVs) by ACH for each P4R deliverable and milestone for the reporting period based on the Independent Assessor's assessment. Please note the following about the information provided in the table:

- The shaded gray items in the table indicate report sections that were originally marked incomplete prior to ACHs providing additional information.
- The potential incentives are estimates that may change based on HCA finalizing DY2 ACH Project Incentive amounts.
- HCA has the final decision-making authority. The actual earned incentives will be based on HCA determination and approval of findings.

Table 1. Achievement Values (AV) and Potential Incentives for Reporting Period January 1, 2018 – June 30, 2018

	BHT	CPAA	GCACH	HealthierHere	NC ACH	NS ACH	OCH	Pierce County ACH	SWACH
P4R Deliverables and Milestones	***Recommendations for AVs Earned Per Project by ACH***								
Completed Semi-annual Report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 1: Capacity Assessment	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 2: Domain I	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 3: Evidence-based Approaches and Target Populations	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Milestone 4: Partnering Providers	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Preliminary Total AVs	***5.0***	***5.0***	***5.0***	***5.0***	***5.0***	***5.0***	***5.0***	***5.0***	***5.0***
Number of Projects	***4***	***6***	***4***	***4***	***6***	***8***	***6***	***4***	***4***
Total AVs Achieved	***20***	***30***	***20***	***20***	***30***	***40***	***30***	***20***	***20***
Potential Incentives	**$9,059,490**	**$8,235,900**	**$11,530,260**	**$18,118,980**	**$4,117,950**	**$12,353,850**	**$3,294,360**	**$9,883,080**	**$5,765,130**

IV. Key Considerations Across ACHs

In this section, the Independent Assessor provides considerations for HCA review for potential ongoing monitoring and identification of potential strengths to consider sharing across ACHs, as applicable. It is important to note that in many instances in the report, ACHs were asked to be concise, providing only brief information or examples. For potential areas noted for additional monitoring, upon further research or discussion, it may be determined that the ACH has extensive work occurring. Therefore, the report findings are best considered in coordination with other available information. More detailed monitoring and discussions with the ACHs would be required to obtain a real-time, detailed understanding of each identified item.

Key considerations are as follows:

- **Continued Progress in Planning by All ACHs:** The semi-annual reports highlighted that the ACHs are continuing to make significant progress in planning for implementation of their selected projects, whether individually or from a project portfolio perspective. Thorough current state assessments were conducted focused on key areas. They have either released or are in process of releasing forms of agreement to potential partnering providers. They have had extensive community engagement and also highlight identified areas of technical assistance needed by partnering providers.

- **Collaboration:** ACHs noted extensive collaboration on a variety of topics, including opportunities to jointly engage partnering providers that participate in two or more regions. ACHs are involved in ongoing meetings, and the ACH Executive Directors meet weekly to coordinate, review initiatives, and foster collaboration. Highlights of collaboration noted by ACHs include:

    - The Health System Capacity Building Work Group is a partnership across all nine ACHs, the University of Washington, the Association of Washington Public Hospital Districts, and the HCA to address workforce issues.

    - ACHs established monthly meetings with all Managed Care Organizations (MCOs) to strategize and operationalize needed capacities within ACHs and organizations to support transition to Value-based Payment (VBP).

    - Collaboration is occurring across ACHs and with the Department of Health for implementation of the Pathways HUB model.

    - Bi-weekly meetings of the ACH data leads are occurring to ensure consistent data needs and collection methods across the regions and with partnering providers.

    - ACH leads have met with the Washington State Hospital and Medical Associations to discuss issues such as consistent messaging with partnering providers, the need for continuous communication around opioid initiatives, and having a standardized statewide reporting resource to find MAT providers.

- **Addressing Administrative Burden:** ACHs noted ongoing meetings where there are regular discussions about coordination opportunities and collaboration where providers cross ACH boundaries. A few specific examples of direct cross-ACH collaboration noted in the semi-annual reports that can lead to decreased administrative burden for partnering providers are as follows:
    - North Sound ACH, SWACH, Better Health Together (BHT), HealthierHere, Greater Columbia ACH (GCACH), and Cascade Pacific Action Alliance (CPAA) met with Providence St. Joseph Health in June 2018 to understand their Medicaid strategy and to discuss where and how the health system can be a strategic partner across all ACHs.
    - ACHs are coordinating for specific providers that span ACH regions. For example, Olympic Community Health (OCH), Pierce County ACH and HealthierHere are coordinating for Catholic Health Initiatives health system, and OCH and CPAA are coordinating for Peninsula Community Health Services and the Olympic Area Agency on Aging. CPAA and SWACH are working to review initiatives, align strategies and review cross-region provider goals.
    - SWACH and GCACH are coordinating regarding Mid-Adopter Integrated Managed Care (IMC) readiness reviews, assessments and potential shared investments related to providers who operate in both regions.
    - SWACH participates with Pierce County ACH on alignment of Quality Improvement strategies through the Institute for Healthcare Improvement IA (Improvement Advisor) Program.
    - For Project 2B, North Central ACH and BHT have a shared partner in the Pathways Community HUB lead agency that is the Health Homes lead agency across the regions. The agency Director and ACHs are noted to have strong working relationships which benefits alignment of how each region is looking at differences and similarities between the Pathways Community HUB and Health Homes programs.
- **Partnering Provider Engagement in Transformation Planning**. ACHs are involving partnering providers in planning in a variety of ways. In addition for asking for their response to various surveys and involvement in interviews as part of current state assessments, below are a few examples noted by ACHs where they are involving partnering providers:
    - Working with partnering providers to articulate specific evidence-based care model and practice guidelines providers will need to follow for each project.
    - Identifying partnering providers who can serve as champions of identified best practices.
    - Collecting feedback from partners on various materials, such as SWACH requesting input on a draft Clinical Transformation Plan template.

- **Partnering Provider Technical Assistance**: ACHs are identifying and acting on needs for technical assistance and training among partnering providers. Various technical assistance, training, and learning collaboratives have been offered and are being planned to meet ongoing needs for support in transformation. *Recommendation:* HCA will want to stay abreast of areas of training that are occurring to identify best practices and well as information sharing opportunities. This will help to increase consistency statewide, as well as to achieve efficiencies in overall efforts.

- **Ongoing Refinements to Target Populations:** Several ACHs discussed ongoing refinement to target populations through input from partnering providers. HCA is aware that this partnering provider input would most likely drive further changes to the identified target populations. Some ACHs discussed narrowing populations or allowing providers to decide on who they will target. *Recommendation:* It will be important to continue to understand the ACHs' approaches to addressing target population definitions and to confirm that populations are not narrowed in size or type so significantly that transformation opportunities are missed or improvement in outcomes will be difficult to achieve. HCA will want to determine if the ACHs should provide the number of targeted individuals as a baseline for understanding moving forward. Additionally, staying abreast of timing of working with partnering providers to finalize populations will be important given the varying timing across ACHs for provider engagement.

- **Project Status Updates:** While all ACHs provided project status updates, many focused on particular projects more extensively than others. This may have been a result of more intensive planning during the reporting period for particular projects or use of the project portfolio approach to address project work holistically. However, some ACHs also provided minimal updates across the portfolio. We assume that ongoing updates to implementation plans provided in future semi-annual reporting will result in more detailed information across project areas. *Recommendation:* HCA and the Independent Assessor will want to confirm that future semi-annual report templates are written to request detail across the ACHs' project portfolios. Additionally, ongoing review of updated implementation plans should consider completeness across project areas or the portfolio.

- **Partnering Provider Requirements and Incentives:** Moving forward, HCA indicated interest in understanding requirements and expectations ACHs are placing on partnering providers and the reasonableness of those for achieving incentives. As this information was not directly requested for the reporting period, ACHs provided varying levels of information. For example, some ACHs included high level descriptions of requirements or may have included their requests to providers for participation. Some included information about incentives for completion of certain materials (e.g., current state assessment survey). However, how each requirement relates to incentives is not described across ACHs. *Recommendation:* HCA may want to request information from the ACHs in more detail to assess plans for incentive payments to partnering providers across ACHs.

- **ACH Staffing***:* Organizational charts were submitted in a variety of ways (e.g., by position title or by staff name). *Recommendation:* For further semi-annual reporting, we recommend HCA request

both position title and staff name for a more detailed understanding as to positions that remain unfilled, as well as to identify trends in ongoing turnover.

- **Value-based Payment (VBP):** ACHs provided information about how they are progressing with VBP. For example, they are collaborating as a group and with the MCOs to align metrics. However, they requested additional insights and support from HCA about the ACHs' roles in advancing VBP. Multiple ACHs requested support from HCA in areas such as the following: guidance and training to fully understand the ACH's role in supporting VBP contracts between HCA, MCOs, and provider organizations; additional clarity about how HCA will measure VBP success for MCOs; specific definitions of what the state means by VBP; and better understanding of the state's plans, strategies, and expectations of ACHs. *Recommendation:* Determine opportunities to work with the ACHs to further define their roles and ongoing support they can provide. Consider whether a further learning symposium could focus on VBP, or if other forums would be appropriate.

- **Allocation of Project Funds:** ACHs were asked to provide information about use of Design Funds to date. *Table 2 provides the* percent funding each ACH had remaining in Design Funds at the time of the report, and then shows by use categories the percent of expenditures made. ACHs are allocating and using Design Funds and DY 1 Earned Incentives in a variety of ways. This table provides a snapshot of spending of Design Funds across ACHs, but cannot be used for comparison, as ACHs are proceeding differently in categorization of activities and use of funds.

Table 2. Allocation of Design Funds by ACH

Percent Design Funds Remaining as of June 30, 2018									
	BHT	**CPAA**	**GCACH**	**HealthierHere**	**NC ACH**	**NS ACH**	**OCH**	**Pierce County ACH**	**SWACH**
Percent Design Funds Remaining	77%	72%	90%	45%	85%	83%	91%	78%	70%
Percent Design Funds Expenditures by Use Category									
Use Categories									
Administration	14%	8%	61%	100%	45%	5%	21%	21%	50%
Community Health Fund	31%*	0%	24%	0%	0%	4%	0%	0%	0%
Health Systems and Community Capacity Building	30%	11%	2%	0%	13%	6%	16%	37%	22%
Integration Incentives	0%	0%	0%	0%	1%	0%	0%	0%	0%
Project Management	17%	69%	12%	0%	41%	80%	21%	29%	10%
Provider Engagement, Participation and Implementation	9%	0%	0%	0%	0%	5%	20%	13%	18%
Provider Performance and Quality Incentives	0%	0%	0%	0%	0%	0%	0%	0%	0%
Reserve/ Contingency Fund	0%	0%	0%	0%	0%	0%	0%	0%	0%
Shared Domain 1 Incentives	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	12%	0%	0%	0%	0%	22%	0%	0%
*BHT indicated this has not been spent but held in a reserve account.									

In addition, for Milestone 2, Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment), Question B.5, HCA asked ACHs to describe needs for additional support or resources, if any, from state agencies and/or state entities to be successful regarding health system capacity building in the Medicaid Transformation. *Table 3* was created collaboratively by some of the ACHs as a common list of support requests.

Table 3. Areas of Additional Support Identified Collaboratively by ACHs

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts.	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/technical assistance series regarding Health Information Technology (HIT)/Health Information Exchange (HIE).	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings.
Strong partnerships with Washington Hospital Association.	Support from HCA for guidance on the ACHs' role in moving towards whole person care and value-based payment.	Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs.	ACH's would benefit from additional training to fully understand the ACH's role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from ACH partners which will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions.	ACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPi Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the value-based payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid Electronic Health Record (EHR) Incentive Program.
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/technical assistance series regarding HIT/HIE.	Clear timelines and transparency about the extent of continued support planned—and needed—for Practice Transformation resources and initiatives.	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.
In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional	Support from the state on VBP, specifically understanding how ACH can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP	ACHs wants to ensure that information held in these data repositories (*All-Payers Claims Database and Clinical Data Repository*) is accurate, accessible, timely, and useful to ACH transformation work and to

Health System Capacity Building	Technical Assistance	Administrative
codes.	Action Team or other technical assistance from the state.	partners.
Systems for Population Health Management support for: data governance, interoperability, HIE, disease registries, telehealth, PreManage/EDIE, and centralized registries.	Training and technical assistance for key workforce positions within required projects (e.g., community health workers, peer support specialists, care coordinators behavioral health specialists).	MCO VBP and quality improvement requirements as well as VBP models to support community health workers, peers, and other positions not reimbursed by Medicaid.
Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing, and licensed social workers.	Training and technical assistance for common training needs: Medicaid Assisted Treatment (MAT), PMP, Six Building Blocks, Transitional Care models, Trauma Informed Practices, Cultural Sensitivity, Teach-back techniques.	Establishing a career path for rural nursing and workforce needs, from high school, through four-year programs.
Support for Dental Health Aide Therapists and other dental professions that expand scope of practice will improve dental access.	Increased capacity for Practice Transformation support directly to participating providers-i.e. Practice Transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions.	Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.
	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models and how it will impact them, and what steps they should take to be prepared.	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care.

Health System Capacity Building	Technical Assistance	Administrative
	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation projects.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. Department of Health's (DOH)'s Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to Medicaid Transformation Project (MTP) goals, specifically behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.
		The state could mandate reimbursement for overdose education and take-home naloxone from MCOs.

V. Key Considerations by ACH

In addition to the overall trends identified above across ACHs, *Tables 4-21* below provide key considerations for each ACH for HCA review for purposes of ongoing monitoring and identification of potential strengths that may want to be shared across ACHs. As noted earlier, the identified opportunities are based solely on information provided in the semi-annual reports. Upon requests for additional detail or discussion, ACHs may be found to have more extensive work occurring in the identified areas.

Better Health Together

Table 4. Better Health Together (BHT) Key Considerations

Findings for Better Health Together	
Examples of Strengths	**Opportunities**
• BHT conducted two online current state assessments and achieved high response rates for both (96% and 100%). - Medicaid Transformation Project (MTP) Capacity Assessment for primary care and behavioral health partnering providers. The survey also focused on Health Information Technology (HIT)/Health Information Exchange (HIE), VBP, workforce, and practice transformation. - Fully Integrated Managed Care (FIMC) readiness assessment with behavioral health agencies using Qualis Health's Behavioral Health Agency Billing Survey tool. This was to help providers assess readiness for MCO contracts and inform regional FIMC transition strategy. • Six county Collaboratives have developed Collaborative Transformation Plans, including a collaboration framework across transformation areas. They will convene in September to build and further operationalize plans. • Primary care and behavioral health partnering providers have developed Partnering Provider Transformation Plans that include detailed plans, strategies/activities, goals, timelines, and budgets for project area activities. They also include commitments to support and participate in regional community-based care pilots. • BHT is working with MCO partners in developing a Top 10 Transformative metrics for Fall 2018 to drive incentive payments. Metrics will be included in VBP contracts and are centered on priority areas: behavioral health access, reducing unintended pregnancies, reducing jail recidivism, and improving oral health. • Six of seven Trial health organizations have signed a Memorandum of Understanding (MOU) to participate. The Tribal Partners Leadership Council provides a platform for engagement with Tribal partners and allows their recommendations and input into Transformation planning and implementation	• BHT intends to explore opportunities to include "alternative" or "non-traditional" services such as acupuncture and peer-based/faith-based methods for personal recovery, wellness, and prevention to support advocacy and reduce barriers to access these services. ***Recommendation:*** Monitor progress in this area, consider targeted guidance for ACHs, and provide opportunities for the development of learning communities on community engagement/health equity. • BHT has shifted workforce development activities from a Pathways HUB and large community health worker workforce to a robust care coordination infrastructure across the region. This will align efforts around shared ability to develop care plans, share patient information, and manage community assets. ***Recommendation:*** While rapid cycle improvement strategies should be encouraged in the healthcare transformation context, monitor ACH project planning and implementation to ensure appropriate overall progress. • BHT noted policy barriers impacting workforce including reimbursement and credentialing for health professionals, including telemedicine. The Department of Health would be a valued partner to revisit scope of practice. ***Recommendation:*** Monitor progress in this area and provide opportunities for state involvement. • A lack of safe and affordable housing is noted as a barrier to improved health in the region. BHT would like to see partnerships with the Department of Commerce and HUD initiatives to increase availability of housing, local jurisdictions, and private philanthropy. ***Recommendation:*** Consider if there are opportunities to assist in coordination with local and state agencies to research financing options and availability.

Table 5. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$4,392,480
2B: Community-based Care Coordination	5	5	$3,019,830
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$549,060
3D: Chronic Disease Prevention and Control	5	5	$1,098,120
Total	**20**	**20**	**$9,059,490**

Cascade Pacific Action Alliance (CPAA)

Table 6. CPAA Key Considerations

Findings for CPAA	
Examples of Strengths	**Opportunities**
• CPAA conducted customized current state capacity assessments: - Survey for Project 2B, Community-Based Care Coordination, focused on detailed requirements specific to the Pathways HUB and implementation of that project. - Survey focused on CPAA's five remaining project areas to assess the project areas, readiness, and project integration. • CPAA contracted the AIMS Center to offer a Bi-Directional Care Integration training program to partners beginning in Fall 2018. • A technical assistance partner, Foundation for Healthy Generations, is in process of becoming a certified master trainer in a curriculum designed for the Pathways model. CPAA plans to utilize this resource to provide training, free of charge, to Care Coordination Agencies that are partnering to implement the Pathways model. • Part of CPAA's strategy for Domain 1 investments for Pathways has been to explore potential partnerships with other ACHs implementing this program. CPAA helped to convene initial cross-ACH meetings on this topic and remains an active participant in discussions. • CPAA's goal is to ensure all critical providers will be fairly compensated using the following funding model bonus pools: - Health Equity Bonus Pool based on extent to which providers serve individuals experiencing health disparities. - Rural Bonus Pool for serving rural residents. - Attribution Bonus Pool for serving Medicaid beneficiaries. • Consumer Advisor Committee. CPAA was mindful about representation, including members who have actual experience. Members include representatives from groups often underrepresented in health system transformation, including Medicaid beneficiaries, ethnic and racial minorities, and members of the LBGTQ community. As was pointed out by a	• CPAA stated lack of regular and deliberate communication between community-based organizations (CBOs) and clinical providers as a critical gap in all six project areas. The majority of CBOs that responded to the assessment reported they do not regularly communicate with medical providers. As a mitigation strategy, CPAA continues to convene both CBOs and clinical providers during monthly council meeting and work group meetings, and will continue to research the possibility of shared care plans between CBOs and clinical providers. ***Recommendation:*** Continue monitoring progress, consider targeted guidance for ACHs, and provide opportunities for learning communities where best practices can be shared on communication strategies between CBOs and clinical providers. • CPAA noted a solution to regional workforce shortages and the resulting lack of access to care is support at the state level for expanding the scope of practice for current providers and allowing for reimbursement on additional codes. ***Recommendation:*** While expanding the scope of practice for current providers and allowing for reimbursement on additional codes may help to address workforce shortages, careful consideration would be required to ensure changes to current scope of practice for a provider type is covered within the provider's license and conforms with nationally recognized standards of care. • Survey respondent (to CPAA survey) stated "All the MCOs that have approached us have wanted to start with Fee-for-Service which moves us backwards from our current VBP contracts." ***Recommendation:*** Continue to collaborate with the MCOs to ensure a consistent and transparent messaging is given to the ACHs and MTP providers. • CPAA noted that their Clinical Provider Advisory Committee agreed to catalog of screening tools to assess social determinants and make the tools available to implementation partners. A next step is for the Committee to review the different tools and identify a few key questions that all providers should include in their social determinants of health screening based on available community resources. ***Recommendation:*** HCA may want to learn more about these tools as they are further defined to determine if they are a potential tool that would be of benefit across the MTP. For example, HCA may want to understand if the screening tools

Findings for CPAA	
Committee member in a discussion about health equity, the health care system is, by design, inequitable: Medicaid reimburses at a lower rate than other insurance, and Medicaid beneficiaries have fewer choices regarding providers and treatment and often struggle with long wait-lists and other barriers to accessing care.	will include questions about access to housing and transportation, as they are significant barriers to care. • CPAA indicated that the Executive Director would leave the position effective August 1 (one day after end of reporting period). ***Recommendation:*** Monitor that position is filled or a plan is in place during next reporting period.

Table 7. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$3,137,486
2B: Community-based Care Coordination	5	5	$2,157,021
2C: Transitional Care	5	5	$1,274,604
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$392,186
3B: Reproductive and Maternal and Child Health	5	5	$490,232
3D: Chronic Disease Prevention and Control	5	5	$784,371
Total	**30**	**30**	**$8,235,900**

Greater Columbia ACH

Table 8. Greater Columbia ACH Key Considerations

Findings for Greater Columbia	
Examples of Strengths	**Potential Opportunities**
• GCACH conducted two regional assessments in 2018. • GCACH is moving to a Patient-Centered Medical Home (PCMH) model of care to strengthen primary care, improve reimbursement through quality improvements, and use population health management tools to track patients and monitor patient outcomes. • GCACH intends to start Learning Collaboratives for the four project areas in Fall 2018. These will take advantage of national expertise and drill down into specific evidence-based approaches. • GCACH is actively engaging Tribal partners (Yakama Nation) to ensure their specific needs are being met to meet project objectives.	• The ACH noted the current state assessment was sent to 81 organizations with a Letter of Interest, only 57 responded. A financial stipend was given for completing the assessment, and completion was a prerequisite to contracting with GCACH. GCACH does believe they have good representation from each healthcare sector across their nine counties. ***Recommendation:*** Monitoring partnering provider involvement ensures a wide array of engagement with the ACH. • The ACH outlined several activities designed to support communities with limited English (LEP) proficiency; however, efforts appear to focus on Spanish-speaking communities and it is unclear if additional language supports would be beneficial/needed. • ***Recommendation:*** Determine if ongoing monitoring is needed and additional language supports may be required by the populations served.

Table 9. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$6,473,128
2C: Transitional Care	5	5	$2,629,708
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$809,141
3D: Chronic Disease Prevention and Control	5	5	$1,618,282
Total	**20**	**20**	**$11,530,260**

HealthierHere

Table 10. HealthierHere Key Considerations

Findings for HealthierHere	
Examples of Strengths	**Potential Opportunities**
• Using the HIE/HIT assessments, HealthierHere developed five principles to guide HIE and HIT investments, and a framework to assess feasibility of investment options. The ACH convened a Partner Summit meeting and project work groups to share and discuss results and refine strategies. • The current state and HIE/HIT assessments helped identify key areas where partnering providers require support for successful implementation and participation in transformation. • The Community and Consumer Voice Committee is comprised of community leaders, CBOs, Medicaid consumers, and others. They meet monthly to provide input into planning and decision-making to ensure community support to advance health equity and that the system is more culturally responsive. • The ACH is developing a small grants program to increase stakeholder involvement to drive transformation. The goal is to increase participation in community engagement, planning, and implementation including outreach to focus populations, especially non-English-speaking populations.	• The ACH indicated partnering providers have reported low and inconsistent use of toolkit care models. ***Recommendation:*** Monitor the extent to which care models are increasingly utilized. • The ACH outlines a number of Tribal outreach activities; however, it continues to experience challenges engaging and collaborating with certain Tribes. ***Recommendation:*** Continue to monitor ACH Tribal engagement activities and progress.

Table 11. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$10,172,059
2C: Transitional Care	5	5	$4,132,399
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$1,271,507
3D: Chronic Disease Prevention and Control	5	5	$2,543,015
Total	**20**	**20**	**$18,118,980**

North Central ACH

Table 12. North Central ACH Key Considerations

Findings for North Central ACH	
Examples of Strengths	**Potential Opportunities**
• In an effort to assess outpatient provider needs and gaps in addition to the Patient-centered Medical Home Assessment (PCMH-A)/Maine Health Access Foundation (MeHAF), the ACH developed and conducted a 52-question survey covering quality improvement and practice coaching, workforce challenges, VBP strategies, HIT/HIE, access to care, and care coordination. • Although not selected in the original project plan, the ACH has elected to further evaluate potential to implement the Law Enforcement Assisted Diversion approach and has engaged in interviews with three key law enforcement agencies in the area to assess their support. • The ACH is conducting an in-depth assessment of how the ACH might help with the shortage of Chemical Dependency Professionals in the region. Also, the ACH hired a full-time Capacity Development and Grant Specialist, and a contractor to evaluate current asset-mapping solutions, to support sustainability and capacity building for addressing social determinants of health. • The ACH has identified a range of systems used by providers for population health management. As such, the ACH is focusing on discrete strategies such as promoting the use of Edie/PreManage, increasing consistency and promoting communication across EHRs, promoting the use of telehealth, and promoting use of the Washington PMP.	• The ACH indicated that four of thirteen agencies indicated interest in becoming a Care Coordination Agency (CCA). ***Recommendation:*** Continue to monitor progress of HUB implementation, specifically the number of entities becoming CCAs. • The ACH outlined a number of Tribal outreach activities; however, it continues to experience challenges with Tribal responsiveness to the ACH's attempts to engage and collaborate. ***Recommendation:*** The Independent Assessor found the response to be complete given HCA's direction regarding completeness where the ACH can provide detail as to status and efforts. HCA will want to continue to track North Central's Tribal outreach and engagement activities, and may want to consider additional opportunities to support the ACH with engagement of the Tribes. • The ACH outlined a considerable number of activities related to community engagement; however, the majority listed appear to target existing partners. ***Recommendation:*** Continue monitoring ACH community engagement activities and/or request that the ACH specifically identify "organizations or individuals which are not formally participating in project activities and not receiving funding." • The ACH outlined several activities and partnerships designed to support communities with LEP; however, efforts appear to focus on Spanish-speaking communities and it is unclear if additional language supports would be beneficial/needed. ***Recommendation:*** Determine if ongoing monitoring is needed, as a limited strategy is provided for ongoing work (i.e., "ACH plans to engage partnering providers to see if there is a specific role the ACH can play in continued engagement.") and additional language supports may be required by the populations served.

Table 13. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$1,432,330
2B: Community-based Care Coordination	5	5	$984,727
2C: Transitional Care	5	5	$581,884
2D: Diversions Interventions	5	5	$581,884
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$179,041
3D: Chronic Disease Prevention and Control	5	5	$358,083
Total	**30**	**30**	**$4,117,950**

North Sound ACH

Table 14. North Sound ACH Key Considerations

Findings for North Sound ACH	
Examples of Strengths	**Potential Opportunities**
• North Sound ACH used a thorough process for planning and conduct of its assessment activities. The assessment included four activities and processes: environmental scan, partner readiness survey, Pathways implementation assessment, and identification of regional themes and strengths. The regional themes and strengths activity included key informant interviews, regional convenings, community forums, and work sessions where over 350 regional partners participated. • For Project 2B, Care Coordination the ACH provides a very detailed description of HUB planning, progress and planned activities. • North Sound ACH appears to have made significant progress in considering opportunities to use a portfolio approach for implementation of all eight projects. • North Sound ACH has undertaken many activities to identify and plan for addressing health equity. For example, the ACH is launching a regional health equity coalition and developing health equity measures with experts from the Haas Institute. • The ACH has developed a comprehensive approach for identifying populations of focus.	• Specific to partnering providers' outreach to populations with limited proficiency in English and strategies that partnering providers have undertaken to address challenges in engaging community groups that may be underrepresented in Transformation efforts, North Sound ACH indicates they will conduct a partner survey in July 2018 that includes questions about these areas. Additionally, the ACH notes that Part 2 of the ACH's Call for Partners application will require attestations of commitment to supporting LEP populations and to engaging underrepresented populations in partners' individual implementation plan. ***Recommendation:*** To further understand North Sound ACH's engagement of these populations as implementation progresses, HCA may want to request additional information as to survey results and whether partnering providers raise concerns about the required attestations to support these areas. • Attestation by providers is required for assuring they serve and will continue to serve the Medicaid population. ***Recommendation:*** HCA may want to request additional information over time as to how North Sound ACH is monitoring that partnering providers are continuing to serve the Medicaid population.

Table 15. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$3,953,232
2B: Community-based Care Coordination	5	5	$2,717,847
2C: Transitional Care	5	5	$1,606,001
2D: Diversions Interventions	5	5	$1,606,001
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$494,154
3B: Reproductive and Maternal and Child Health	5	5	$617,693
3C: Access to Oral Health Services	5	5	$370,616
3D: Chronic Disease Prevention and Control	5	5	$988,308
Total	**40**	**40**	**$12,353,850**

Olympic Community Health

Table 16. Olympic Community of Health (OCH) Key Considerations

Findings for Olympic Community of Health	
Examples of Strengths	**Potential Opportunities**
• OCH is offering training to better serve specific populations, for example, Tribal populations and LGBTQ-inclusive care. Training also includes topics such as health equity, trauma-informed care, and adverse childhood experiences. • OCH is incenting providers to disaggregate data to identify and work to address inequities in access and outcomes across sub-populations. • OCH piloted an IT platform to reduce barriers to care communication between providers on shared patients and clients. The HIT Commons pilot phase ended on time, under budget, and with encouraging results. The use case for the Commons pilot included one primary care provider and one Substance Use Disorder (SUD) treatment provider sharing information on shared patients requiring treatment for Opioid Used Disorders (OUDs). Because of the pilot's success, the OCH Board is deliberating over a proposal for Phase 2. If successful at full-scale, OCH thinks Commons will be a central nervous line for partnering providers to share information in real-time about shared patients or clients across the entire MTP portfolio of work. GCACH and Puget Sound Fire in the Healthier Here ACH are collaborating with OCH on the development and potential cost-sharing of a statewide Commons. • OCH has identified questions for which Implementation partners will report every six months. OCH will use these reports to continuously inform how OCH targets shared learning support	• In regards to addressing health equity, OCH's change plans require providers/partners to assess for social determinants of health and to provide referral to community providers for services into standard practice. ***Recommendation:*** HCA may want to request additional information over time as to how OCH is monitoring that partnering providers are meeting this requirement.

Findings for Olympic Community of Health	
opportunities, and to understand how Implementing Partners may expand transformation strategies and approaches, target populations, and/or activities in later DSRIP years.	

Table 17. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$1,621,839
2D: Diversions Interventions	5	5	$658,872
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$202,730
3B: Reproductive and Maternal and Child Health	5	5	$253,412
3C: Access to Oral Health Services	5	5	$152,047
3D: Chronic Disease Prevention and Control	5	5	$405,460
Total	**30**	**30**	**$3,294,360**

Pierce County ACH

Table 18. Pierce County ACH Key Considerations

Findings for Pierce County ACH	
Examples of Strengths	**Potential Opportunities**
• Pierce County ACH conducted five separate assessments tailored to specific audiences. Assessments were as follows: Health System/Clinical Organization; CBO; HIT/HIE; Community Voice survey; and Behavioral Health Billing and Information Technology Toolkit (Qualis). • Pierce County ACH launched live operations as the Community HUB in March, including securing a contract for a cloud-based Care Coordination Systems software platform. • The ACH indicates extensive learning activities and technical assistance being provided to partnering providers. • The ACH has provided onsite or virtual facilitation by Improvement Advisors to support smaller organizations with completion of Organizational Assessment and Phase I Action Plan templates. • The ACH incorporated health equity into the Funds Flow Methodology.	• Pierce County ACH notes continued challenges with engaging and having participation of the Tribes. One has elected to work with CPAA and another continues to not be responsive. Therefore, Pierce County ACH is not compliant with required representation to include on the decision-making body, as they have not secured Tribal/IHS/ UIHP membership on the governing body. ***Recommendation:*** The Independent Assessor found the responses to be complete given HCA's direction that attestations should be considered complete where the ACH can provide detail as to status and efforts. HCA will want to continue to track Pierce County's efforts to engage Tribes, IHS and UIHPs, and may want to consider additional opportunities to support the ACH with engagement. • The ACH provided a limited response to efforts regarding LEDP that is specific to one project. ***Recommendation:*** While the ACH provided a complete response to the question, HCA may want to request additional information and particularly as implementation occurs.

Table 19. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

Pierce County ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$4,791,796
2B: Community-based Care Coordination	5	5	$3,294,360
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$598,975
3D: Chronic Disease Prevention and Control	5	5	$1,197,949
Total	**20**	**20**	**$9,883,080**

SWACH

Table 20. SWACH Key Considerations

Findings for SWACH	
Examples of Strengths	**Potential Opportunities**
• Clinical and HIT assessments included very strong response rates. • A substantial number of non-traditional providers were listed in response to D.1 regarding partnering providers registered. • The ACH appears to be making considerable progress engaging Tribal partners (including clinical assessments). • SWACH notes a strong training history and focus on health equity during the reporting period. Continued efforts are identified to target rural providers. SWACH also notes a staff member is dedicated to community health equity efforts. • SWACH noted close collaboration with Greater Columbia ACH to assess readiness for Klickitat County providers, the only Mid-adopter.	• The ACH cites a number of specific examples regarding progress to identify potential strategies for each Domain 1 focus area; however, there appears to be heavy reliance on the Health Systems Capacity Building Partnership (HSCBP) (i.e., a collective effort lead by HCA and including the Association of Washington Public Health District (AWPHD), University of Washington, State Agencies and all nine ACHs). ***Recommendation:*** Continue monitoring ACH-specific efforts in addition to HSCBP. • The ACH appears to have three key positions that have changed, though it is unclear if these were related to new hires or turnover. Two may have been the result of turnover, as interim titles are listed. ***Recommendation:*** Continue monitoring ACH staffing to ensure adequate support for project oversight and implementation. • SWACH appears to be progressing in planning, and has not yet used the regions integration incentive dollars. They also did not provide projected expenditures providing the following response: "This section, particularly projected expenditures, is intentionally left blank out of deference to a process currently underway. Proposing projected costs prior to completing our regional process is not prudent. It is anticipated that during the next reporting period, SWACH will have completed the community process and that SWACH's board will approve the funds flow for integration incentives." Myers and Stauffer noted this response as complete given they indicate the process in place for moving forward. ***Recommendation:*** Continue monitoring use and planned use of incentive dollars by requesting additional information during the reporting period and review of the subsequent semi-annual report.

Table 21. Achievement Values and Earned Incentives for Reporting Period January 1, 2018 – June 30, 2018

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Potential Incentives**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$2,795,215
2B: Community-based Care Coordination	5	5	$1,921,710
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	5	5	$349,402
3D: Chronic Disease Prevention and Control	5	5	$698,804
Total	**20**	**20**	**$5,765,130**