Healthier Washington Medicaid Transformation

Accountable Communities of Health

Semi-annual reporting guidance

Reporting period: January 1, 2019 – June 30, 2019

SAR 3.0

Release date: January 31, 2019

Table of contents

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 on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each year of the Medicaid Transformation:

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

The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state's contracted Independent Assessor (IA) will review semi-annual report submissions.

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

Reporting requirements

The semi-annual report for this period (January 1, 2019 to June 30, 2019) includes three sections as outlined in the table below.

Semi-annual reporting requirements (January 1, 2019 – June 30, 2019)		
Section	**Item num**	**Sub-section components**
Section 1. ACH organizational updates	1-8	Attestations
	9-14	Attachments/documentation - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	15-17	Attachments/documentation - Implementation work plan - Partnering provider roster - Quality improvement strategy update
	18-19	Narrative responses - General implementation update - Regional integrated managed care implementation update
	20	Attestations
Section 3. Pay-for-Reporting (P4R) metrics	21	Documentation

There is no set template for this semi annual report. ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

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 they completed reporting requirements and demonstrated performance on outcome metrics. The amount of Project Incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given payment period.

For DY 3, 75% of all Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of January 1 through June 30, 2019, determines achievement for half of the available P4R-associated Project Incentives. The remaining half of the P4R Project Incentives will be earned through the semi-annual report covering the period from July 1 to December 31, 2019.

ACHs will earn AVs and associated incentive payments for demonstrating fulfillment of expectations and content requirements. AVs associated with this reporting period are identified in the table below.

Table 1. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period Jan. 1- June 30, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	8	6	-	-	7	-	-	6	27
Cascade Pacific Action Alliance	7	6	6	-	7	6	-	6	38
Greater Columbia ACH	8	-	6	-	7	-	-	6	27
HealthierHere	8	-	6	-	7	-	-	6	27
North Central ACH	8	6	6	6	7	-	-	6	39
North Sound ACH	8	6	6	6	7	6	6	6	51
Olympic Community of Health	7	-	-	6	7	6	6	6	38
Pierce County ACH	8	6	-	-	7	-	-	6	27
SWACH	8	6	-	-	7	-	-	6	27

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than July 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: https://cpaswa.mslc.com/.

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled "Semi-Annual Report 3 – July 31, 2019."

The folder path in the ACH's directory is:

Semi-Annual Reports → Semi-Annual Report 3 – July 31, 2019.

See WA CPAS User Guide available in each ACH's directory on the CPAS website for further detail on document submission.

File format

ACHs must submit semi-annual reports that provide HCA and the IA an update on regional project implementation progress during the reporting period. Reports should respond to all required items in this guidance document. ACHs are encouraged to be concise in narrative responses.

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. 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, Microsoft Excel, and/or a searchable PDF format. Below are examples of the file naming conventions ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR3 Report. 7.31.19
- *Attachments:* ACH Name.SAR3 Attachment X. 7.31.19

Upon submission, all submitted materials will be posted publicly to HCA's Medicaid Transformation resources webpage.[1]

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2019 – June 30, 2019.

ACH semi-annual report 3 – submission and assessment timeline			
No.	**Activity**	**Responsible party**	**Anticipated timeframe**

[1] https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents

ACH semi-annual report 3 – submission and assessment timeline			
1.	Distribute semi-annual report template and workbook for reporting period January 1 – June 30, 2019 to ACHs	HCA	February 2019
2.	Submit semi-annual report	ACHs	July 31, 2019
3.	Conduct assessment of reports	IA	Aug 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 26-31, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 27- Sept 15, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Aug 28-Sept 30, 2019
7.	Issue findings to HCA for approval	IA	September 2019

Contact information

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

ACH contact information

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

ACH name:	Olympic Community of Health
Primary contact name **Phone number** **E-mail address**	Celeste Schoenthaler (360) 633-9241 celeste@olympicch.org
Secondary contact name **Phone number** **E-mail address**	Margaret Moore (360) 689-2345 margaret@olympicch.org

Section 1. ACH organizational updates

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: • 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 • 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	
4. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH's decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits.[2]	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	X	

[2] https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26

If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

Attachments

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

9. Key staff position changes. If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

If applicable, attach or insert current organizational chart.

Please see **OCH. SAR3 Attachment 1. 7.31.19**

During the reporting period, Olympic Community of Health (OCH) underwent significant administrative changes. The former executive director transitioned out and a new executive director was onboarded. The change in leadership necessitated a pause in strategic planning while onboarding. Overall, activities during this reporting period are reflective of this change in pace. Some OCH approaches now reflect the change in leadership and inevitable course corrections identified. Moving forward, OCH approaches will continue to reflect the prioritized direction of new leadership.

10. Budget/funds flow.

- Financial Executor Portal activity for the reporting period. The Financial Executor will provide to the Independent Assessor an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. Use Category reconciliation documentation will be included, if applicable. No action is required by the ACH for this item.
    - Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal, etc.).

On January 11 2019, OCH withdrew $133,640 from the Financial Executor Portal. An OCH Implementation Partner, Kitsap Medical Group, required payment outside of the regular financial executor disbursement timeline. OCH moved the dollars to OCH bank accounts and promptly paid the partner directly.

Documentation

The ACH should provide documentation that addresses the following:

11. Tribal Collaboration and Communication. Provide two examples that demonstrate how the ACH furthered the relationships with Tribes and Indian Health Care Providers (IHCPs)

with whom the ACH shares the region.

OCH is fortunate to partner with the seven tribes in the Olympic region. Currently, three of those partners have a formal contract with OCH for transformation work. During the SAR3 reporting period, OCH conducted site visits with all partners who have a Change Plan and contract with OCH, Implementation Partners, including three tribal health clinics (Jamestown Family Health Clinic, Port Gamble S'Klallam Health Services, and Sophie Trettevick Indian Health Center). OCH staff traveled to each of the three tribal health clinics to meet with their teams and learn more about the work that each clinic does, including successes and challenges with transformation efforts. These site visits demonstrate OCH's commitment to spend time in communities throughout the region, including remote tribal communities.

On March 11, 2019 OCH hosted a training titled "Tribal Sovereignty 101 and Indian Heath Care Systems 201". The audience for the training included OCH Board of Directors, OCH staff, and regional partners. The purpose of the training was to strengthen knowledge regarding the history of Tribes with a focus on sovereignty and the unique ways that healthcare is delivered in tribal clinics and systems. We were fortunate to have excellent presenters in Jessie Dean, Tribal Affairs Administrator at the Health Care Authority; Melissa Naeimi, Senior Policy Analyst, Tribal Affairs, Health Care Authority; Lena Nachand, Tribal Liaison for Medicaid Transformation, Health Care Authority; and Vicki Lowe, Executive Director for the American Indian Health Commission of Washington State. Approximately 30 people participated in this training.

12. Design Funds.

- Provide the ACH's total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.
- If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

An outline of Design Fund expenditures to date and future anticipated expenditures by Use Category is provided below. Design funds have been used to support internal organizational operations and will continue to be used for such purposes.

Use Category	Funds Expended as of June 30, 2019	Anticipated Spending of Remaining Design Funds	Notes
Administration	$489,175	$1,651,016	Includes expenses related to financial management, human resources, oversight, and other expenses related to internal operations.

Health Systems and Community Capacity Building	$158,227	$0	Includes the previous Use Category "Information Technology." Moving forward, OCH will support these activities with funds received in the Financial Executor.
Project Management	$636,373	$2,060,050	Includes the majority of programmatic personnel expenses, as well as those costs related directly to the implementation of MTP.
Provider Engagement, Participation and Implementation	$254,698	$625,712	These expenses are related to partner communication and engagement, including written, electronic, and in-person communications.
Other	$124,749	$0	These funds were spent under the old Use Category, "Project Plan Development," which is no longer in use.
Total	**$1,663,222**	**$4,336,778**	

Acronyms used in this table:
MTP – Medicaid Transformation Project

13. Funds flow. If the ACH has made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission, attach:

- The ACH's current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.

In July, 2017 the OCH Board of Directors authorized the formation of a funds flow workgroup, tasked with determining the methodology for distributing incentive payments to participating providers. The funds flow workgroup met fourteen times and determined a methodology which was approved by the OCH Board of Directors August 13, 2018.

The OCH funds flow model outlines a methodology for calculating incentive payments based on projected earnings by OCH over the life of the Medicaid Transformation Project (MTP). The total estimated pool is divided into sub-pools (**see table 1 below**):

- Natural Community of Care (NCC): Clallam, Jefferson and Kitsap counties. Each NCC or

regional county is weighted based on the population of Medicaid lives.

- Change Plan type (primary care, behavioral health)
- Hospitals pull from a separate sub-pool of $1.6 million over four years (2018-2021)
- Community Based Organizations and Social Services (CBOSS) Implementation Partners pull from a separate sub-pool of $1.4 million over six years (2018-2023)

Table 1: Funds flow model by NCC and Change Plan type

	Clallam 28%	Jefferson 16%	Kitsap 55%	Total 100%
Primary Care Change Plans	$2,603,000	$1,498,000	$5,063,000	$9,164,000
Behavioral Health Change Plans	$1,464,000	$843,000	$2,848,000	$5,155,000
Hospitals	Each participating hospital (total 4) capped at $100,000 per year over 4 years			$1,600,000
Community Based Organization and Social Services Change Plans	CBOSS partners pull from 1 regional pool*			$1,425,700

*CBOSS funds flow model approved by OCH Board of Directors February 11, 2019

The table above outlines the total estimated amount of the sub-pool from which an Implementation Partner can earn. Payments are also calculated by scale and scope:

- Scale of the partner organization:
    - Primary care: number of Medicaid members served during previous calendar year
    - Behavioral health: number of behavioral health encounters during previous calendar year
    - Hospital: fixed maximum of $100,000 per year over 4 years, *scale not used to calculate*
    - CBOSS: outcomes identified in Change Plan and ability of those outcomes to impact the 14 selected OCH core measures
- Scope of Change Plan activities:
    - Primary care/behavioral health/hospital: number of selected voluntary (not required) outcomes in Change Plan
    - CBOSS: number of new and expanded partnerships as they relate to selected Change Plan outcomes

The relative weights of "scale" and "scope" used to calculate incentive payments change year to year, moving each year towards weighting "scope" more heavily.

On February 11 2019, the OCH Board of Directors adopted the 2019 Medicaid Transformation Project Payment Model, which is included as attachment: **OCH.SAR3 Attachment 2. 7.31.19**, to guide the distribution of project incentives to provider partners in 2019. The model

is based on the funds flow framework described above and is consistent with the framework used to calculate incentive payments in 2018.

As with 2018 incentives, 2019 partner incentives are based on scale and scope as described above. In the 2019 MTP Payment Model, scope was expanded to include quantitative and qualitative reporting, completion of a site visit with OCH staff, participating in an NCC convening, formation of a Quality Improvement team, and the quantity and quality of community-clinical linkages (partnerships).

- Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.

The OCH funds flow model and 2019 MTP Payment Model include a pool of money held in reserve. An estimated $2 million may be available in reserve, depending on actual incentives received. These funds have yet to be allocated, decisions are expected in 2020.

14. Incentives to support integrated managed care. Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care.

- Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- ACHs may use the table below or an alternative format as long as the required information is captured.
- Description of use should be a brief line item (not narrative).

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	**Expenditures ($)**	
	Actual (2018)	**Projected**
Project Incentives to Implementation Partners to support clinical and financial integration	$217,646	$197,627

OCH supports project incentives for Integrated Managed Care (IMC) activities to support the 2020 deadline. The OCH Change Plan template includes mandatory and voluntary outcomes for care integration and encourages partners to commit to these outcomes in order to earn incentives. In 2018, Integration outcomes accounted for 5% of potential Change Plan incentives for primary care partners, and 8.6% of incentives for behavioral health partners. The potential shares of incentives in 2019 are estimated at 0.9% and 1.5%, respectively. The actual dollar value of IMC–related Change Plan incentives is dependent on the specific performance of individual Implementation Partners relative to all other partners in their incentive sub-pool. Actual awards will vary based on the relative performance of partners.

In addition to these incentive funds, OCH has secured $20,000 of additional funding from Amerigroup to provide project management support of IMC. A full description of IMC activities is provided in Section 2, Question 19.

Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attachments

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

15. Implementation work plan

Implementation plans are "living documents" that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA with the information required to monitor the ACH activities and project implementation timelines.

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.[3]

- The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
    - Work steps and their status.
        - At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:
            - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
            - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
            - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
            - Not Started: Work step has not been started.
        - The ACH is to add a "Work Step Status" column to the work plan between the

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

"Work Step" column and the "Timing" column. This column should reflect the status assigned to the work step.

  - The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to bet started.

- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

Submit updated implementation work plan that reflects progress made during reporting period.

The current updated implementation work plan is included in PDF format. There are 3 attachments, one for each stage (1, 2, and 3). Please review the following attachments:

OCH.SAR3 Attachment 3. 7.31.19

OCH.SAR3 Attachment 4. 7.31.19

OCH.SAR3 Attachment 5. 7.31.19

16. 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 through the ACH under Medicaid Transformation.[4] ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:[5]

- *Health systems and community capacity building*
- *Financial sustainability through participation in value-based payment*
- *Bidirectional integration of physical and behavioral health*
- *Community-based whole person care*
- *Improve health equity and reduce health disparities*

The partnering provider roster is a standard component of semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in Medicaid Transformation activities.

[4] Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

[5] https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf

To earn the achievement value associated with this reporting component, ACHs are required to confirm and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites ("potential site list"), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites ("potential site list") to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific "potential site list" to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
    - Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Place an "X" in the appropriate project column(s).
    - When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

Submit partnering provider roster.

Please see the attached Partnering Provider Roster, **OCH.SAR3 Partnering Provider Roster. 7.31.19.** Per instruction, all changes and additions to the originally provided template have been highlighted**.**

Documentation

The ACH should provide documentation that addresses the following:

17. Quality improvement strategy update

The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and the IA apprised of quality improvement activities and findings. ACHs may determine the format to convey this information.

Semi-annual updates should demonstrate that the ACH has insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided by the ACH to partnering providers to promote achievement of transformation outcomes and objectives.

Through these updates, ACHs are expected to report developments over the reporting period, such as:

- Modifications to the ACH's quality improvement strategy

- Summary of findings, adjustments, and lessons learned
- Support provided to partnering providers to make adjustments to transformation approaches
- Identified best practices on transformation approaches

For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of forward momentum, including evidence that partnering providers have the resources and support required for success.

Attach or insert quality improvement strategy update.

- Modifications to the ACH's quality improvement strategy

  OCH.QI Strategy. 7.31.19 is the original submission of OCH's quality improvement strategy.

- Summary of findings, adjustments, and lessons learned

  Progress to Date report:

  -Coordination of Electronic Health Records (EHRs): Three mental health agencies transitioned to the same EHR, Care Logic. This transition will support increased in-sector and cross-sector care coordination. Four Community Connect Epic users collaborate to streamline care coordination and reporting practices. Four Substance Use Disorder (SUD) providers use the same EHR (ReliaTrax).

  -Social Determinants of Health (SDOH) screening and implementation: There is a strong commitment across Implementation Partners to screen for SDOH needs with high potential to collaborate and share screening templates, resources, and workflows.

  -Bi-directional integration: There is significant movement toward integrating physical and behavioral health across all Implementation Partners (e.g. hiring new staff, contracting cross-sector, expansion of services).

  -Opioid work: Three Implementation Partners have begun 6 Building Blocks and OCH continues to expand involvement. The 3 County Coordinated Opioid Response Project (3CCORP) remains active and partners are invested in opioid work.

  -Expansion: Increase in services and access across NCCs: new programs, new service lines, expansion of existing services, new staff hires, and capitol expansion programs.

  Intermediary Metrics:

  OCH is revising metrics based on strong partner feedback related to quantity and feasibility of the original metric set released in March. Partner feedback on revised metric set was due June 26. The final set will be reviewed by the Performance

Measurement and Evaluation Committee (PMEC) and submitted for approval by the Board of Directors in September 2019.

Early 2019 Implementation Partner Site Visits:

Facilitators:

-Partnerships: Increased collaboration amongst partners including coordination of EHR and reporting systems. Convening partners allows for opportunities to connect. Partners report, "Care has never been so coordinated."

-Investments Beyond MTP Funds: Many Implementation Partners are using multiple funding sources to fully implement all transformation activities. Some Implementation Partners have sought external funding or invested significant organizational funds to carry out many Change Plan activities.

-Expansion of Services: Several Implementation Partners have expanded service lines including: three new dental clinics across all NCCs, increased crisis and residential services for mental health and SUD, and investment in care coordination staff.

-Commitment to Transforming Care: Overall, Implementation Partners understand Change Plan activities and the necessity of transforming care. While various barriers to accomplishing transformation activities have been identified, all Implementation Partners are highly invested in improving care and finding sustainable solutions.

Barriers:

-Workforce: Frequent staff turnover and hiring difficulties delay work. There is a lack of qualified applicants in rural communities, particularly for: data analysts, nurse care managers, and chemical dependency providers.

-EHR/Health Information Technology (HIT)/Health Information Exchange (HIE) limitations: Significant EHR limitations exist across all sectors, especially with clinical tools for building registries and tracking patients. Providers across all sectors use off-line tracking systems (i.e. Excel files). Additionally, transitioning to a new EHR and restructuring systems present time and staffing challenges. CBOSS partners remain largely without access to any comprehensive technology platform. In addition, varying interpretations of 42 Code Federal Regulations Part 2 limit coordinated care across physical and behavioral health providers.

-Access: Access to specific services remain limited, particularly in rural communities, resulting in long wait times and loss of clients/patients without adequate transportation.

-Managed Care Organization (MCO)/Sustainability/IMC: Behavioral health providers are intently focused on successful financial integration and possess minimal bandwidth to focus on other activities. Few physical health providers in Clallam NCC have contracts with MCOs and CBOSS partners have limited knowledge of what changes MCO contracting will bring. Some integrated clinics are unable to bill for certain behavioral health services until they secure the appropriate agency license.

- Support provided to partnering providers to make adjustments to transformation

approaches

Practice coaching via Comagine practice coach facilitator and Pediatric Transforming Clinical Practices initiative (P-TCPi) practice facilitator:

- 14 Implementation partners engaged in coaching with Comagine during the reporting period. Due to changes in staffing and contract terms, OCH ended its contract with Comagine in May 2019; ongoing partner support will be provided through other mechanisms.
- 6 partners have been engaged in coaching with P-TCIPi practice facilitator. This Department of Health project sunsets in September 2019, OCH is planning how to transition to ongoing partner support through other mechanisms.

Partner convenings (one individual per NCC, and one regional):
OCH provided space for partners to share knowledge in alignment with the work and goals of MTP, build and strengthen partnerships across the region, and learn about early successes and best practices of MTP work. Examples of activities:

- Partnership identification matrix
- Partner presentations on promising best practices (successful Medication Assisted Treatment, coordination between SUD and prescribers, implementation of PreManage to reduce emergency department (ED) visits, equity efforts to improve LGBTQ patient experience)
- Review Pay for Performance metric data and 2019 targets
- Breakout sessions by provider type (behavioral health, primary care and CBOSS) to share experiences developing partnerships and brainstorm solutions to shared challenges

- Identified best practices on transformation approaches

- Successful launch of a community paramedicine program in Clallam and police navigator program in Jefferson to reduce ED visits
- Successes in broadening the Opioid Use Disorder (OUD) treatment system from an abstinence-only model to a more comprehensive approach, which has positioned the region as a leader in OUD treatment in the state

Narrative responses.

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

18. General implementation update

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols:* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.
    - Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?

Summary of progress in adoption of policies, procedures, and protocols by Change Plan Domains:

Domain	Summary and examples
Care Coordination	Implementation Partners across the region have begun coordinating to streamline EHR systems and coordinate reporting practices. Several Implementation Partners are interested in screening for SDOH and have expressed interest in sharing templates and workflows. Examples: • Standardized process for clinicians to link clients with a primary care provider • New reporting procedures for tracking no show rates on a monthly basis • Implementation of PreManage with new work flows and procedures • Implementation of new procedures for 3 mental health agencies for how to enter and track clients in new EHRs • Creating and using registries to track high ED utilizers
Care Integration	Significant movement toward integrating physical and behavioral health include hiring new staff, expanding services, and contracting cross-sector to provide services. Behavioral health providers are in process of negotiating contracts with MCOs. They are testing new reporting systems while anticipating changes to clinical workflows and data collection. Examples: • Procedures for credentialing providers and keeping this updated for MCOs • Optimizing EHR and procuring new technology to meet the demands of direct billing
Care Transformation	Implementation partners continue to work on addressing opioid use and chronic disease. Examples: • Three primary care clinics started Six Building Blocks for improving opioid management and have begun revising policies related to opioid prescribing and management • Registries to track chronic disease and support proactive outreach to clients is a new concept to behavioral providers. Several partners are working with practice coach facilitators to create registries to track chronic diseases.
Care Infrastructure	Implementation Partners have invested in increasing service lines, expanding existing services, and hiring new staff. Examples: • New oral health services in 3 primary care clinics

Acronyms used in this table:
ED – Emergency Department, EHR – Electronic Health Record, MCO – Managed Care Organization, SDOH – Social Determinants of Health

OCH can attest to successful adoption of these policies based on a review of submitted Progress-to-Date reporting and early 2019 site visits. Additionally, OCH closely tied Change Plan activities to coaching technical assistance and aligned results of practice transformation assessments. OCH staff also review assessment notes and action plans from Six Building Blocks to monitor progress of participating clinics.

- Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.

The three mental health agencies that transitioned to Care Logic did so through shared contracting. They have since received shared assistance in training staff, creation of workflows and protocols, and migrating data from their previous EHR.

One mental health agency and a SUD provider collaborate to share release of information forms and embed the same protocol in their respective EHRs, resulting in more timely continuity of care between providers.

OCH expects more sharing to occur during future reporting periods. In order to facilitate this, OCH shared a list of standard operating procedures with all Implementation Partners during the reporting period site visit, which OCH plans to collect during future site visits and share via ORCA, Olympic Reporting and Community Activities, OCH's online information sharing and reporting platform.

- Describe any challenges faced by partnering providers in the adoption of policies, procedures and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?

Workforce, HIT limitations, and time rank as the top challenges Implementation Partners face in adopting new policies, procedures, and protocols. Frequent staff turnover and hiring difficulties delay transformation work. Significant and pervasive HIT limitations exist across all sectors which create barriers to pulling relevant data and participating in transformation of work systems. Revising policies and implementing new workflows demand significant time, which is already limited. OCH contracted with Comagine Health to provide coaching technical assistance from February through May of the reporting period, aligned with the P-TCPi practice facilitator in the region, and continued to contract and expand participation in Six Building Blocks to support Implementation Partners.

- Describe the key challenges or risks identified in implementing selected transformation strategies, including potential impacts and mitigation strategies for specific transformation project areas or Domain I strategies. Include impacts across projects, as well as within a specific project area.

	Challenges/Risks	Potential Impacts/Mitigation Strategies
HIT/HIE	• Providers are using EHRs with	• Facilitate smaller providers to gain

	limited functions without the resources to upgrade to more robust EHRs. • Lack of interoperability remains an issue for achieving seamless care coordination or sharing of client records	Epic view-only access to access shared client records in 4 of the bigger healthcare systems (Jefferson Healthcare, Jamestown Family Health Center, Olympic Medical Center, and North Olympic Healthcare Network) • Health Commons • Future implementation of Pre-Manage for behavioral health providers
VBP	Behavioral health providers are focused on transitioning to integrated managed care and do not have information on future VBP contracting expectations	Continue to facilitate information sharing and convening as necessary between MCOs and providers
Integration	Further work in clinical integration might be delayed due to current focus on financial integration	Work closely with SBHO, MCOs, and HCA through the Interlocal Leadership Structure to ensure successful transition to integrated managed care

Acronyms used in this table:

EHR – Electronic Health Record, HCA – Health Care Authority, HIE – Health Information Exchange, HIT – Health Information Technology, MCO – Managed Care Organization, SBHO – Salish Behavioral Health Organization, VBP – Value Based Payment

19. Regional integrated managed care implementation update

- **For 2019 adopters,** list the date in which the ACH region implemented, or will implement, integrated managed care.

- For **January 2019 adopters**, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken to address these challenges?

- For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region's early warning system, communications workgroup, and provider readiness/technical assistance workgroup.

OCH and Salish Behavioral Health Organization (SBHO) leadership held monthly Interlocal Leadership Structure (ILS) meetings throughout the reporting period with MCO, HCA, and county commissioners to develop collaborative plans for these three workgroups:

Provider readiness/technical assistance workgroup	Early warning system	Communications workgroup
The Salish provider readiness workgroup launched in March. This workgroup meets monthly and is led by SBHO. During this reporting period, there were 4 meetings attended by	This workgroup is planned to start in August 2019. OCH will be the lead coordinating entity of the group and participants will include SBHO, HCA, MCOs, providers, and others.	This workgroup is planned to start in August 2019 and will be co-led by SBHO and HCA. OCH will participate and represent the ACH to bring feedback from stakeholders. Partnering providers will also

providers, SBHO, OCH, MCOs, and HCA.		be invited to participate in this group.

Acronyms used in this table:

ACH – Accountable Community of Health, HCA – Health Care Authority, MCO – Managed Care Organization, OCH – Olympic Community of Health, SBHO – Salish Behavioral Health Organization

- For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the ACH has identified as it pertains to integrated managed care. What steps has the ACH taken to address these needs?
    - Behavioral health provider readiness:
        - Behavioral health providers are actively participating in the monthly provider readiness workgroup. During this reporting period, organizations worked on submitting their rosters for provider credentialing.
        - Three of the four community mental health agencies in the region transitioned to a new EHR, Care Logic, and are setting up systems for integrated managed care billing and population health management. The fourth agency is finalizing their selection of a new EHR.
        - Several SUD provider organizations on the EHR, ReliaTrax, are working closely with the vendor to prepare for integrated managed care billing and collaborating with each other to streamline workflows.
    - Physical health provider readiness:
        - Clallam county is not currently mandated to contract with MCOs to provide Medicaid services, so readiness in Clallam includes both behavioral and physical health providers. At the provider readiness kick-off event in March, behavioral health providers raised concerns about whether physical health providers in Clallam county will be contracted with MCOs in time for beneficiaries to be able to access both physical and behavioral services seamlessly through MCO plans. The executive director of OCH has brought this issue to the attention of HCA and is actively engaged with physical providers on this issue.
    - Technical assistance needs:
        - ILS meetings: OCH provides meeting space for SBHO to host monthly ILS meetings. OCH staff participate in these meetings along with HCA and MCOs. The executive directors of OCH and SBHO meet regularly to plan the agenda for these meetings.
        - Communications platform: MCOs, HCA, and providers needed an online platform that could serve as a repository for files and learning space. OCH made this available on ORCA (OCH's online reporting platform used for MTP). MCO and HCA contacts involved in IMC as well as all providers going through IMC are now registered on ORCA.
            - Staffing needs: SBHO and OCH are collaborating to distribute the work of leading IMC workgroups.

Attestations.

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

	Yes	No
20. 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: • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.	X	

If the ACH checked "No" in item 20 above, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

Section 3. Pay-for-Reporting (P4R) metrics

Documentation.

21. P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.[6] Twice per year, ACHs will request partnering providers respond to a set of questions. ACHs will gather the responses and report them to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: How to read metric specification sheets.[7]
- Full P4R metric specifications are available on the Medicaid Transformation metrics webpage, under *ACH pay for reporting metrics*.[8]
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for

[6] For more information about ACH pay for reporting (P4R) metrics, see Measurement Guide Chapter 6 and Appendix K. Link: https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf
[7] https://www.hca.wa.gov/assets/how-to-read-p4p-metric-specifications.pdf
[8] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics

response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.

- It is HCA's expectation that ACHs will facilitate participation of practice/clinic sites and CBOs and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to summarize the number of potential sites and actual respondents by provider type for each reporting period.

Instructions:

- Submit line-level P4R metric responses collected from partnering provider sites. Include partnering provider organization name and site name for each respondent.
- Provide a count of partnering provider sites participating in Project 2A and 3A, and a count of P4R metric respondents, stratified by provider type (practice/clinic site and community-based organization).

Format:

- ACHs have the option to submit P4R metric information using the workbook provided by the state or via an alternative format (as long as all data fields are represented and consistent with the P4R metric required data fields list).

Submit P4R metric information.

Please see the attached P4R workbook, it is **OCH. SAR3 P4R Workbook. 7.31.19.**

In an effort to reduce provider burden and assessment fatigue, OCH is submitting Me-HAF and PCMH-A assessments as well as pediatric assessments conducted by the Comagine contracted practice transformation coach and the PTCP-i practice facilitator. The Comagine contracted practice transformation coach utilized the PCMH-A for primary care clinics, and the Me-HAF for behavioral health clinics. The PTCP-i practice facilitator used their own pediatric assessments. There was not enough time during this reporting period to transition all assessment tools to the Me-HAF. OCH intends to transition assessments to the Me-HAF for future reporting periods.

Participating providers have loudly voiced their fatigue of the amount and frequency of assessments they are asked to complete, therefore OCH aims to minimize the burden of P4R reporting. Completing the Me-HAF on a semi-annual basis may be too frequent to see real change in clinics and may not offer a value add for participating providers. OCH is committed to fulfilling reporting requirements to the HCA as well as to supporting providers towards successful and sustainable transformation.