



Board of Directors Meeting

August 3, 2016

Clallam • Jefferson • Kitsap

2. Consent Agenda

1. Director's Report, Pages 2-5
2. Cover Letter for HCA deliverable, Page 6
3. What is the Olympic Community of Health, Page 7
4. Board Minutes 7.6.2016, Pages 9-14

3. Budget

- 2016-2017 Budget: Actual versus projected and year-to-date spend
 - Page 15

Approved 2016 budget versus year-to-date spend

PERSONNEL	TOTAL	SPEND JAN-JUN '16	% SPENT (Target 50%)
Director: 1.0 FTE for 9 months	103,171	38,780	38%
Program Coordinator: 0.5 FTE for 4 months	19,399	0	0%
Epidemiologist: 0.5 FTE for 11 months	48,463	12,624	26%
Assistant 0.4 FTE for 10 months	20,186	12,681	63%
Subtotal Personnel Costs	191,219	64,085	34%
NON-PERSONNEL	TOTAL		
Professional Services:			
Interim Project Manager (Jan. - March 2016)	23,605	19,690	83%
Communications Support (website)	3,500	0	0%
Legal or other consultant ²	5,000	0	0%
Travel	4,000	794.64	20%
Supplies	3,000	702.59	23%
Event/Meeting Expenses	5,000	1,998	40%
Other	0		
Subtotal Non-Personnel Costs	44,105	23,185	53%
Indirect Costs (25% of salaries & benefits) ¹	47,805	16021.13	34%
TOTAL EXPENDITURES³	283,129	103,291	36%
DESIGNATED RESERVES⁴	206,871		

APPROVED 2016 BUDGET	
PERSONNEL	TOTAL
Director: 1.0 FTE for 9 months	103,171
Program Coordinator: 0.5 FTE for 4 months	19,399
Epidemiologist: 0.5 FTE for 11 months	48,463
Assistant 0.4 FTE for 10 months	20,186
Subtotal Personnel Costs	191,219
NON-PERSONNEL	TOTAL
Professional Services:	
Interim Project Manager (Jan. - March 2016)	23,605
Communications Support (website)	3,500
Legal or other consultant ²	5,000
Travel	4,000
Supplies	3,000
Event/Meeting Expenses	5,000
Other	0
Subtotal Non-Personnel Costs	44,105
Indirect Costs (25% of salaries & benefits) ¹	47,805
TOTAL EXPENDITURES³	283,129
DESIGNATED RESERVES⁴	206,871

PROJECTED 2016 BUDGET	
PERSONNEL	TOTAL
Director: 1.0 FTE for 9 months	103,171
Epidemiologist: 0.3 FTE for 11 months	29,078
Assistant 0.6 FTE for 10 months	30,280
Subtotal Personnel Costs	162,528
NON-PERSONNEL	TOTAL
Professional Services:	
Interim Project Manager (Jan. - March 2016)	23,605
Communications Support (website)	3,500
Legal or other consultant ²	5,000
Program Coordinator: 75 hrs/month for 4 mo	22,254
Travel	4,000
Supplies	3,000
Event/Meeting Expenses	5,000
Directors and Officers Liability Insurance	700
Other	0
Subtotal Non-Personnel Costs	67,059
Indirect Costs (25% of salaries & benefits) ¹	40,632
TOTAL EXPENDITURES³	270,219
DESIGNATED RESERVES⁴	302,603

PROJECTED 2017 BUDGET

PERSONNEL	TOTAL
Executive Director: 1.0 FTE for 12 months	134,915
Program Coordinator: 1.0 FTE for 12 months	90,500
Subtotal Personnel Costs	225,415
NON-PERSONNEL	TOTAL
Professional Services:	
Legal or other consultant ²	5,000
Epidemiologist: 43 hrs/month for 12 months	45,872
Assistant: 86 hrs/month for 12 months	38,143
Professional Development	2,600
Travel	4,500
Supplies	1,500
Event/Meeting Expenses	6,000
Directors and Officers Liability Insurance	2,000
Other	0
Subtotal Non-Personnel Costs	105,615
Indirect Costs (15% of salaries & benefits) ¹	33,812
TOTAL EXPENDITURES³	364,842
DESIGNATED RESERVES⁴	196,760

Budget Summary

- On track to stay within budget for 2016
- Financial future of the OCH is uncertain
- Recommend approving 2017 budget at November Board meeting

4. Coordinated Opioid Response Project

Proposal submitted to the HCA as part of our July Deliverable:

- *Three-County Coordinated Opioid Response Project*
- Pages 16-26

4. correct

Phone: 390-455-5417

...set of projects

☐ General ☐ Financial ☐ Marketing ☐ Operations ☐ Other	☐ New ☐ Existing ☐ Former	☐ General ☐ Financial ☐ Marketing ☐ Operations ☐ Other	☐ General ☐ Financial ☐ Marketing ☐ Operations ☐ Other
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Order #	Order Date	☐ Ship to a different address	☐ Web Order
Qty. and Unit	Quantity	☐ Ship by Date	
Unit Price	Amount		

Chickadees are everywhere. It is one of the most common birds in the area. The goal of Chickadee is to provide information and resources to help you learn more about this little bird.

sample of 1000 parents did not reveal general ability in music, speech and cognitive abilities (Kaufman, 1990a,b). As part of the screening process, all parents were given a 10-minute video with information on screening procedures.

[illegible]

...and the support of new crops has been a major factor in the development of the country.

The Department of Health and Human Services has announced that it will release the results of its study on the health effects of electromagnetic fields (EMF) from power lines and electrical equipment.

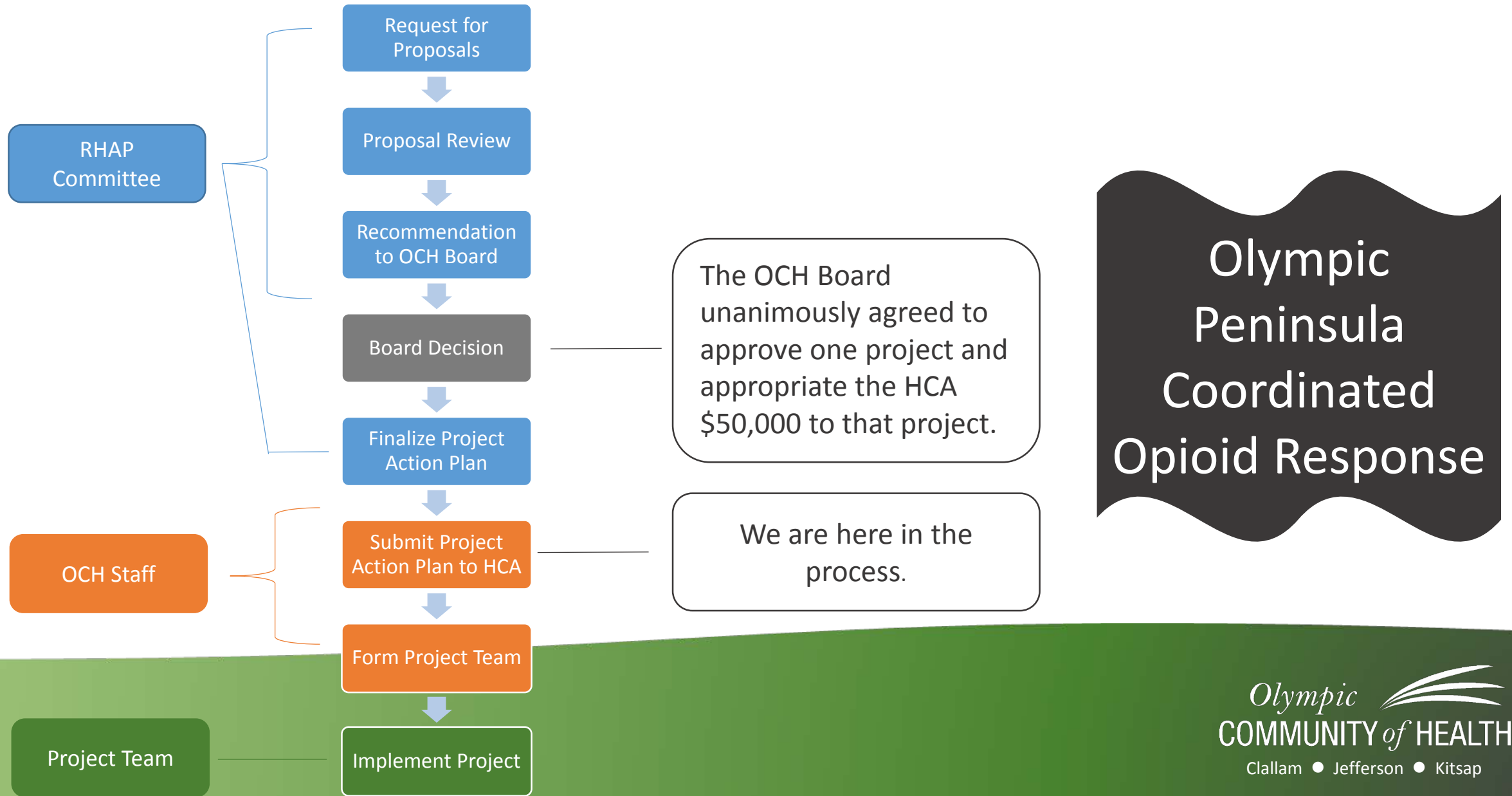
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Mathematics

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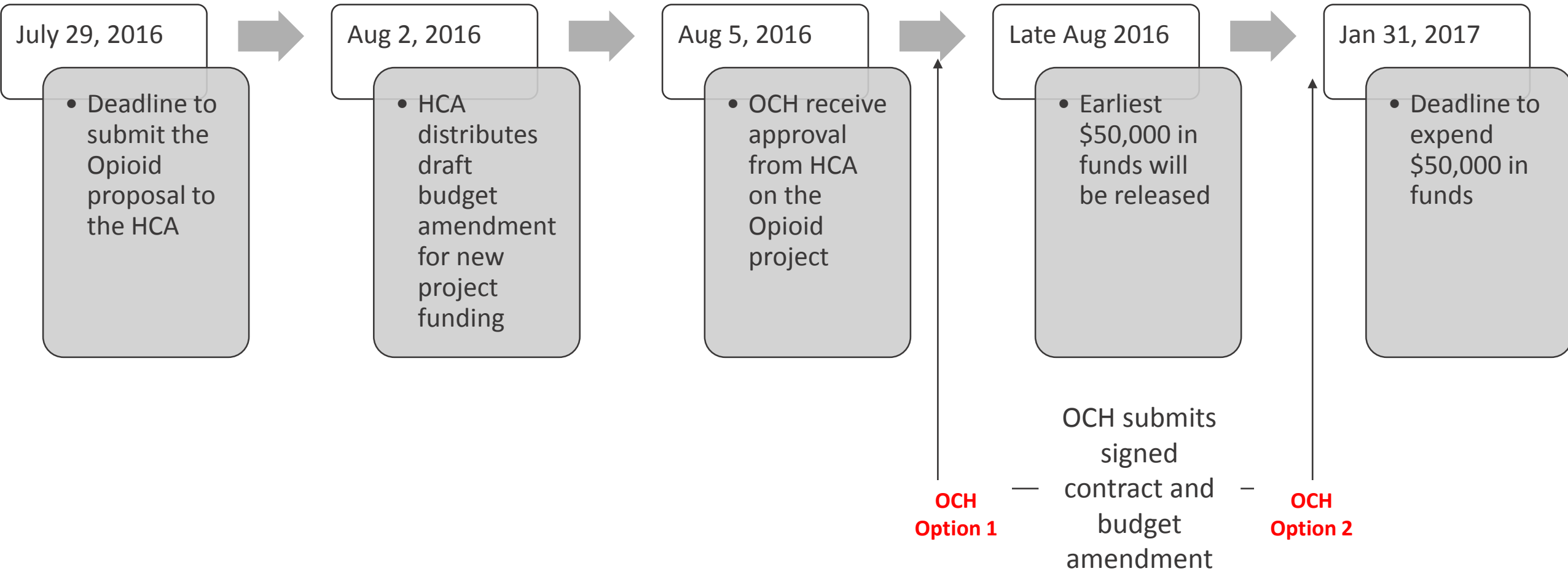
Overview Opioid Project Selection Process



Opioid Project **Planning** Phase Project Activities

Activity	Timeline
Perform a three-county assessment into the scope of the problem and the current solutions already underway	August to November 2016
Identify and engage with key partners	August 2016 onwards
Form a multi-county, cross sector leadership committee to advise the overall project that includes tribal participation	October 2016
Hold a three-county Opioid Summit	January 2017
Select 3-5 measures to gauge success	January 2017
Begin work on project implementation plan as consensus builds during the planning phase; develop a visual tool to represent implementation plan.	February 2017

Opioid Project Operational Milestones



****Proposed** Opioid Project Budget**
August 1, 2016-January 31, 2017

Personnel	Salaries	Benefits	Total
Director: 0.10 FTE for 6 months	5,291	1,587	6,878
Epidemiologist: 0.15 FTE for 6 months	6,100	1,830	7,930
Assistant 0.10 FTE for 6 months	2,329	699	3,028
Subtotal Personnel Costs	13,720	4,116	17,836
Non-Personnel			Total
Travel			1,000
Consultant or Contractor: ave 60 hrs/month for 5 months			22,254
Supplies			1,500
Event/Meeting Expenses			2,950
Other			0
Subtotal Non-Personnel Costs			27,704
Indirect Costs (25% of salaries & benefits)			4,459
TOTAL EXPENDITURES			49,999

Contract #: K1434

Contact Person: Elya Moore

Phone: 360 337-5289

Email: elya@olympicch.org

Instructions:

Please specify Q3 and Q4 2016 projections related to the \$50,000 in additional funding only. SIM Q3 = August 1 - October 31 and SIM Q4 = November 1 - January 31.

These projections will later be incorporated in your updated 2016-2018 projections, but for now please simply outline the projections for this \$50,000 increase. When incorporating these numbers in the forthcoming 2016-2018 projection template, we will provide additional instructions for any adjustments between the current contract categories (i.e., if an ACH plans to shift current unspent category 3 fund to another category).

Please note that ACHs have the option of submitting a revised Q4 projection by October 10 to account for anticipated carry over from the previous quarter. Without this amendment HCA will award the original amount projected, resulting in the potential loss of the unanticipated carry over.

This same form will also be used to provide a report on actual expenditures. The Q3 report is due November 30 and the Q4 report is due February 28.

Budget Line Item	Q3 2016	Q4 2016	Total	Notes
3: Health and Delivery System Transformation (projected)	\$22,499.26	\$27,500.06	\$49,999.33	Assumes contractor begins 9/1/2016
3: Health and Delivery System Transformation (actual)	\$0.00	\$0.00	\$0.00	

Proposed Project Staffing

- Salish Behavioral Health Organization (SBHO) has asked the OCH to staff the project
 - The SBHO is willing to staff the project, but prefer the OCH
- Whatever the staffing model, given the timeline, an independent contractor will likely be engaged

1. Staff submits the budget and contract amendment with guidance from the OCH Executive Committee and KPHD Administrator as soon as possible after receipt of contract amendment from HCA
2. Once funds are received, staff operationalizes the project

5. Articles of Incorporation

DRAFT Articles of Incorporation

- Pages 27-28

Situation | Background | Action | **Recommendation** | **Motion**

- Page 29

ACTION	RECOMMENDATION
Executive Committee discussed:	Executive Committee recommended:
501c3: All other versions selected nonprofit status to file Articles of Incorporation.	For the time being, identify nonprofit 501(c)3 as the OCH legal status in the Articles of Incorporation until the Board can have a full discussion to elect a legal entity, either at this meeting, or the September Board meeting.
Simplicity: One ACH went beyond the articles required to incorporate while another restricted their articles to the basic requirement.	Keep the Articles of Incorporation short and simple. Details and additional structure can go in the bylaws, which are much easier to amend.
Directors: How should we list Directors?	In the spirit of simplicity, list only the five officers as Directors.
Incorporators: How should we determine the Incorporators?	In the spirit of simplicity, list only the five officers as Incorporators.

Motion

The OCH Board of Directors authorizes the Executive Director to electronically submit the Articles of Incorporation as presented with the Washington Secretary of State pending legal review from interested parties and an approved motion from the Board to move forward and select 501(c)3 as the legal entity.

BREAK

OCH Staff Contact Details

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Email: siri.kushner@kitsappulichealth.org

Website

<http://www.olympiccommunityofhealth.org>

6. Bylaws

DRAFT Bylaws

- Pages 30-41
- **Red font** indicates additions or diversions from the ACH bylaws template

Situation | Background | Action | Recommendation | Motion

- Page 42-43

6. Bylaws: Recommendation

Pages 42-43

ACTION	RECOMMENDATION
Executive Committee discussed:	Executive Committee recommended:
501c3: All other versions articulated a nonprofit status.	For the time being, identify nonprofit 501(c)3 as the OCH legal status in bylaws until the Board can have a full discussion to elect a legal entity, either at this meeting, or the September Board meeting.
Purpose: We have not yet gone through the process of creating a mission, purpose, or vision yet.	Keep the purpose concise and vague enough to allow the OCH to evolve, but specific enough so we can all agree to it. We can revise the bylaws later.
Tribes: Does the language in the bylaws about Tribes represent the will of the Board?	Yes, however, each Tribe may wish to take the bylaws to their leadership and seek their own legal counsel to ensure no interference with the Tribe's government-to-government relationship.
Committees: Are the committees the bylaws the right committees?	Yes. The number and type of committees should meet our needs.
Nominations: Should we stick with our policy?	Yes, we should stick with our policy.
Term Limits: How do we want to handle term limits? There is a limited number of people with the skills and experience to represent their sector.	The bylaws should not limit the number of terms a board member can serve. At the end of three consecutive terms, a sector can opt to select a new representative. Terms should be two years and membership staggered.
Insurance: Should we purchase Directors and Officers (D&O) insurance?	See advice from counsel on page 43.

Motion 1. The OCH Board authorizes the Executive Director to **accept the draft bylaws** as per the discussion at the August 3rd Board meeting and circulate the revised version to Board Members as soon as possible to facilitate independent legal review. The Executive Committee will review a revised version of the bylaws at their August 26th meeting and make a recommendation to the Board at the September 7, 2016 meeting.

Motion 2. The OCH Board authorizes the Executive Director to investigate **Directors and Officers Liability Insurance** and select and purchase a plan prior to the Articles of Incorporation being accepted by the Secretary of State's office.

Motion 3. The OCH Board authorizes the Executive Director to draft a **Fiscal Sponsorship Agreement** for review and recommendation by the Executive Committee for the full Board at the September 7, 2016 OCH Board meeting.

Motion 4. The OCH Board authorizes the Executive Director to draft a **Conflict of Interest Policy** as described in the bylaws for review and recommendation by the Executive Committee for the full Board at the October 5, 2016 OCH Board meeting.

Comments or questions from the public?

BREAK - Upcoming Meetings and Events

OCH upcoming meetings and events

- 8/26/2016, **OCH Executive Committee**, 8:00 am – 10:00 am
- 9/7/2016, **OCH Board of Directors**, 8:30 am – 11:00 am
- 9/12/2015, **RHAP Committee**, 1:00 pm – 3:00 pm
- 9/13/2016, **OCH Partner Convening**, 9:00 am – 12:00 pm, Jamestown S’Klallam Red Cedar Hall

Healthier Washington upcoming meetings and events

- 8/4/2016, **Medicaid Transformation Waiver Update**, 11:00 am – 12:30 pm
- 8/8/2016, **Paying-for-Value Webinar Series**, 1:00 am – 2:00 pm
- 10/24/2016, **Stakeholder Symposium**, SeaTac, details to come

Other upcoming meetings and events

- 8/11/2016, **Different Regions, Different Care** (*focus on opioids*), All-Alliance Meeting, Washington Health Alliance, 2:00 pm-4:00 pm Cambia Grove, Seattle
- 9/14/2016, **State of Reform**, Spokane, Washington

Work Session I

Understanding the MCO experience of health care

Work Session I: Outline & Objectives

Outline

1. Identify questions for the MCOs
2. Work through key questions

Objectives

1. An enhanced understanding of the role and functions of MCOs
2. *Transition to next work session:* Begin thinking of ideas of where there are opportunities for OCH-MCO alignment on mutually supportive strategies

Work Session I: Questions

1. What is *managed care* and why do we have it?
2. How do funds flow to the MCOs and then to providers?
3. How does the administrative rate work for MCOs?
4. What role do MCOs play in community care management?
5. How are MCOs approaching value-based purchasing (care)?
6. What goals or priorities do MCOs have regarding making health improvements and cost savings for our region or other ACHs?
7. Are there key core measure set items the MCOs are focused on and how do they align with our regional priorities?

Medicaid Managed Care 101

Olympic ACH

August 3, 2016

Presented jointly by Amerigroup, Community Health Plan of Washington,
Coordinated Care, Molina Healthcare of Washington and UnitedHealthcare

What is Medicaid Managed Care?

- Managed Care is a health care delivery system organized to manage cost, utilization, and clinical and service quality.
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs), such as health plans and behavioral health organizations (BHOs), that accept a set per member per month (capitation) payment for these services.
- By contracting with MCOs, states can reduce Medicaid costs and better manage utilization of health services.
- MCO contracts with the State Medicaid Agency are profit-limited contracts.
- MCOs strive to reinvest cost savings through shared savings programs and provider partnerships.
- Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Medicaid Managed Care in Washington Today

- 1.8 million Washingtonians enrolled in Apple Health (Medicaid) and approximately 92% are enrolled in managed care and growing
- The five health plans are Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina Healthcare of Washington and UnitedHealthcare
- In 2016, Washington is transitioning from a county by county basis for managed care contracts to a regional managed care approach to better align across the care continuum (shared regions for Physical Health and Behavioral Health (BHOs))
- 5 Medicaid Managed Care Plans are contracted with the state to deliver physical health and mild to moderate mental health services
- In SW Washington, Fully Integrated Managed Care (FIMC) went live on 4-1-2016, with the full continuum of physical and behavioral health services within one contract. CHPW and Molina are the 2 FIMC plans in SW.

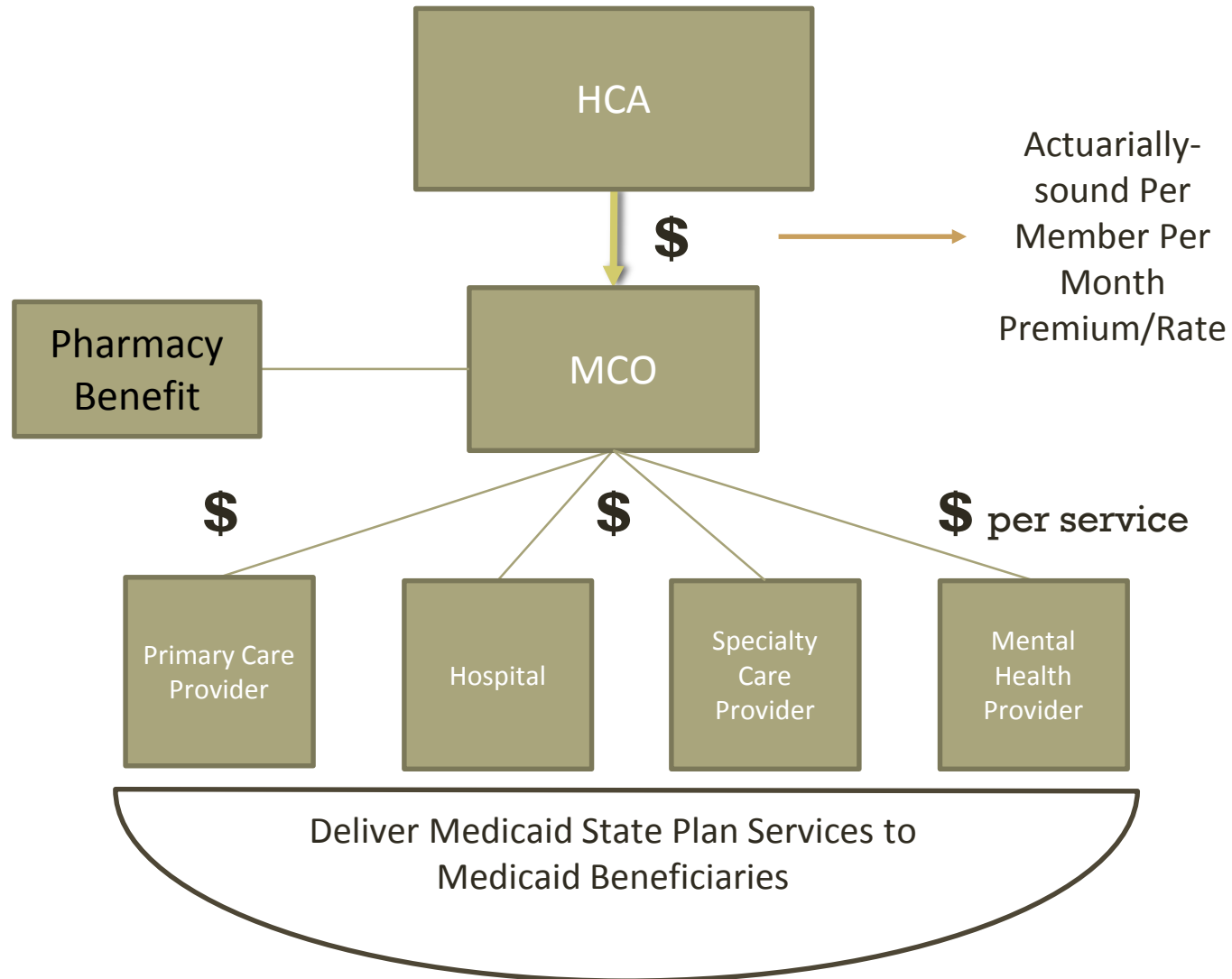
Role of MCOs in Washington

- MCOs provide coordinated care through a defined network of health care systems and providers.
- MCO role goes far beyond paying claims and approving or denying authorization for services...MCOs invest significant time and resources to:
 - Facilitate Care Management, Health Promotion, & Wellness
 - Assure Clinical and Service Quality
 - Build Provider Networks
 - Engage & Partner with Communities
 - Leverage Data and Technology
 - Monitor & Maintain Compliance
 - Maintain Program Integrity

Financial Details

- MCOs are risk-bearing entities contracted by HCA for the full continuum of physical health (ie IP, OP, ED, Medical Specialty, DME. Carve outs include long term care, SMI for MH, SUD, and dental)
- MCOs have risk-adjusted rates
- MCOs are profit-limited. The State Medicaid agency sets a maximum profit of 3%. Profits greater than 3% must be returned to the Medicaid Agency (50% of profits between 3% and 5%; 100% of profit greater than 5%).
- MCOs maintain sufficient reserves as required by the OIC
- MCOs have payment model expertise
- MCOs have actuarial resources in order to validate that rates are actuarially sound

MCO Funds Flow Visual-Current



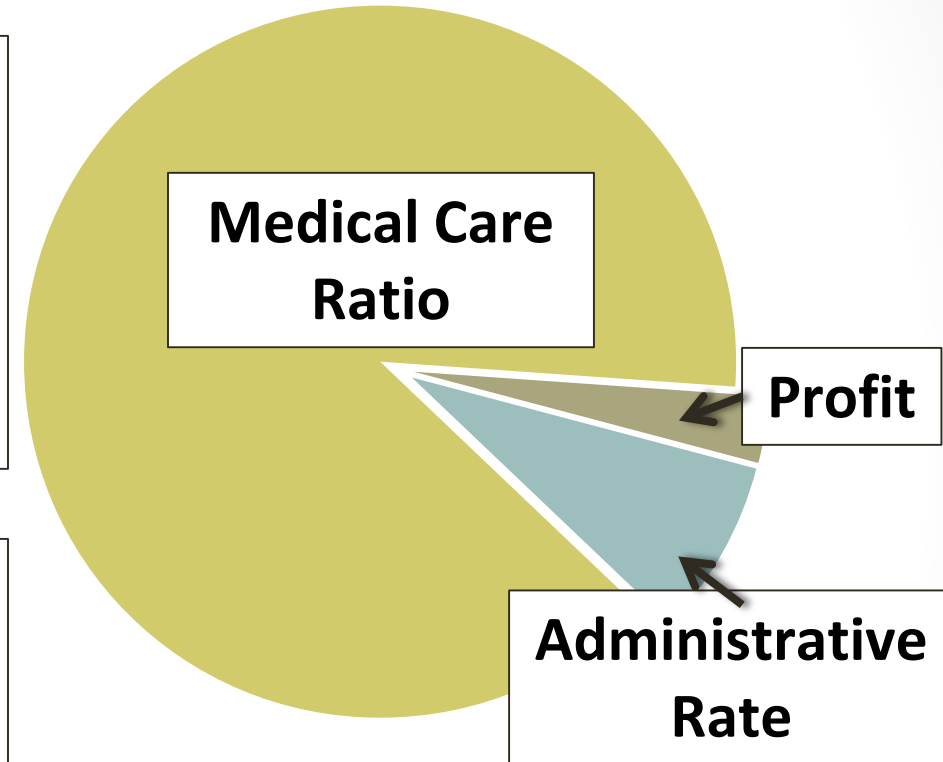
Experience + Age/Gender + Risk + Geography + Enhancements = Premium

MCR – Medical Care Ratio

- Percent of premium spent on medical care
- *Generally*, services that are claim based
 - Primary care, facility, specialty care, pharmacy, behavioral health
 - Encounter data requirements
- * *Some services can be re-classified as medical within contract constraints*

Administrative Rate

- Percent of premium for administration
- Assumed load is set % for rate setting
 - 8.5% for AH Family, SCHIP
 - 6.55% for AH BD
- Examples:
 - Enrolling members, paying claims, ID cards, member/provider services, Community Engagement, *Care Coordination/Case Management; Quality Improvement**



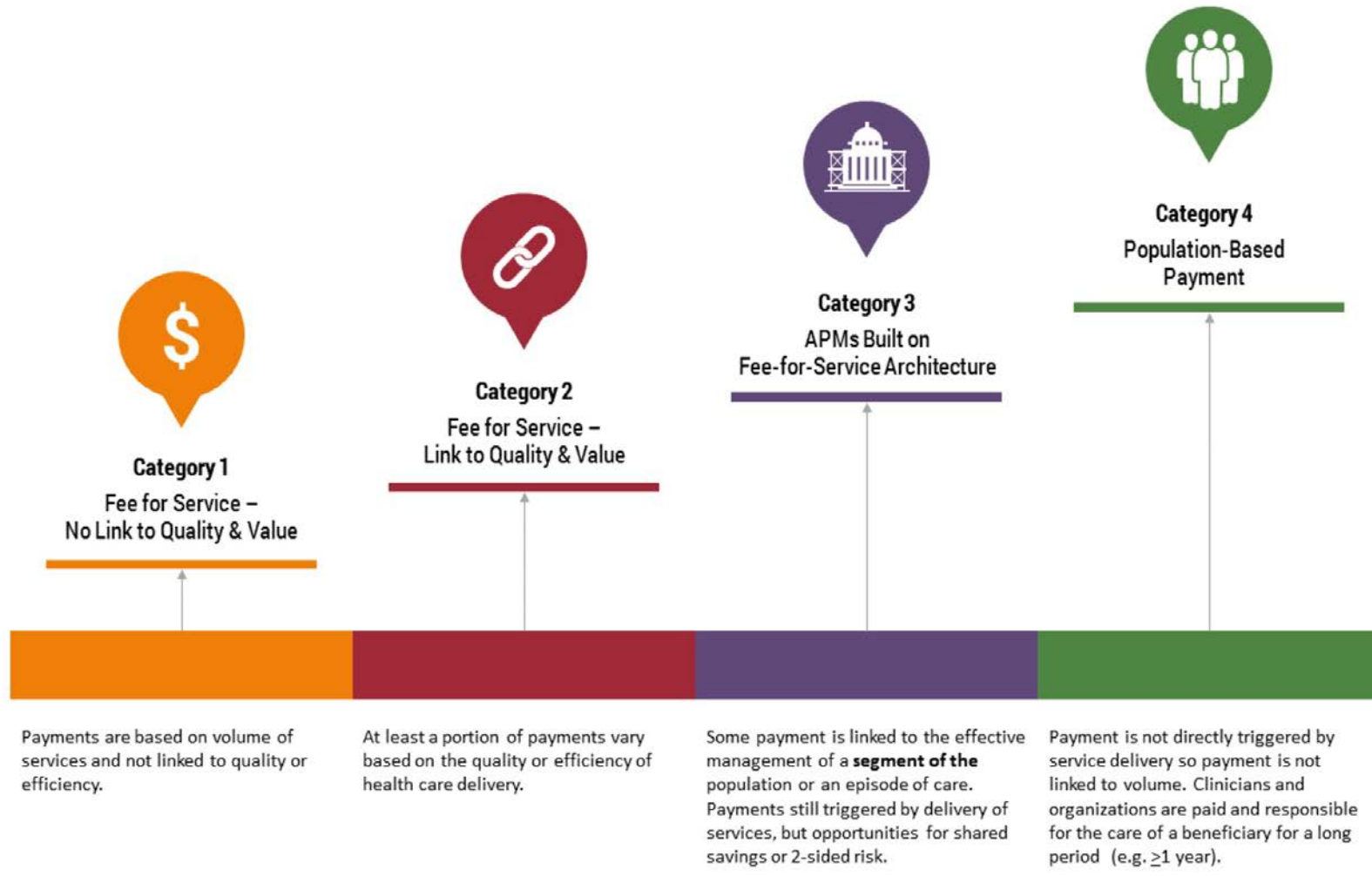
Profit

- Limited by Gain Share Program in contract
 - 3-5% requires 50% payback
 - >5% requires 100% payback

Value Based Purchasing

- Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019
 - With Waiver, 90% by 2021
- 2017 Contract measures that have a quality incentive tied to it
 - Antidepressant Medication Management
 - Childhood Immunization Status
 - Comprehensive Diabetes Care: Blood Pressure Control
 - Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
 - Controlling High Blood Pressure
 - Use of Appropriate Medications for Asthma
 - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

HCP-LAN VBP Spectrum



Value Based Contracting

Fee For Service (FFS)

- Payment for services rendered

FFS with Gain Share

- Payment for services rendered
- Quality metrics
- MLR Threshold
- Distribution of funds when below threshold and quality metrics met

FFS with Shared Risk

- Payment for services rendered
- Quality metrics
- MLR Threshold
- Distribution of funds when below threshold and quality metrics met
- Withhold when above threshold

Full Risk Capitation

- Payment as a percent of premium or PMPM
- **Quality metrics**
- *Sometimes* delegation

Service Based



Value Based

Building Provider Networks

- Contract with providers to ensure the availability of a sufficient number and type of providers within a required distance to meet the diverse needs of the members
- To engage providers, most MCOs offer a continuum of payment approaches including value based models for provider partners to provide opportunities to share savings and be rewarded for high quality care
- Networks are routinely monitored to ensure Access & Availability standards are maintained
- The Continuum of Care is harder for us to map oftentimes because of the broad requirements we have for our network

Benefits/Services/Provider Types

- Primary Care
- Pharmacy
- Specialty services (from cardiology and oncology to otolaryngology)
- Acupuncturists
- Emergency Departments
- Urgent Care
- Children's hospitals
- Mild-Moderate Mental Health Services

Questions?

Work Session II

Connecting the MCO experience with opportunities
to align with OCH goals and priorities

Work Session II: Outline & Objectives

Outline

1. Identify breakthrough opportunities for collaboration
2. Prioritize these opportunities
3. Discuss how to make the opportunities actionable

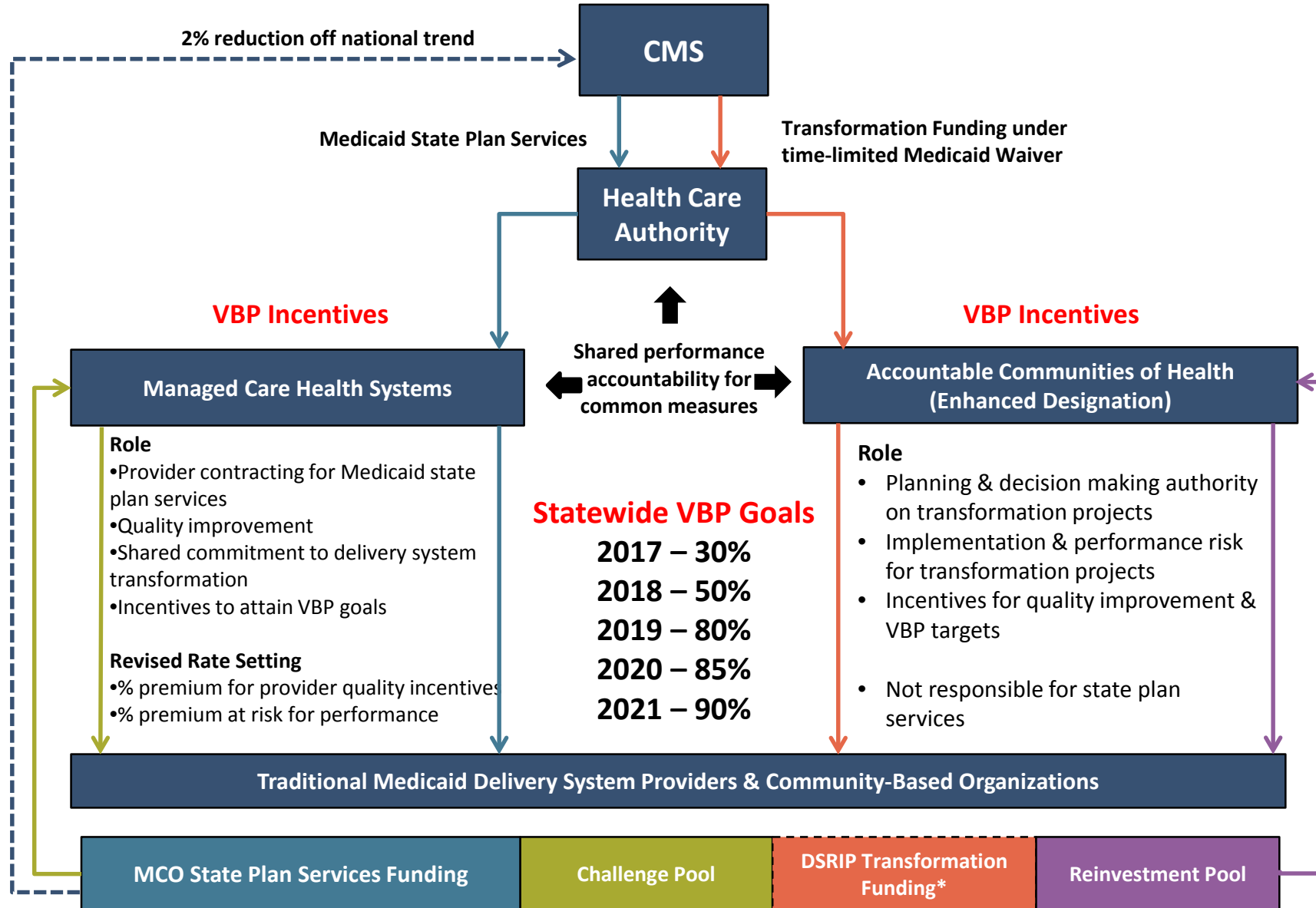
Objectives

1. A shared understanding of the promise of an OCH-MCO partnership
2. Identify one actionable strategy to collaborate on together

Work Session II: Icebreaker suggestions

- Care management
 - How can ACHs and MCOs partner to support a more efficient, effective care management strategy?
- Value-based payment (care)
 - How can ACHs and MCOs partner to help providers achieve quality metrics?
- Administrative burden
 - How can ACHs partner with MCOs and providers to address barriers to data sharing, measure selection, data reporting and other administrative duties.

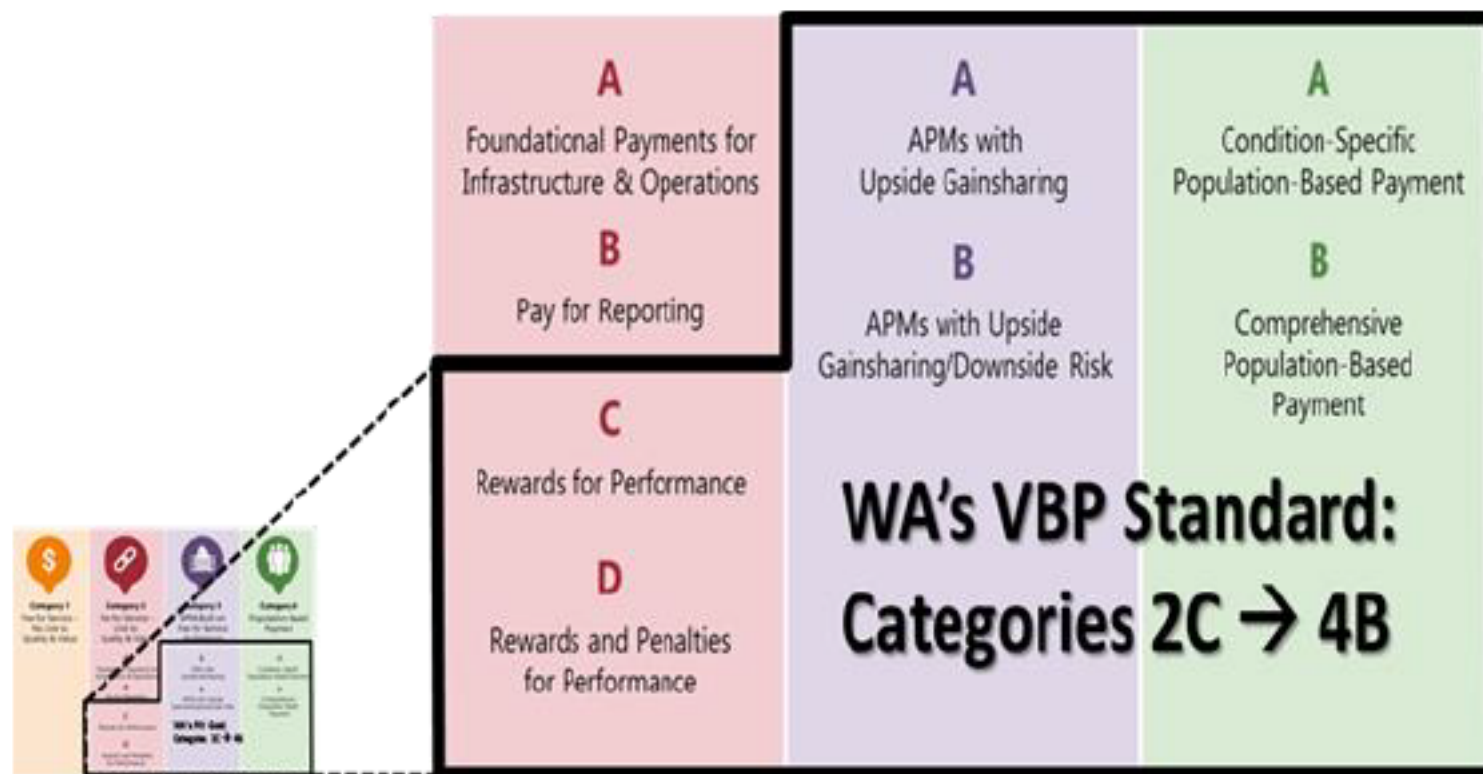
Washington State Value-Based Purchasing Framework



*Time Limited – 5 years



Transition to Value-Based Payment



HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021

2016: 20%

2019: 80%

2017: 30%

2020: 85%

2018: 50%

2021: 90%

CALENDAR YEAR	VBP INCENTIVES			MANAGED CARE ORGANIZATION (MCO) INCENTIVES		CHALLENGE POOL	REINVESTMENT POOL
	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)	STATE VBP Target	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)
	VBP Target Incentive ¹ % of each incremental % point of premium over/under VBP target ²	Region Specific VBP Target Incentive ¹ \$ tied to each 1% over State VBP Target ³		Provider Incentives % premium for provider quality incentives	Quality Withhold % premium at Risk for performance ⁴	Unearned VBP Incentives ^{5,6} % of unearned MCO Incentives and withhold	Unearned ACH VBP Incentives ^{5,6} % of unearned ACH VBP and a share of unearned MCO incentives
<i>Pre</i>	-	-	20%	-	-	-	-
2017	(+/-) 2%	\$200k for each 1%	30%	0.75%	1.0%	(up to) 1%	
2018	(+/-) 1.5%	\$300k for each 1%	50%	1.0%	1.5%	(up to) 1%	
2019	(+/-) 1%	\$666k for each 1%	75%	1.5%	2.0%	(up to) 1%	
2020	(+/-) 0.75%	\$1m for each 1%	85%	2.0%	2.5%	(up to) 1%	
2021	(+/-) 0.5%	\$1.2m for each 1%	90%	2.5%	3.0%	(up to) 1%	
<i>Post</i>	Not extended beyond the five year waiver period		90%+	3.0%	2.5%	0.25% + 25% of remaining withhold ⁷	0.25% + 75% of remaining withhold ⁷



Sample Scenario

CALENDAR YEAR	VBP INCENTIVES		
	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)	STATE VBP Target
	VBP Target Incentive ¹ % of each incremental % point of premium over/under VBP target ²	Region Specific VBP Target Incentive ¹ \$ tied to each 1% over State VBP Target ³	
Pre	-	-	20%
2017	(+/-) 2%	\$200k for each 1%	30%
2018	(+/-) 1.5%	\$300k for each 1%	50%
2019	(+/-) 1%	\$666k for each 1%	75%
2020	(+/-) 0.75%	\$1m for each 1%	85%
2021	(+/-) 0.5%	\$1.2m for each 1%	90%
Post	Not extended beyond the five year waiver period		90%+

- ACH "A" exceeds VBP regional target by 10% in year 1 and earns \$2M of DSRIP incentive.
 - It is expected, as part of project design, that earned VBP incentives will be paid to providers
- ACH "B" is short in meeting the VBP regional target in year 1 and does not earn a DSRIP incentive.
- Unearned incentive dollars are sent to the Reinvestment Pool.



Sample Scenario

CHALLENGE POOL	REINVESTMENT POOL
Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)
Unearned VBP Incentives ^{5,6}	Unearned ACH VBP Incentives ^{5,6}
% of unearned MCO Incentives and withhold	% of unearned ACH VBP and a share of unearned MCO incentives
-	-
(up to) 1%	
(up to) 1%	
(up to) 1%	
(up to) 1%	

- The challenge pool is funded with a portion of unearned VBP incentives (red columns) and uncollected withhold payments from managed care premiums (blue columns).
- The reinvestment pool is funded with a portion of unearned VBP incentives (red columns). If all incentives are earned, there will not be any funds available in the reinvestment pool.
- Total combined value of challenge and reinvestment pools will not exceed \$25M on an annualized basis.