Olympic Community of Health

Agenda

Board of Directors Meeting

January 8, 2018, 1 pm to 3 pm

New Location Kitsap Regional Library, 700 NE Lincoln Rd, Poulsbo, WA

Web: https://global.gotomeeting.com/join/937538149

Phone: +1 (872) 240-3311

Access Code: 937-538-149

KEY OBJECTIVES

AGENDA (Action items are in red)

Item		Topic	Lead	Attachment	Page(s)
1	1:00	Welcome and Approve Agenda	Roy		
2	1:05	Consent Agenda	Roy	1. DRAFT: Board Minutes 12.11.2017 2. Director's Report 3. Letter to HCA re: High-Performance Measures 4. WA Health Alliance Community Check-Up: Key Findings from the Olympic Region	2-5 6-8 9 10-13
3	1:10	Vacant Board Seats	Elya	5. DRAFT: Revised Vacant Board Seat Policy	14-15
4	1:25	Finance Committee Replacement	Hilary		
5	1:30	Domain 1 Investments and MTP Funding	Elya Dan	6. Overview: Funding Reductions and Mitigation Strategies 7. OCH Impacts of HCA DSRIP Funding Estimates	16-20 21
6	2:00	Shared Change Plan Strategic Planning		8. DRAFT Shared Change Plan	22-25
7	3:00	Adjourn	Roy		

Acronym Glossary

HCA: Health Care Authority
IMC: Fully integrated managed care
MTP: Medicaid Transformation Project
SBAR: Situation. Background. Action. Recommendation.
VBP: Value-based contracting

Olympic Community of Health

Meeting Minutes

Board of Directors

December 11, 2017

Date: 12/11/2017	**Time: 1:00pm-3:00pm**	**Location:** Jefferson Health Care, 2500 W. Sims Way (Remax Building) 3rd Floor, Port Townsend

Chair: Roy Walker, *Olympic Area Agency on Aging*

Members Attended: Allan Fisher, *United Health Care*; Anders Edgerton, *Salish BHO*; Brent Simcosky, *Jamestown Family Health*; Caitlin Safford, *Amerigroup*; Chris Frank, *Clallam Public Health*; Eric Lewis, *Olympic Medical Center*; Gill Orr, *Cedar Grove Counseling*; Hilary Whittington, *Jefferson Healthcare*; Jennifer Kreidler-Moss, *Peninsula Community Health Services*; Joe Roszak, *Kitsap Mental Health Services*; Karol Dixon, *Port Gamble S'Klallam Tribe*; Katie Eilers, *Kitsap Public Health District;* Larry Eyer, *Kitsap Community Resources*; Meriah Gille, *Lower Elwha Klallam Tribe*; Thomas Locke, *Jefferson Public Health*

Members Attended by Phone:

Alternate Members: Gary Kriedberg, *Harrison Health Partners*; Mike Maxwell, *North Olympic Healthcare Network*; Vicki Kirkpatrick, *Jefferson Public Health*

Non-Voting Members: Jorge Rivera, *Molina Healthcare*; Kat Latet, *CHPW*; Laura Johnson, *United Health Care*; Allan Fisher, *United Health Care*

Guests: Amy Etzel, *Washington State Department of Health*; Christine Quinata, *Health Care Authority*; Gina Lindal, *Washington State Department of Social and Human Services*; G'Nell Ashley, *Reflections Counseling*; Jim Weatherly, *Washington State Department of Social and Human Services*; Kennedy Soileau, *Health Care Authority*; Kristina Bullington; Kvell Brittain; Mary Franzen; Ryan Billie; Sandy Goodwick; Stephanie Lewis, Craig Nolte

Staff and Contractors: Claudia Realegeno, *Olympic Community of Health*; Elya Moore, *Olympic Community of Health,* Lisa Rey Thomas*, Olympic Community of Health,* Maria Klemesrud, *Qualis*; Margaret Hilliard, *Olympic Community of Health*; Rob Arnold, *University of Washington;* Siri Kushner*, Kitsap Public Health District* (phone); Dan Vizzini, *Oregon Health Sciences University*

Person Responsible for Topic	Topic	Discussion/Outcome	Action/Results
	February Objectives	1. Director's Report 2. OCH- HCA Contract 3. Minutes Board Meeting 1/9/2017	
Roy Walker	**Welcome and Introductions**	Roy called the meeting to order at 1:04pm.	
Roy Walker	**Consent agenda**	Consent agenda	Consent agenda APPROVED unanimously with correction of a typo

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Roy Walker	**Public Comment**	Public comment regarding adult behavioral health systems and supports. Request for conscientious consideration of peer recovery support in the community and support of these programs from OCH. Special mention of United Peers of WA, Holding to Hope, WA Recovery Alliance, National Empowerment Center, Wellness Recovery Action Plan, Honest Open Proud, Emotional Cigar. A second speaker spoke about challenges for those in substance use disorder (SUD) recovery in efforts to offer peer recovery support, as well as the benefits of enlisting those in recovery as part of treatment programs.	
Elya Moore	**Updates**	OCH has received feedback from the independent assessor and estimates a current score of about 78%. Staff will address noted issues during the two write-back periods. Most issues were covered in another area and just need to be copied and pasted. Changes to high performance measures were presented. Three have been removed from the ACH reinvestment pool. Board Members requested that OCH staff push back because the removed measures are important to the region. These measures are additionally built into Value-Based Payment (VBP) and need to be reported by MCOs regardless. Suggestion made to cc legislators and local representatives when submitting this letter.	MOTION: Authorize ED to construct a letter to the HCA that we take exception to the elimination of blood pressure and diabetes measures and recommend for consideration the reinstatement of these measures, including request for clarification regarding why measures are included or removed Motion to construct letter APPROVED with abstention from MCO caucus.
Hillary Whittington	**2018 Budget**	The 2018 budget was presented. Notable factors include: • Balance between recruitment/retention and working with scarce resources. The benefits allocation was bumped up to ~17%, though the actual value may vary. • Non-personnel costs include areas where there wasn't a need for a full employee and consultants would be well-utilized. • There is an "Other" category to acknowledge the flexibility and adaptability required as needs change throughout the year. • Admin services include rent, subscriptions, travel, meeting costs, etc. • Net income will be $0, meaning that as money is spent, it is pulled from liabilities and reduces deferred revenue for the following year. Finance committee discussed managing funds through OCH despite a push from the Health Care	

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		Authority (HCA) to use the financial executor. Finance Committee opted to request that funds flow through the OCH so as to avoid delegitimizing OCH's ability to manage funds, as well as to take advantage of any available interest. This hasn't been brought up to the HCA yet and they are finalizing their rulings. OCH will aim to secure written confirmation if domain 1 investments (capacity building/ infrastructure) can flow through OCH. This will depend on rulings currently underway. Suggestion made to move cost-of-living increases and the merit pool into personnel costs.	MOTION: Approve 2018 budget as presented with the following changes: - Cost of Living and Merit pool rolled into Personnel costs Motion to approve the 2018 budget with changes to personnel costs APPROVED unanimously
Elya Moore	**Contracts Management and Compliance Charter**	The Contract Management and Compliance Committee charter was included in the packet. This committee would ideally be populated by representatives outside of the OCH and Board. The goal is to advise staff of how to hold providers to benchmarks and mediate grievances. This committee may benefit from members with legal experience. This committee will be formed following the NCC convenings, when there is a better idea of how things will play out. The next OCH hire will be a Contracts and Compliance Coordinator, who will manage day-to-day aspects and decisions of the committee. MCO note that reporting is semi-annual, so the committee should meet semi-annually, with additional meetings as needed.	MOTION: OCH will form the Contract Management and Compliance Committee with legal counsel as needed, to meet semi-annually with additional meetings as needed. Motion to form Contract Management and Compliance committee APPROVED unanimously
Rob Arnold, Kristina Bullington, and Elya Moore	**IT Care Coordination Pilot Project Update**	Progress on the IT care coordination (ITCC) project was presented with a recommendation to continue with the project for review in April 2018. The project is currently ahead of schedule and under budget.	MOTION: Authorize continuation of the ITCC pilot project for review in April 2018 Motion to continue ITCC APPROVED unanimously
Hillary	**Vacant Board Seats**	The current document is in an outdated format and assumes familiarity with sector definitions. Request made to reformat and add definitions of sectors.	Approval of the Vacant Board Seats Policy tabled for revisions by staff
	Resignations	Eric Lewis announced his resignation from the OCH Board of Directors effective December 31st, 2017. He previously spoke with leadership at the other hospitals toward the decision to nominate Bobby Beeman to represent Public Hospitals. This recommendation is supported by Mike Glenn and Tim Cournyer. Eric Lewis will continue as Bobby's alternate.	MOTION: Replace Eric Lewis with Bobby Beeman for Public Hospital Sector representation on the OCH Board of Directors

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		Larry Eyer announced his retirement and related resignation from the Board of Directors. He is in the process of identifying a nomination to take the role for the Community Action Programs sector. January 2018 will be his last meeting. Caitlin Safford announced her resignation and will be replaced by Kayla Down effective December 31, 2017. Caitlin will continue to serve as Kayla's alternate.	Motion to appoint Bobby Beeman APPROVED unanimously MOTION: Appoint Kayla Down to represent Amerigroup in MCO Caucus. Motion to appoint Kayla Down APPROVED unanimously
Elya	**Provider Readiness: IMC & VBP**	OCH region commissioners opted to pass on midadopter incentives. As a consequence, providers in OCH region are not permitted to participate in upcoming procurement activities. There is interest in having the OCH perspective voiced and concerns addressed. Suggestion proposed to survey the OCH region and provide results to the HCA. This would then put them in a position of either taking regional priorities into account or ignoring input. MCOs noted that they will compete to address the needs of providers in communities, so having this info would be very important to them. Executive committee will inform survey to submit to HCA ahead of the February midadopter input deadline. Suggestion to let HCA at CPAA know about these plans.	ACTION: Executive committee will create survey after reviewing other ACH questions, toward the goal of getting input from the region and submitting to the HCA.
Katie	**Legislative Forum**	Discussion regarding efforts that can be made in Olympia to inform legislature and representatives about accountable communities of health (ACHs) and to separate ACHs from the HCA. No action taken.	
	Side Note	Concern voiced regarding Kitsap NCC Convenings happening in Kingston rather than a more central location. A correction to minutes from November was noted.	ACTION: Explore alternative venues for Kitsap NCC Convenings ACTION: Note Karol Dixon as representative from Port Gamble S'Klallam Tribe rather than Keri Ellis in November 2018 minutes
Roy Walker	**Adjourn**	The meeting adjourned at 3:34pm.	

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Top 3 Things to Track (T3T) #KeepingMeUpAtNight

1. The shared change plans for the natural communities of care and the change plans for provider organizations are mutually dependent, which adds a level of complexity in design and roll-out.

2. The continued updates from HCA about funding under the Medicaid Transformation Project could undermine provider's willingness to actively participate in the activities.

3. We are excited about the potential for a web portal to ease the administrative burden on providers participating in the Medicaid Transformation Project and to facilitate shared learning across the region.

OCH Meetings

- Board Meeting, January 8, Poulsbo
- Finance Committee, January 19, Virtual
- Executive Committee, January 23, Virtual
- Board Meeting, February 12, Poulsbo

CONFIRMED! Natural Community of Care Convenings

As part of our plan to convene partners and develop a shared change plan by each natural community of care (NCC), OCH scheduled three convenings per NCC over the months of January and February. Prior to the convenings, OCH is hosting an informational webinar to bring partners up to speed and ensure that partners have a shared understanding of the Medicaid Transformation Project.

Pre-NCC Convening Informational Webinar
January 9, 10:30 am to 12 pm
Web: https://global.gotomeeting.com/join/914768229
Phone: +1 (312) 757-3121
Access Code: 914-768-229

NCC	Convening 1	Convening 2	Convening 3
Clallam	Thursday, January 11; 1-4pm Red Cedar Hall Jamestown S'Klallam Tribal Center 1033 Old Blyn Hwy, Sequim, WA 98382	Friday, February 9; 1-4pm North Olympic Healthcare Network 240 W Front St A, Port Angeles, WA 98362	Tuesday, February 20; 9am-12pm Red Cedar Hall Jamestown S'Klallam Tribal Center 1033 Old Blyn Hwy, Sequim, WA 98382
Jefferson	Wednesday, January 17; 1-4pm Jefferson Healthcare (3rd floor) 2500 W. Sims Way, Port Townsend, WA 98368	Thursday, February 1; 9am-12pm Fort Worden Building 204 Up North, 200 Battery Way, Port Townsend, WA 98368	Friday, February 23; 9am-12pm Jefferson Healthcare (3rd floor) 2500 W. Sims Way, Port Townsend, WA 98368
Kitsap	Thursday, January 18; 1-4pm Harrison Medical Center 1800 NW Myhre Road, Silverdale, WA, 98383	Monday, February 5; 1-4pm Harrison Medical Center 1800 NW Myhre Road, Silverdale, WA, 98383	Wednesday, February 21; 9-12pm Harrison Medical Center 1800 NW Myhre Road, Silverdale, WA, 98383

Please email support@olympicCH.org with questions or to confirm details.

UPDATE: Project Plan Submission

We are pleased to report that OCH had no additional edits from the independent assessor after our first write-back. This means that OCH will likely earn 100% of earnable Year 1 revenue for our region (est. $4 million dollars).

Potential Portal for Provider Organizations Participating in the Medicaid Transformation Project (MTP)

OCH and North Sound ACH recently reviewed a portal product from a company called CSI solutions, which designs portals that enable communication and updates for the public and provide secure log-on functionality to support collaboration. The portal might be a perfect fit for OCH's approach to the MTP because it supports subcommunities, like the natural communities of care, around defined collaboration initiatives, such behavioral health integration or chronic care management. Basic functionality includes:

- *Document management* - storing of tools, documents, resources to enable sharing of best practices.
- *Calendar*- A master calendar function and sub-calendars where important meetings, webcasts and events can be communicated and offering a single place to track down dial in information.
- *Social networking* tools such as listservs, forums, and discussion groups.
- *Announcements*- ability to push out content
- *Video archiving*- the ability to record and archive videos
- *Web forms*- the ability to capture information from the field and aggregate the information into a database. *An example would be automating the change plans.*
- *Reporting tool*-the ability to capture provider level data and roll-up the data for comparison purposes and identification of best practices.

Thus far North Central ACH, North Sound ACH and OCH are exploring this tool and OCH is encouraging consideration by all ACHs in hopes this product could be leveraged for economies of scale.

COMING SOON: Executive Director Performance Evaluation Survey

Please be on the look out for the Executive Director Performance Evaluation Survey the week of January 8th. This survey will be sent by Margaret Hilliard, the Office and Administrative Coordinator. The Executive Committee is requesting a 360 evaluation, meaning that staff, board members, and community partners will be asked to complete the performance evaluation survey.

SUMMARY: Washington Health Alliance Community Check Up Report

The Community Checkup Report, produced jointly by the Washington Health Alliance and Healthier Washington, provides annual updates on the state of health care performance throughout Washington State. Included in your board packet is a summary of key points from the larger 2017 report with highlights pertaining to the Olympic Community of Health (attachment 6). The full report can be accessed here.

HCA Communication

1. As per the Board discussion on December 11th, OCH sent a letter to the HCA asking for clarification as to how HCA decides which measures are included in the high-performance pool. This letter is included in your Board packet (attachment 5).
2. Pursuant to the Board discussion about collecting provider input ahead of the Integrated Managed Care (IMC) procurement, HCA is offering a webinar. This creates some room for OCH to do a more thorough assessment without the time pressure of the RFP. The webinar is Monday January 8, 2018 from 12pm-1pm and will cover the structure of the IMC RFP and provide an opportunity for comment (register here). The webinar is primarily intended to provide an opportunity for providers within Salish, Great Rivers, and Thurston-Mason regions to learn more and offer feedback. There is also an opportunity to provide written feedback using this template, due by 5pm January 10, 2018. The webinar will be recorded.

UPDATE: IT Care Coordination

We have moved into the next phase of the IT Care Coordination Pilot Project – the technical phase. Rob Arnold, OCH's IT general contractor, has negotiated a trial with Strata technologies and CMT, the parent agency to EDIE and Premanage. The pilot continues to move forward on time and under budget.

COMING UP! Executive Director Succession Plan

In January, the executive committee will be reviewing an executive director succession plan. This is standard procedure for all nonprofits and is important to safeguard the organization given the complexity of funds flow under the Medicaid Transformation Project.

UPDATE: Three County Coordinated Opioid Response Project (3CCORP)
On behalf of the 3CCORP co-chairs and OCH staff we want to express our gratitude to the 3CCORP Steering Committee and Workgroup members. You have worked hard over the past year and it shows! 3CCORP is pausing our monthly meetings so partners can participate in their NCC convenings; we will resume 3CCORP meetings in March so stay tuned! Please see here for a recent 3CCORP update and please contact lisarey@olympiccch.org if you have any questions or want more information. Happy New Year!

UPDATE: Community and Tribal Partnership
The Tribes and Urban Indian Health Care Providers (IHCP) submitted the "MTP IHCP Planning Funds Plan" on December 29, 2017. If approved by CMS this will trigger up to 5.4 million design pool funds for the Tribes and IHCP. Assuming CMS approval, the Tribes and IHCP will submit a Tribal Project Plan by March 31, 2018 to trigger Tribal DSRIP funds.

Olympic COMMUNITY of HEALTH

CLALLAM • JEFFERSON • KITSAP

December 28, 2017

MaryAnne Lindeblad,
Medicaid Director
Washington State Health Care Authority
626 8th Ave SE
Olympia, WA 98501

Re: Request for clarification on the high-performance measures under the Medicaid Transformation Project

Dear MaryAnne:

We are writing to inquire how the HCA determined which statewide accountability metrics were selected to form the high-performance pool. The high-performance pool is the basis of incentive payments to accountable communities of health under the Medicaid Transformation Project (MTP). The table below includes the full list of statewide accountability metrics with a strikethrough indicating those metrics not included in the high-performance pool.

Antidepressant Medication Management - Acute Phase tx
Antidepressant Medication Management - Continuation Phase tx
~~Comprehensive Diabetes Care: Blood Pressure Control~~
~~Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)~~
~~Controlling High Blood Pressure~~
Medication Management for People with Asthma (5-64 Years)
Mental Health Treatment Penetration (Broad Version)
Outpatient Emergency Dept Visit Rate per 1000 Member Months
Plan All-Cause Readmission Rate (30 Days)
Substance Use Disorder Treatment Penetration
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

While we understand that the above measures remain pay-for-performance and statewide accountability measures, the slate of high-performance measures signals the state's health improvement priorities to Medicaid providers. Not including measures in the slate that incentivize providers to improve population management for patients with diabetes and hypertension sends a confusing signal to providers participating in the MTP. The OCH Board of Directors believes that effective chronic disease management is a pressing issue facing the health care delivery system and associated metrics should be considered for inclusion in the high-performance pool.

Thank you for your consideration and time. Please do not hesitate to reach out to me if you have additional questions: elya@olympicCH.org, (360) 633-9241.

Respectfully,

Elya Moore, PhD
Executive Director, Olympic Community of Health

Olympic COMMUNITY of HEALTH

CLALLAM • JEFFERSON • KITSAP

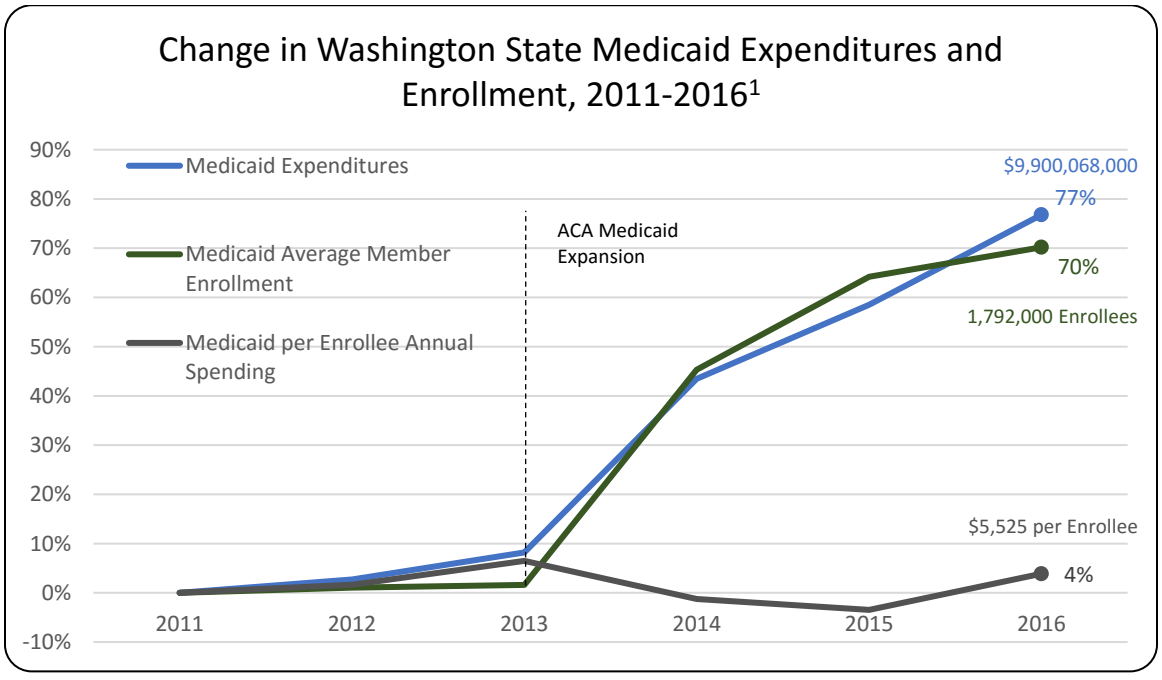
OCH: WASHINGTON COMMUNITY CHECKUP SUMMARY

The Community Checkup Report, produced jointly by the Washington Health Alliance and Healthier Washington, provides annual updates on the state of health care performance throughout Washington State. Here is presented a summary of key points from the larger 2017 report with highlights pertaining to the Olympic Community of Health. The full report can be accessed at: https://www.wacommunitycheckup.org/media/46740/2017-community-checkup-report.pdf.

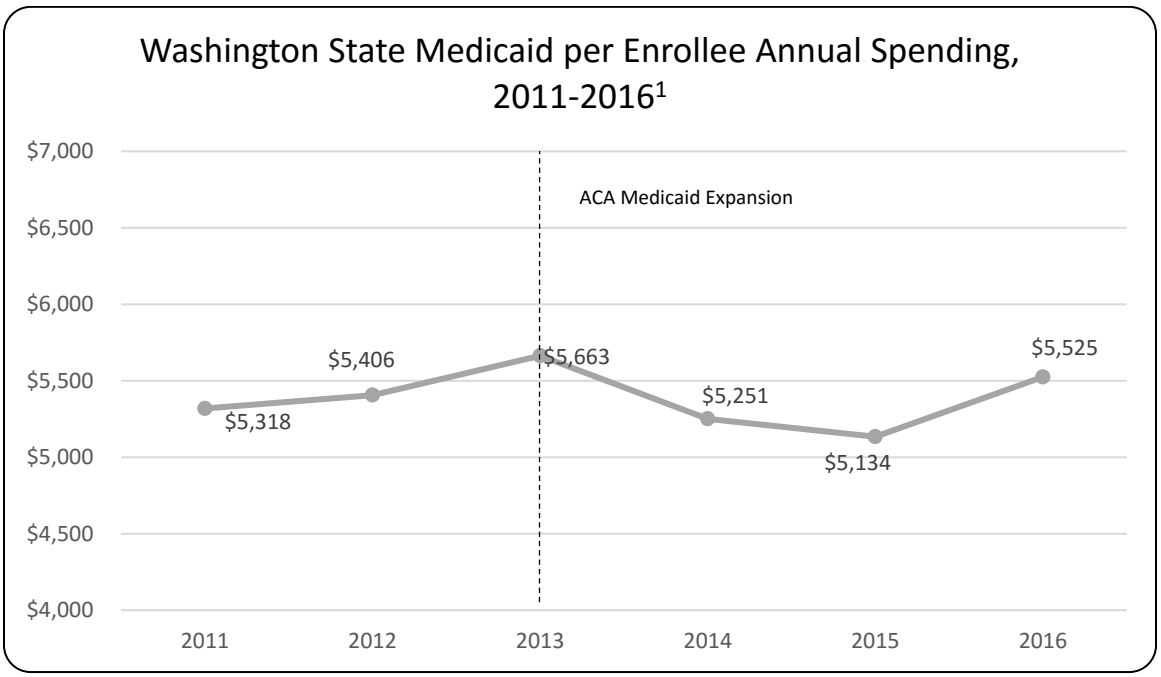
MEDICAID SPENDING	MEDICAID PROVIDERS	MEDICAID MEASURES
Since 2013 (ACA Medicaid Expansion), Washington State Medicaid expenditures and enrollment have increased 63% and 67%, respectively. Spending per enrollee has remained relatively constant during this period (overall 2% decrease).	12 medical groups in the OCH serving have five or more publicly reportable measures for Medicaid insured individuals. Of the 144 measures reported by these groups, just 25 (17%) of results were above the state average.	Washington State ranks above the National 90th Percentile for just two of 28 (7%) measures and below the 25th percentile for 11 of 28 (39%). Within the OCH, there is notable variation in measure performance between counties.

SPENDING

Since 2011, Washington State Medicaid expenditures have increased 77% and enrollment 70% while spending per enrollee has increased 4%. Looking more specifically at the period immediately following the ACA Medicaid Expansion, Washington State Medicaid expenditures and enrollment have increased 63% and 67%, respectively, while spending per enrollee has decreased 2%.



Annual Washington State Medicaid spending per enrollee has remained relatively constant over time. The greatest changes in recent spending occurred immediately following the Washington State ACA Medicaid expansion (2013-2014) (7% decrease) and from 2015 to 2016 (8% increase).

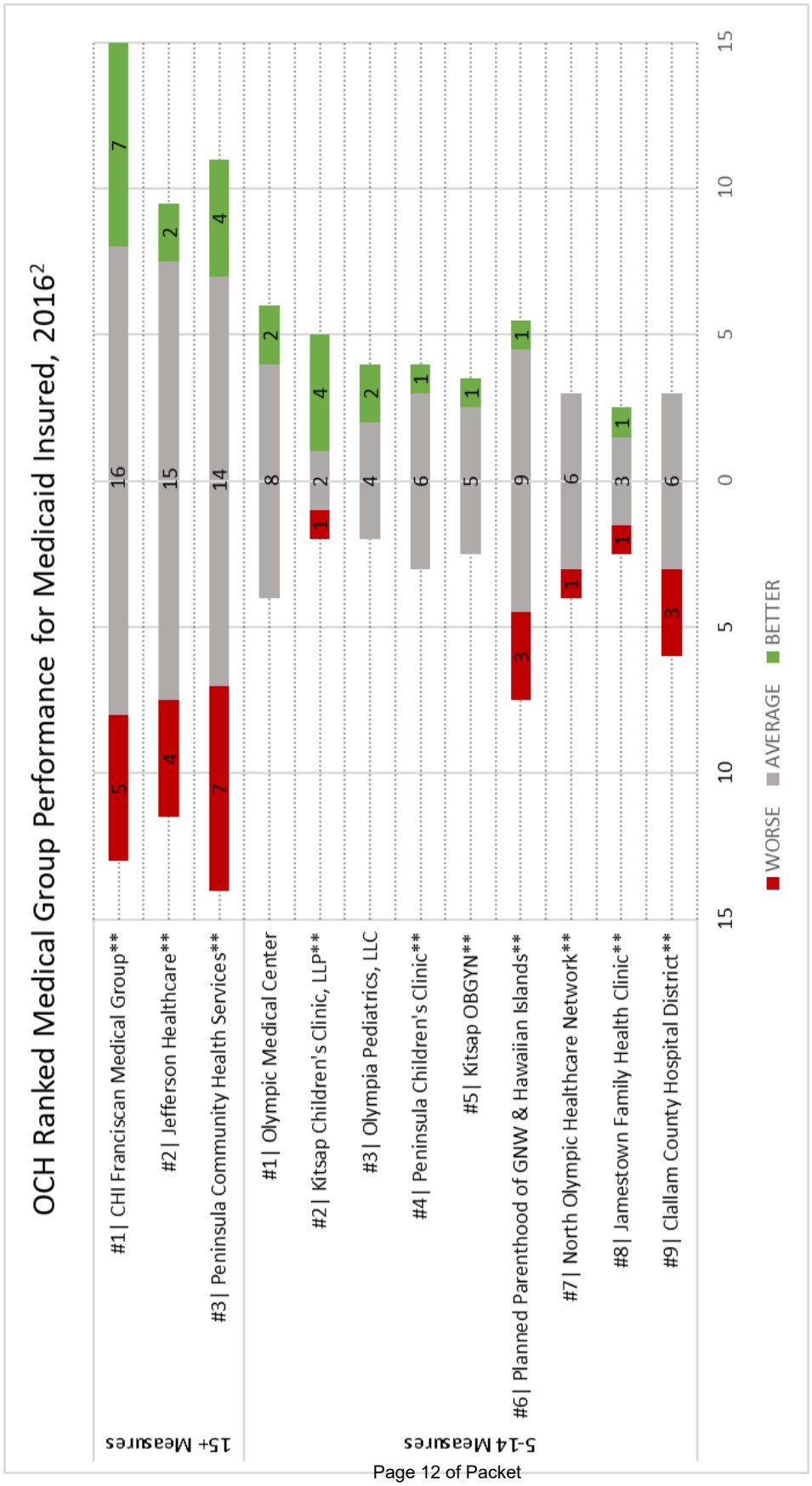


PROVIDERS

Medical groups vary in the types of care they provide and the size of Medicaid population they serve. Both factors contribute to the number of publicly reportable measures available, with more types of care and larger Medicaid populations generally yielding more publicly available measures.

Medical groups with 15 or more publicly reportable measures are ranked separately from those with 5 to 14 measures to maintain appropriate comparisons. Those with less than 5 publicly reportable measures are not included. Rankings result from point earnings and deductions. Two points are earned for each above average result, one for each average result, and two points are deducted for each below average result.

More details for provider attribution methodology are located on page 36 of the full report.



**At least 50% patients attributed have Medicaid Coverage

MEASURES

The following table includes the most recent values for measures highlighted in the report that are relevant to the OCH's selected projects. The values of bolded columns are proportions for the Medicaid population only. Cells shaded green, gray, and red denote values better, no different, and worse than that of Washington State, respectively.

	Well-Child Visits (first 15 months)	Immunization by Age 13	**Potentially Avoidable ER Visits**
NCQA 90th Percentile*	**72%**	Not Available	**Not Available**
WA State (reference)	**43%**	15%	**18%**
OCH	**47%**	14%	**20%**
Clallam	**37%**	7%	**17%**
Jefferson	**59%**	9%	**17%**
Kitsap	**50%**	15%	**21%**

*National Committee for Quality Assurance

REPORT EXCERPT

"Washington State has nine Accountable Communities of Health and all of us are working hard to support local health improvement, practice transformation and value-based purchasing. Health systems transformation requires access to reliable performance data from a local partner we can trust. The Alliance's Community Checkup is a tremendous resource, offering trusted and detailed information on specific areas for our communities to target for improvement."

– **Elya Moore, PhD, MS,** Executive Director, Olympic Community of Health

SOURCES

1. Medicaid Expenditures—February 2017 Forecast; Medicaid Administrative Expenditures—CMS 64; LTSS, SUD, and MH Expenditures based on Agency Financial Reporting System (AFRS) data; Medicaid Expenditures include medical, dental, vision, pharmacy, long-term support services, mental health, and substance use disorder expenditures; and excludes Part D Clawback and pass-through payments.
2. Based on claims and encounter data with dates of service between 1/1/2004–6/30/2016 and the measurement year of 7/1/2015–6/30/2016.

Olympic COMMUNITY of HEALTH

Olympic Community of Health policy for vacant Board seats

Approved by the Governance Subcommittee May 19, 2016
Approved by the OCH Board of Directors June 1, 2016
Revised and Approved by the OCH Board of Directors January 8, 2018

Nominations to the Olympic Community of Health (OCH) Board of Directors (Board) are to be made when a new sector seat is identified, a member's term limit is nearing, a member retires, a member resigns, or a member can no longer represent his or her sector. Sector nominations will be confirmed at Board meetings.

Table 1. Summary of Board Voting Seats

Sectors with voting seats on the Board (n=15)	Tribes with voting seats on the Board (n=7)
1. Federally Qualified Health Clinic 2. Primary Care 3. Mental Health 4. Substance Use Treatment 5. Behavioral Health Organization 6. Medicaid Managed Care Organization 7. Private/Not for Profit Hospital 8. Public Hospital 9. Rural Health 10. Public Health 11. Long Term Care/Area Agency on Aging/Home Health 12. Housing 13. Community Action Program/Social Service Agency 14. Oral Health 15. Chronic Disease Prevention Across the Lifespan	1. Hoh Tribe 2. Jamestown S'Klallam Tribe 3. Lower Elwha Klallam Tribe 4. Makah Tribe 5. Port Gamble S'Klallam Tribe 6. Quileute Tribe 7. Suquamish Tribe

Nomination to the Board is to be made among and by peers within the sector for whom the individual serves as the representative. Sectors are to be inclusive of their peers within the tri-county region in making the selection for representation, and to inform their representative by meeting regularly and independently of OCH. Representatives are expected to communicate on behalf of and represent the sector as a whole and to ensure a system for regular communication and feedback within their sector and as a responsibility of their Board participation. Each sector will constitute one "vote" in decision making.

In the event a brand new sector is offered a seat on the Board for which there has been little engagement, staff will assist in facilitating the nomination process.

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In the event that partners within a sector cannot agree on their sector representative, or are unable to do the due diligence to caucus with other members within their sector to select a representative, an *ad hoc* Nominating Committee of at least three Board members will receive and vet nominations and recommend a sector representative to the Board.

Tribes are governments, not sectors, therefore each Tribe is allotted one vote may appoint alternate representatives as desired. The Board does not have authority to confirm or deny Tribal appointments.

Medicaid Managed Care Organizations (MCO) are allotted one voting seat on the Board and may rotate that seat as decided within the sector.

This policy shall be renewed bi-annually.

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Deleted: thereafter

_____ _____

OCH Board President OCH Executive Director

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_____ _____

Date Date

Washington Medicaid Transformation Project

Funding Reductions and Mitigation Strategies

December 22, 2017

DRAFT

The following findings were compiled from information provided by the Washington Health Care Authority to representatives of Accountable Communities of Health (ACHs) during a conference call on December 20, 2017. The Center's interpretation of HCA information and commentary is subject to confirmation from HCA, and are offered here to advance that process of review and refinement.

Funding Reductions

1. CMS has not approved HCA's original interpretation of federal DSRIP funding rules as they pertain to Inter-Governmental Transfers (IGT). At the same time, Washington's income from the Designated State Health Programs (DSHP) funding stream has been less than expected, with similar income levels expected in future years. As a result of these concurrent changes to the originally-planned DSRIP funding formula, HCA has issued new estimates of available funding for ACH projects throughout the five-year MTP.

2. If no further changes are made, the DSRIP Project Incentive Pool will be reduced from an original estimated value of $847 million to $297 million. All estimates from HCA are considered "up to" amounts, subject to change and contingent on the meeting of performance criteria.

3. HCA has identified mitigating strategies to offset the reductions. If fully adopted, these strategies would result in a DSRIP Project Incentive Pool totaling $514 million.

Mitigation Strategies

1. For the first year of DSRIP funding, HCA proposes to (1) optimize the claiming of eligible expenditures for approved Designated State Health Programs, (2) lower HCA fund use and capture program savings (delays experienced in Initiatives 2 and 3 implementation), and (3) allocate fewer funds this year for HCA's administration. These steps, in combination with the IGT measures described below, would have the effect of increasing Year 1 DSRIP funding for ACHs by $28.4 million, to an estimated $103 million.

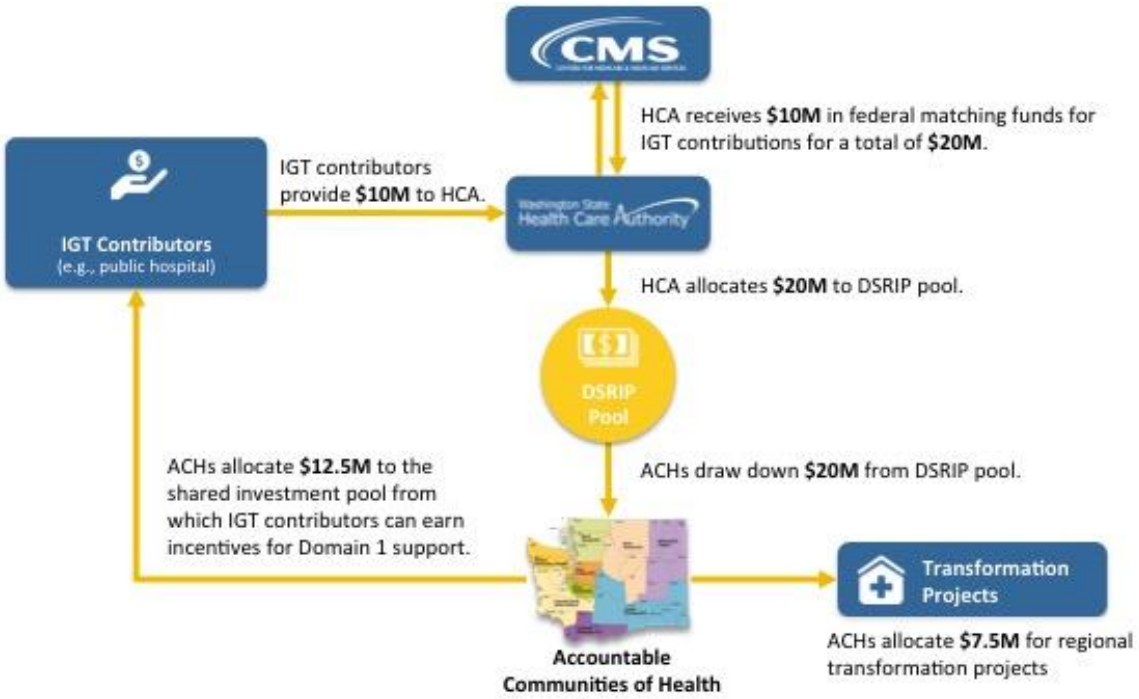
2. IGT investors (e.g. the University of Washington) will make Domain 1 investments that are eligible for a federal mach. This increased federal match will significantly increase the funding available to ACHs in the reinvestment pool.

3. For the remaining years of DSRIP funding, HCA proposes a financing strategy that fully utilizes available IGT funding to raise an additional $188.6 million in available DSRIP funding (i.e. federal matching dollars) that may be earned by ACHs. This strategy raises the DSRIP Project Incentive Pool to $411 million for Years 2 through 5 (2018-2021) of the MTP.

4. The IGT strategy relies on a set of voluntary agreements by HCA, the ACHs, and IGT investors. ACHs are not obligated to participate.

5. The more ACHs that participate, the larger the earned federal match and, therefore, the larger the funding pool. The maximum federal match is earned if all nine ACHs participate. By contrast, if eight out of nine ACHs participate, the total generated funding is "reduced" in proportion to the size of non-participating ACHs. All ACHs would experience that reduction equally – i.e. the non-participating ACH would experience the same proportional reduction that the participating ACHs experience.

Illustration of the IGT Matching Mechanics and Funds Flow



6. The more ACHs that participate, the larger the earned federal match and, therefore, the larger the funding pool. If all nine ACHs participate, the result will be a maximum federal match. By contrast, for instance, if eight out of nine ACHs participate, the total generated funding would be "reduced" in proportion to the non-participating ACH's size. All ACHs would experience that reduction equally – i.e. the non-participating ACH would experience the same proportional reduction that the participating ACHs experience.

7. The first agreement must be confirmed by March 2018. Agreements must subsequently be re-confirmed for each six-month funding cycle.

8. The IGT Investors' Domain 1 investments will be manifested in a set of services. The specific menu of services is under development. Because the investments are dedicated to Domain 1 activities, they are not available to directly compensate ACHs or their provider/partners.

9. The IGT strategy is performance-based. IGT partners earn semi-annual compensation for their investments in the same manner that ACH partners earn DSRIP project incentives. Although specific details are TBD, each IGT investor will be registered with the Financial Executor (FE) for each participating ACH. The ACH will be responsible for authorizing the release of earned compensation to the investor (i.e. using the same process that it uses for releasing funds to providers and other partners).

Risk Assessment

HCA's IGT strategy relies on full concurrence by CMS and voluntary participation of IGT partners and ACHs. The primary risk to ACHs comes from any action taken by CMS, HCA, IGT partners or ACHs to lessen or eliminate the additional federal match that is leveraged by IGT investments. Given the voluntary basis of the entire strategy, this risk may materialize at any six-month interval during the MTP. Conservative financial planning would require ACHs to treat the added potential earnings from the IGT strategy will less assurance than the "baseline" level of DSRIP funding projected by HCA under the "No-IGT" scenario (see attached schedules).

Another risk relates to the exposure to legal action. The IGT strategy must be based on solid legal foundations in order to survive potential lawsuits brought by disgruntled DSRIP participants and others with legal standing. The risk of lawsuit depends largely on the collaborative relationships of ACHs and their participating providers and partners and the perceived fairness of funds flow mechanisms implemented by the ACHs.

Risks associated with public opinion and politics may also threaten the IGT strategy. This risk may center on the IGT matching mechanism and/or the premium earned by IGT partners. According to examples developed by HCA, it appears that IGT partners could earn back their full contribution plus a 25% bonus if they achieve agreed-upon Domain 1 performance measures.

One additional risk predates the current mitigation efforts and relates to DSRIP funding that is contingent on Washington's achievement of statewide performance measures. HCA has identified these "at-risk" amounts as ranging from $10 million to $71.5 million depending on the implementation and size of the IGT match.

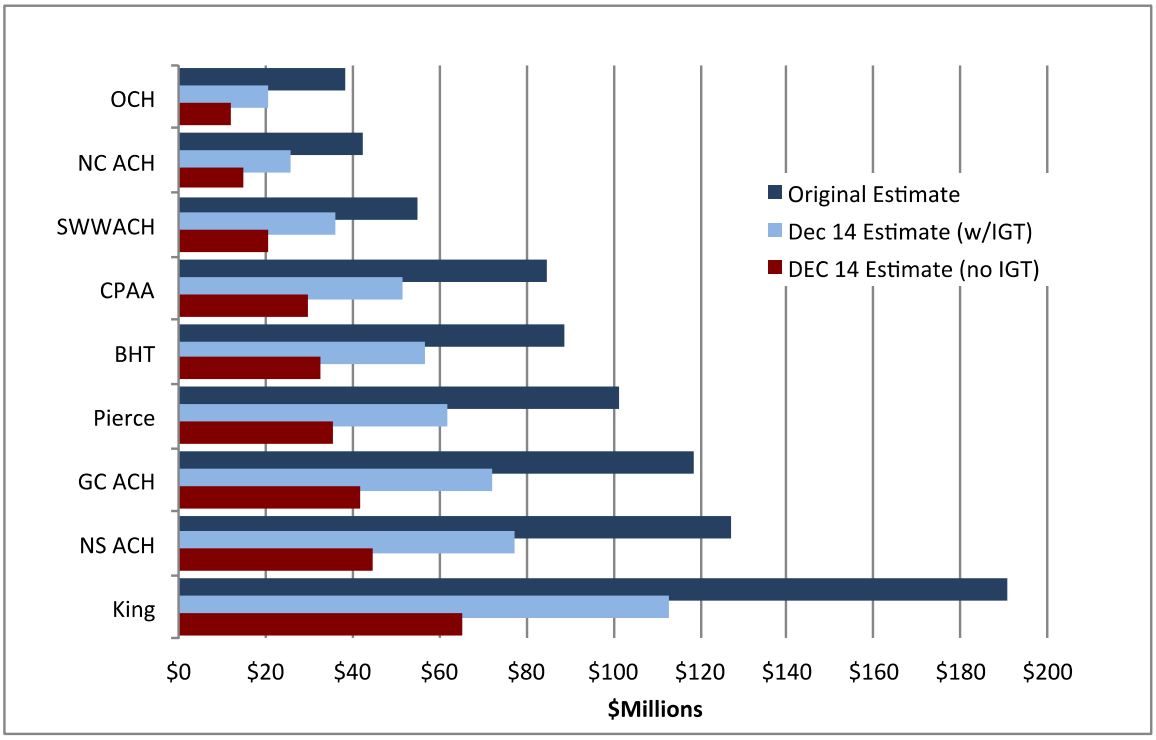
Bottom Line: Based on HCA projections, the ACHs can rely on a Project Incentive Pool of $297 million, of which $10 million is at-risk if statewide performance measures are not achieved. The proposed IGT strategy would $189 million to the Project Incentive Pool and $6,300,000 to the VBP Incentive Pool and would increase the at-risk amount to $71.5 million. IGT partners shoulder 100% of the risk associated with Domain 1 performance, totaling $371 million.

Attachments

The following tables and charts are derived from published information provided to ACHs prior to the December 20 conference call. The Center offers additional analysis and extrapolation based on HCA's funding estimates. The sample funds flow chart is a modified version of a chart that HCA included in a slide presentation to ACHs in December 2017.

Comparison of DSRIP Project Pool Incentive Funding Estimates

	Original	Revised Projects	
ACH	Projections	With IGT	No IGT
OCH	$38,115,000	$20,563,000	$11,883,000
NC ACH	$42,350,000	$25,703,000	$14,853,000
SWWACH	$55,055,000	$35,983,000	$20,795,000
CPAA	$84,700,000	$51,405,000	$29,706,000
BHT	$88,935,000	$56,546,000	$32,676,000
Pierce	$101,640,000	$61,688,000	$35,647,000
GC ACH	$118,580,000	$71,968,000	$41,588,000
NS ACH	$127,050,000	$77,109,000	$44,559,000
King	$190,575,000	$113,094,000	$65,353,000
Total Incentives	$847,000,000	$514,059,000	$297,060,000



HCA Estimates of the available DSRIP Project Incentive Pool without IGT

ACH	DY1	DY2	DY3	DY4	DY5	Total
OCH	$2,987,000	$5,192,000	$2,429,000	$1,275,000	$0	$11,883,000
NCACH	$3,733,000	$6,490,000	$3,036,000	$1,594,000	$0	$14,853,000
SWWACH	$5,227,000	$9,086,000	$4,250,000	$2,232,000	$0	$20,795,000
CPAA	$7,467,000	$12,979,000	$6,072,000	$3,188,000	$0	$29,706,000
BHT	$8,213,000	$14,277,000	$6,679,000	$3,507,000	$0	$32,676,000
Pierce	$8,960,000	$15,575,000	$7,287,000	$3,825,000	$0	$35,647,000
GCACH	$10,453,000	$18,171,000	$8,501,000	$4,463,000	$0	$41,588,000
NSACH	$11,200,000	$19,469,000	$9,108,000	$4,782,000	$0	$44,559,000
King	$16,427,000	$28,554,000	$13,359,000	$7,013,000	$0	$65,353,000
Total Incentives	$74,667,000	$129,793,000	$60,721,000	$31,879,000	$0	$297,060,000

HCA Estimates of the available DSRIP Project Incentive Pool with IGT

ACH	DY1	DY2	DY3	DY4	DY5	Total
OCH	$4,121,000	$6,521,000	$4,286,000	$3,755,000	$1,880,000	$20,563,000
NCACH	$5,152,000	$8,151,000	$5,358,000	$4,693,000	$2,349,000	$25,703,000
SWWA	$7,212,000	$11,411,000	$7,501,000	$6,570,000	$3,289,000	$35,983,000
CPAA	$10,303,000	$16,302,000	$10,715,000	$9,386,000	$4,699,000	$51,405,000
BHT	$11,333,000	$17,932,000	$11,787,000	$10,325,000	$5,169,000	$56,546,000
Pierce	$12,364,000	$19,563,000	$12,858,000	$11,264,000	$5,639,000	$61,688,000
GCACH	$14,424,000	$22,823,000	$15,002,000	$13,141,000	$6,578,000	$71,968,000
NSACH	$15,455,000	$24,453,000	$16,073,000	$14,080,000	$7,048,000	$77,109,000
King	$22,667,000	$35,865,000	$23,574,000	$20,650,000	$10,338,000	$113,094,000
Total Incentives	$103,031,000	$163,021,000	$107,154,000	$93,864,000	$46,989,000	$514,059,000

Extrapolation of IGT Funding Strategy based on Increased Project Incentives
DY2 through DY 5 Only (based on December 14 estimates from HCA)

	IGT Funding Strategy (PIP Extrapolation)			
MTP Year	IGT Investors	CMS Match	Other HCA	Total
DY2	$44,304,000	$44,304,000	$1,893,000	$90,501,000
DY3	$61,910,667	$61,910,667	$2,642,666	$126,464,000
DY4	$82,646,667	$82,646,667	$3,524,666	$168,818,000
DY5	$62,652,000	$62,652,000	$55,093,000	$180,397,000
Total	$251,513,334	$251,513,334	$63,153,332	$566,180,000

	IGT Funding Strategy (PIP Extrapolation)			
MTP Year	IGT Investors	CMS Match	Other HCA	Total
DY2	$44,304,000	$44,304,000	$1,893,000	$90,501,000
DY3	$61,910,667	$61,910,667	$2,642,666	$126,464,000
DY4	$82,646,667	$82,646,667	$3,524,666	$168,818,000
DY5	$62,652,000	$62,652,000	$55,093,000	$180,397,000
Total	$251,513,334	$251,513,334	$63,153,332	$566,180,000

Olympic Community of Health
Impacts of HCA DSRIP Funding Estimates
January 2, 2018

Potential DSRIP Revenue based on Medicaid Lives

	Project Plan	HCA IGT Strategy	Reduction
Design Funds and SIM Carryover	$6,220,000	$6,220,000	$0
Project Plan Award (Baseline)	$3,974,000	$4,121,000	$147,000
P4R Incentives	$13,254,000	$12,083,000	($1,171,000)
P4P Incentives	$7,164,000	$4,359,000	($2,805,000)
Total Potential Revenue	$30,612,000	$26,783,000	($3,829,000)

Estimated Revenues for Project Planning

	Project Plan	HCA IGT Strategy	Reduction
Revenue Sources			
Design Funds and SIM Carryover	$6,220,000	$6,220,000	$0
Project Plan Award (Baseline)	$4,371,400	$4,533,000	$161,600
P4R Incentives	$11,928,600	$10,874,700	($1,053,900)
P4P Incentives	$1,791,000	$1,089,800	($701,200)
Total Estimated Revenues	$24,311,000	$22,717,500	($1,593,500)
Transformation Components			
Provider Payments	$12,198,600	$10,768,000	($1,430,600)
Provider-Based Project Mgmt	$600,000	$600,000	$0
Domain 1 Projects	$3,278,600	$3,400,000	$121,400
IT Care Coordination	$1,355,600	$1,316,000	($39,600)
Advocacy and Empowerment	$518,600	$527,600	$9,000
Community SDOH Projects	$368,000	$335,000	($33,000)
Operations & Administration	$5,306,300	$5,173,000	($133,300)
Reserves/Wellness Fund	$686,000	$598,000	($88,000)
Total DSRIP Revenue	$24,311,700	$22,717,600	($1,594,100)
Example of NCC and Regional Allocations			
NCC/Provider Change Plans	$16,189,600	$15,106,600	($1,083,000)
OCH Project Investments	$2,815,800	$2,438,000	($377,800)
OCH Project Management	$5,306,300	$5,173,000	($133,300)
Total DSRIP Allocations	$24,311,700	$22,717,600	($1,594,100)
Example of Potential Allocations to NCC Collaboratives			
Clallam NCC	$4,426,000	$4,120,000	($306,000)
Jefferson NCC	$2,550,600	$2,376,000	($174,600)
Kitsap NCC	$8,611,800	$8,015,000	($596,800)
Total NCC Allocations*	$15,588,400	$14,511,000	($1,077,400)

*excludes $600,000 in project management payments to provider partners.

Shared Change Plan

Draft for discussion purposes only

January 2, 2018

This shared change plan represents agreement by the listed parties on mutual expectations and shared goal and strategies of the Medicaid Transformation Project (MTP), a statewide initiative to improve care for the Medicaid beneficiaries of Washington.

Adoption of OCH MTP Goals

We share Olympic Community of Health's (OCH) goal of a health care delivery system that facilitates the following for Medicaid beneficiaries:

- accessible, patient-centered primary care that is well integrated with behavioral health, reproductive, maternal and child health, and dental services
- effective linkages between primary care, social services and other community based service providers
- common data metrics and shared information exchange
- provider adoption of value-based payment contracts

Signed Partners

By signing below, we agree to being signed partners of the MTP. A signed partner is an organization committed to implementing transformational activities under the MTP. This commitment includes an approved change plan, signed standard partnership agreement, enrollment into the financial executor portal and a signature from leadership on this document. Signed partners are eligible to earn DSRIP payments from the financial executor if they meet their contractual reporting requirements and targeted benchmarks. OCH will evolve these above expectations to accommodate Tribal participation in the OCH MTP in consultation with each Tribe.

Expectations and Roles of Signed Partners

Signed partners agree to:

- upload reports and data (no PHI) as needed, no more frequently than monthly and no less than every six months, into the MTP portal. Tribal data will be handled on a case-by-case basis and in consultation with each Tribe.
- commit staff to participate in implementation teams and/or committees yet to be defined and as determined necessary by the natural community of care signed partners.
- share lessons learned and best practices, included supporting documentation where applicable, with other signed partners, including those in other natural communities of care.
- participate in the MTP with an open mind, willingness to listen, mutual respect of one another, and a commitment to doing the right work.

Shared MTP Goals

Health Equity

We have a shared commitment to improving health equity and agree that achieving the MTP goals are not sufficient to address the health disparities in our region. We will actively incorporate health equity into our change plans and hold one another accountable to this shared vision. At a minimum, we will come to agreement on how to invest DSRIP funds in one or more local organizations dedicated to improving wellness and addressing social influences of health and that will further our natural community of care's shared change plan.

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Integration of Care
We will participate in the regional transformation efforts to integrate primary care, substance use treatment, and mental health care between our organizations using at least one evidence-based practice included in the OCH Project Plan submission and also charting our own course, identifying new, innovative methods that improve care for the whole person.

Coordinated Opioid Response
We are aware of the opioid crisis impacting our community and are fully supportive of the 3 County Coordinated Opioid Response Project (3CCORP). We will carefully consider recommendations from this body pertaining to safe opioid prescribing, community and provider education, stopping overdoses and deaths from overdoses, and increasing access to the spectrum of treatment of opioid use disorder. If we are unable to come to immediate agreement on recommendations from this group, we commit to concerted efforts to get swift consensus with relevant parties.

Connectivity
We understand that we must effectively communicate with one another to provide the highest quality care for the people we serve. We commit to exploring multiple mechanisms to connect us to each other and the Medicaid beneficiaries we serve, such as data sharing and/or business associate agreements and innovative pilots that leverage technology to improve the coordination of care.

Accountability
We agree to hold one another accountable for the following five, Medicaid population-based metrics: 1) well-child visits, 2) unnecessary emergency room visits, 3) hospital readmissions, 4) homelessness, and 5) arrests. Estimates for these measures will be shared within the natural community of care as frequently as possible and data stewards for each measure agree to leverage their data systems to provide timely reports.

Advocacy
We agree that our voice is stronger and more effective together than as individuals. When the need arises, we agree to form a collective voice on behalf of the people we serve.

Transformational Activities
We will identify and collaborate on transformational activities (Appendix A) that would benefit by and/or require an interdisciplinary approach in order to be successful. Success is gauged both by moving the metrics (see Appendix B below) and improved clinical-community linkages.

Here is where an NCC adds language about community paramedicine, law-enforcement assisted diversion, mobile dental van, Stanford model, Six Building Blocks for Safe Opioid Prescribing, or other shared strategies. NCCs should also list out specific partners that have agreed to implement each part of a multi-disciplinary strategy. For example: A primary care practice that wishes to deploy the Chronic Care Model will partner with community organizations to provide community-based chronic disease case management or education.

Shared MTP Goals	Objectives	Metrics

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Health Equity	improved access and outcomes for populations experiencing health disparities	At least XX% increase in the percentage of Medicaid enrollees attributed to a medical home who have accessed care in the previous year.
Integration of Care	primary care, substance use treatment, mental health and whole person care	At least XX% increase in the percentage of practices participating in an evidence-based integration project, and undertaking care integration.
Coordinated Opioid Response	safe prescribing, community/provider education, stopping overdoses and deaths from overdoses, and increasing access to the spectrum of treatment of opioid use disorder	At least XX% decrease in the number of opioid-related deaths. At least XX% increase in the percentage of covered persons undergoing best practice treatment for opioid abuse disorder. At least XX% increase in the number of PCP trained in the AMDG opioid prescribing guidelines.
Connectivity	data sharing and/or business associate agreements, and technology to coordinate care	At least XX% of practices and providers engaged in data sharing agreements, business associate agreements, memorandum of understanding, or other similar arrangements. At least XX% increase in the percentage of practices and providers using care coordination or population health management technologies.
Accountability	reporting on well-child visits, unnecessary emergency room visits, hospital readmissions, homelessness, and arrests	The following percentage improvements in five accountability metrics: well-child visits (X%), unnecessary emergency room visits (X%), hospital readmissions (X%), homelessness (X%), and arrests (X%).
Advocacy	collective voice on behalf of the people we serve	At least XX% increase in the number of Medicaid population participating in education and advocacy initiatives. XX number of community forums, workshops and presentations to elected officials.

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We have read this shared change plan for XXXXX County and agree to the terms listed above. Each of our organizations agree to move forward in the spirit of collaboration, mutual respect, and positive intent.

PRINTED NAME	TITLE	ORGANIZATION	SIGNATURE	DATE

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Appendix A. Evidence Based Practices

Appendix B. Performance Metrics