ACH Decision-Making and Management Expectations

Updated October 27, 2016

Background: Accountable Community of Health (ACH) representation and decision-making adjustments are occurring statewide. This document is a draft of the State's expectations for ACHs in their development and refinement of decision-making. This is in response to many requests from partners and ACH leaders for more direction and clarity regarding ACH development. These expectations are consistent with progress and lessons learned to-date here in Washington State, as well as informed by promising practices and standards related to delivery system reform in other states. These expectations also maintain a commitment to a multi-payer and multi-sector approach. It is important to note that requirements under the existing ACH sub-awards and future certification process under the Medicaid Transformation Project (MTP) Demonstration will be aligned.

a. ACH Decision-Making and Management

The ACH must demonstrate that a structure to facilitate and oversee decision-making is in place. The structure must be consistent with the following principles:

- *Balanced*: ACH partners represent a broader perspective of health and health care coverage, considering the entire population within the region and a broader understanding of health and social determinants.
- *Representative:* ACH partners involved in decision-making serve on behalf of a sector or population.
- *Tiered and Participatory*: ACH partners participating in regional transformation projects and other regional work actively inform project design and ACH decisions.
  To meet both the balanced and participatory principles, decision making and project design will occur at multiple levels, recognizing that the final ACH decision-making may rely on subject matter experts (SMEs) and specific "design teams" to inform priorities and strategies.
- *Accountable*: The ACH and participants in health systems transformation are accountable to each other and the communities within the region, with clearly defined, transparent mechanisms to facilitate vetting and decision-making. This includes the expectation that individual community members (e.g., consumers, Medicaid beneficiaries, those who will be impacted) will be included in the decision-making processes.[1]
- *Flexible*: Within the framework outlined in this document and in partnership with the State, each ACH should consider the unique regional environment and implement a structure that works best for the region.

Recognizing the importance of partner capacity within each ACH region, HCA is interested in feedback or current approaches to assess the ACH's "ask" and corresponding capacity/commitment of its partners. This includes considerations regarding individuals serving in multiple leadership roles or decision-making processes within a single ACH or across multiple ACHs.

Nimble means making decisions frequently and/or unexpectedly. For example, a decision could be required in the short-term, well before a meeting on the calendar the following month.

[1] The State will continue to support the definition and pursuit of authentic community engagement that extends beyond governance to include the voices of individual consumers or beneficiaries across the region. The State is exploring the option for additional technical assistance and/or resourcing as part of the ACH role under initiative 1 of the Medicaid Transformation demonstration.

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An ACH must identify a primary decision-making process and structure (e.g., a Board or Steering Committee) that is subject to the outlined composition and participation guidelines. The primary decision-making body will be the final decision-maker for the ACH. This structure is expected to be nimble in its decision making, and guided by the views of the whole community as represented by those participating in the ACH. While a primary decision-making process and structure is required, it is anticipated that an ACH will have an overall structure that is participatory and guides the decisions of the ACH. There must be established accountability mechanisms from the primary decision-making body to the overall structure of the ACH, consistent with the principles identified within this document. Decision making should be both efficient and representative.

The ACH and the State, as an element of their enhanced partnership under Healthier Washington, will collaborate and agree on each ACH's approach to its decision-making structure. Intended to provide maximum flexibility while also considering the structure and approach necessary to ensure the ACH is serving as a community and state asset in various efforts, the ACH will propose an approach to its partners and the State that fulfills the expectations outlined in this document. ACHs reserve the right to modify decision-making structures at any point as they learn and evolve through the process of health systems transformation. That being said, the State requests that proposed changes to the ACH decision-making structure prompt discussion with the State as partners. The State is committed to fulfillment of expectations, effectiveness, best and promising practices, and community-specific factors that support the approach.

The overall organizational structure established by the ACH must reflect capability to make decisions on, and be accountable for the following six domains, at a minimum:

- ***Financial***, including decisions about the distribution of funds, the roles and responsibilities of each partner organization, and budget development. The ACH should be able to manage foreseen or unforeseen shifts in costs/revenues.
- ***Clinical***, including systems of care for their population and strategies for monitoring outcomes. The ACH will be responsible for monitoring care delivery redesign activities and should establish appropriate clinical leadership.

As one example, under initiative 1 if a region is not achieving agreed upon progress and outcome metrics, the participating providers within the ACH region are at risk for not drawing down the entirety of eligible incentive payments. If this occurs, an ACH as the lead entity would need the financial capacity and flexibility to appropriately adjust budgets accordingly.

As the principles reinforce expectations around transparency and accountability in decision making, the priorities and cultural values of different communities should be reflected in the work of the ACH. The intent of the community domain reflects an expectation that meaningful community engagement will extend beyond a single consumer voice included in decision making to the broader concept of "nothing about us without us." This includes several perspectives regarding the definition of community, including: geographical regions, language, race or ethnicity, or a commonality based on specific health conditions.

- ***Community***, including a process by which the ACH will consider health equity in decision making and engage the community in the development and implementation of ACH efforts.
- ***Data***, including the processes and resources to support data-driven decision making and formative evaluation.
- ***Program management and strategy development***, including sound visionary and consistent leadership. The ACH should have the organizational capacity and

established mechanisms to respond to community priorities and strategically contribute to complex health systems transformation efforts. It also should have administrative support for regional coordination and communication on behalf of the ACH.

ACHs may need to establish additional domains to support decision-making and regional efforts. For example, ACHs should consider a Compliance/Legal domain as an appropriate capacity.

b. Composition and Participation

Each ACH will consist of multi-sector partner organizations and will represent a multi-payer approach. The diversity and expertise of providers and social service organizations are important. As such, at a minimum each ACH decision-making body must include partners from the following categories:[2]

1. One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;
2. One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;
3. Health plans, including but not limited to Medicaid Managed Care Organizations;
4. One or more hospitals or health systems;
5. One or more local public health jurisdiction;
6. 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 the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers or consumer advocacy organizations, childcare, veteran services, community supports, legal assistance, etc.

To ensure broad participation in the ACH and prevent one group of ACH partners from dominating decision-making, at least 50 percent of the primary decision-making body must be represented by non-clinical, non-payer participants. In addition to balanced sectoral representation, where multiple counties/regions exist within an ACH, a concerted effort to include a person from each county/region on the primary decision-making body must be demonstrated.

The intent is balanced, multi-sector participation where one group of people cannot control the decisions of the ACH in a way that undermines or overrides the broader goals.

To define non-clinical, ACHs could consider whether the member is or is not engaged primarily in clinical health care delivery. For example, the ACH may not define Emergency Medical Services as primarily clinical health care delivery. The state is open to feedback to help add clarity without being too prescriptive.

[2] ACHs are also expected to abide by the forthcoming Tribal Collaboration and Engagement policy. This policy addresses communication and collaboration expectations and is part of the ongoing work with the American Indian Health Commission.