COUNCIL MEETING

NOVEMBER 9, 2017

Welcome and Introductions

Introduce yourself: Name, organization, and county

WELCOME

Review Desired Meeting Outcomes

- ✓ Review Board meeting outcomes
- ✓ Discuss Medicaid Transformation Project Plan
- ✓ Discuss next steps after Project Plan submittal
- ✓ Discuss financial news (scoring methodology change & FIMC)
- ✓ Learn about Workgroup and Committee activities
- ✓ Review and “test-drive” a Health Equity decision aid
- ✓ Learn about Tribal health priorities

Announcements

- CPAA Board Vacancies:
  - Health System
  - At Large - Wahkiakum County
  - Tribal Gov't Services
- CPAA Board Report:
  - October Meeting

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CPAA Board Report: October Board Meeting

- ✓ Approved FY 2017-18 CPAA LLC Operating Budget
- ✓ Approved the six recommended projects to include in the Project Plan application:
  - Opioid Response
  - Bi-Directional Integration of Care
  - Care Coordination
  - Reproductive & Maternal/Child Health
  - Transitional Care
  - Chronic Disease Management

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Review Major Decisions from October CPAA Board Meeting (continued)

- ✓ Adopted the CPAA Finance Committee's Fund Allocation Principles and Fund Allocations by Use Category and Organization Type, with the following addition: *Reward collaboration among various sectors and partners, including Tribes*
- ✓ Agreed to approach the HCA with the Olympic ACH to request access to mid-adopter incentive funds

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Medicaid Transformation Project Plan

- Gaps and questions identified by staff
- Gaps and questions identified by Council Members

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What's Next: Planning Phase and Early Implementation in 2018

- Project Application due Nov. 16th
- Independent Assessor reviews and scores project applications and makes decisions in Jan – Feb 2018
- Implementation Planning phase January – June 2018:
  - Make implementation plans
  - Conduct environmental scans / needs-gap assessments
  - Finalize target populations
  - Determine partnering providers
  - Outline roles and responsibilities
- Implementation begins July 2018

Monitoring Project Implementation and Partnering Provider Performance

- Review suggested approach
- Discussion
- Recommendation to the Board

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Shared Investments Across Project Areas

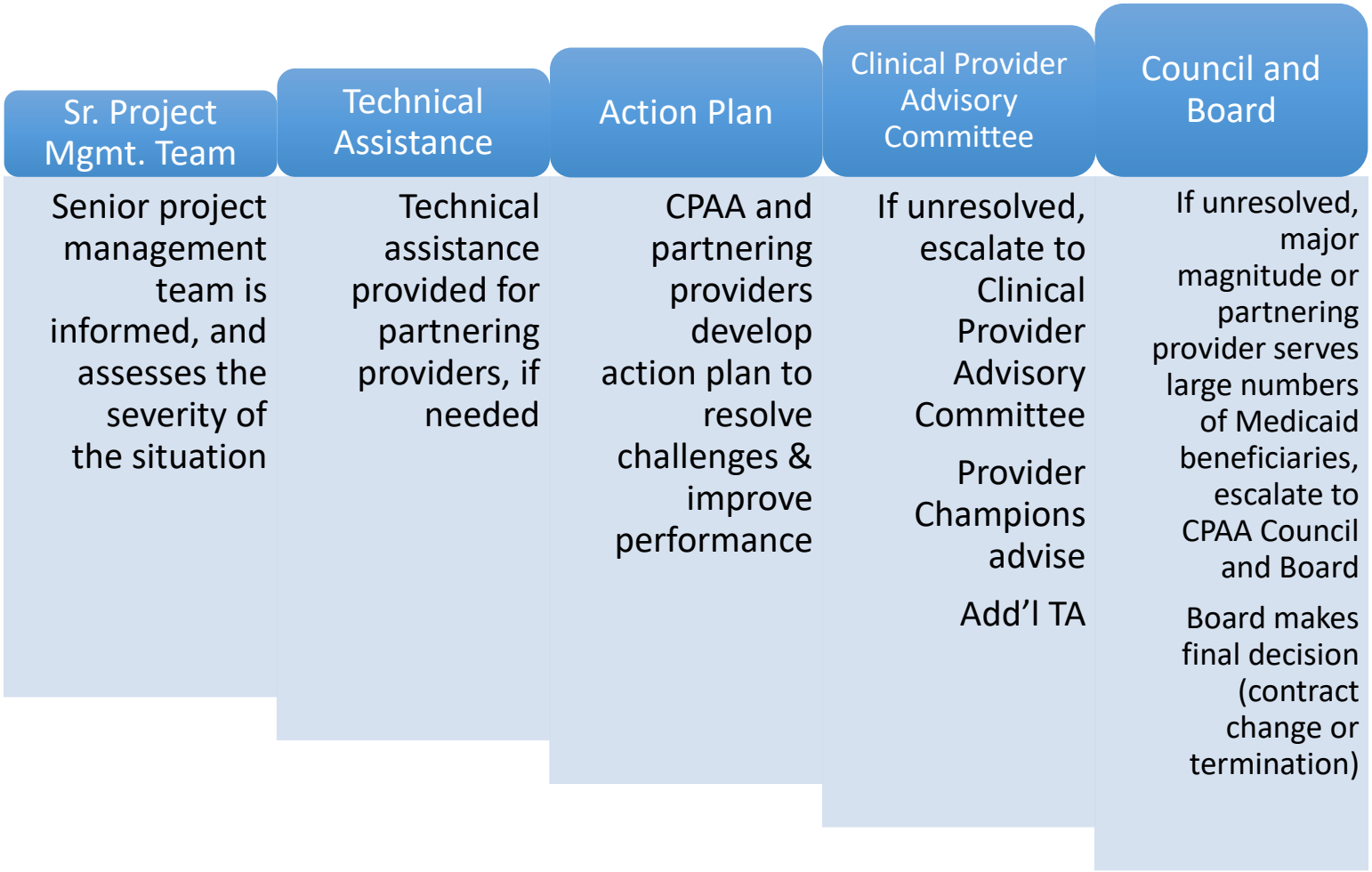
Describe the investments or infrastructure the ACH has identified as necessary to carry out the projects in domains 2 and 3.

The following table lists the various investments and/or infrastructure CPAA has identified to date as required to implement the selected projects successfully. CPAA will expand on this list during implementation planning as additional infrastructure investments are being identified.

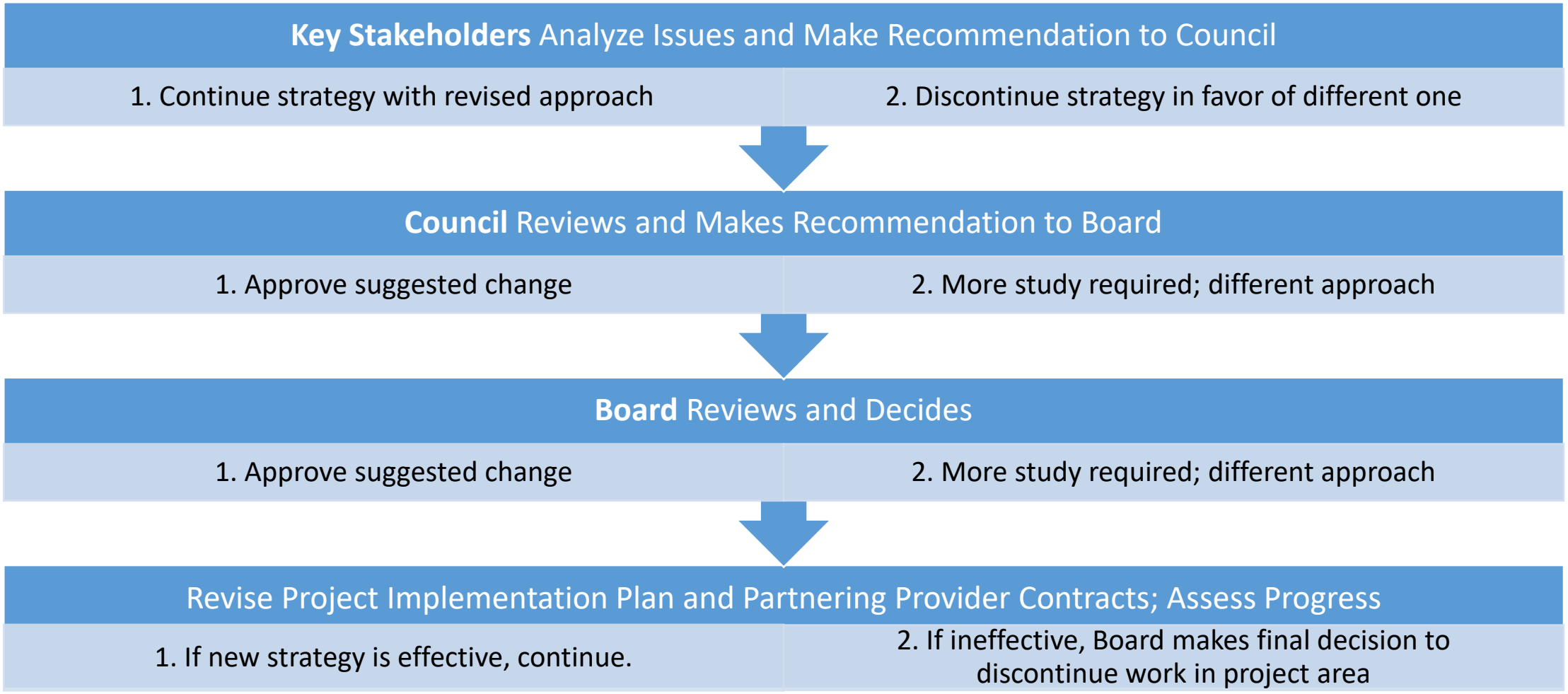
	Project Areas					
Required Investment or Infrastructure	2A-CI	2B-CBCC	2C-TC	3A-OUR	3B-RMCH	3D-CDCP
Value-Based Payment						
Training for Partnering Providers about Value-Based Payment	X	X	X	X	X	X
Convening Payers to Align Expectations for Providers & Outcomes	X	X	X	X	X	X
Bridge Funding for Partnering Providers to Make Transition to VBP	X	X	X	X	X	X
Workforce						
Formal Survey Partnering Providers about Workforce Needs	X	X	X	X	X	X
Expanding Telehealth Capacity	X			X		
Tuition Support for Key Shortage Areas	X				X	
Partnering with Schools for Internships	X	X	X		X	
Expanding the Use of Family Members as Caregivers			X			
Learning Collaboratives for Partnering Providers	X	X	X	X	X	X
Onsite Trainings for Partnering Providers (potentially partner with medical societies or provider associations for provider CME credits)	X	X	X	X	X	X
Population Health Management Systems						
Formal Inventory of Partnering Providers about Existing HIT usage and capacity	X	X	X	X	X	X
HIT Systems that Support Partnering Providers to Participate in VBP and that Allow for Cross-System Data Sharing (between partnering providers, between partnering providers and MCOs, and HCA)	X	X	X	X	X	X
Provider Registries	X					X
Care Coordination Software		X				

Implementation and Performance Monitoring

If Progress Becomes Questionable or Progress is Delayed



Addressing Ineffective Strategies



It’s All About the Money – Or is it?

WINFRIED DANKE - EXECUTIVE DIRECTOR/CEO

CHOICE REGIONAL HEALTH NETWORK/CASCADE PACIFIC ACTION ALLIANCE

Medicaid Transformation Finances

- Original Funding & Project Plan Scoring Framework
- New information
- Analyze implications
- Discussion: Project Portfolio Implications

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Relative Medicaid Attribution Influences ACH-Level Distribution

- Statewide total Project Pool funds is set by year, and will be distributed amongst ACHs primarily based on **share of Medicaid attribution**
- Receipt of total available Project Pool funding will adjusted based on performance

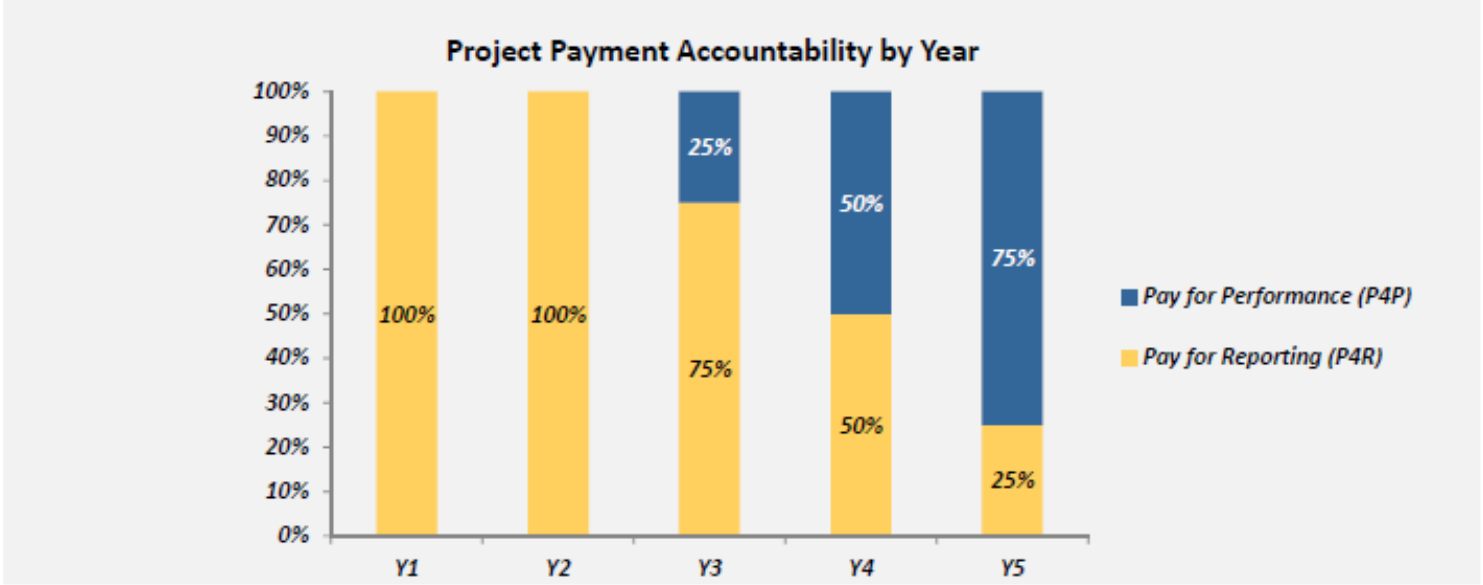
ACH		Estimated Potential Project Pool Funding (millions)**					
ACH Name	Est. % Medicaid Attribution*	TOTAL	Y1	Y2	Y3	Y4	Y5
Olympic Community of Health	**4.5%**	**$38**	$6	$9	$9	$8	$7
North Central	**5%**	**$42**	$7	$10	$9	$9	$8
Southwest Washington	**6.5%**	**$55**	$9	$13	$12	$11	$10
Cascade Pacific Action Alliance	**10%**	**$85**	$14	$19	$19	$18	$15
Better Health Together	**10.5%**	**$89**	$15	$20	$20	$18	$16
Pierce County	**12%**	**$102**	$17	$23	$23	$21	$18
Greater Columbia	**14%**	**$119**	$19	$27	$26	$25	$21
North Sound	**15%**	**$127**	$21	$29	$28	$26	$23
King County	**22.5%**	**$191**	$31	$43	$43	$39	$34
STATEWIDE PROJECT POOL FUNDS	100%	**$847**	**$138**	**$193**	**$189**	**$175**	**$152**

Reduced by up to 36%

** Estimated Medicaid attribution estimate based on 2016 Medicaid eligibility report. Final attribution will be based on HCA's client-by-month file, as of November 2017. ** **Estimate, subject to change and intended only to provide general scale**; does not reflect adjustments based on Project Plan score or project selection (Y1 only), tribal projects, project performance, nor enhancements for fully integrated care, among other factors.*

ACH Project Funds Adjusted Based on Performance

- Performance metrics will be used to monitor progress toward achieving the overall waiver vision. Project Pool incentive payments in Years 2 -5 will be **adjusted based on level of performance** against these metrics
- **ACHs will report semi-annually** on progress and, starting in Y3, on their outcomes to date for selected projects
- Accountability emphasis shifts from **process** metrics to **outcome** metrics and from **reporting** to **performance** thresholds over the course of the 5-year program



Preliminary Project Plan Scoring Framework

An ACH's overall score on its Project Plan is based on the quality of the ACH's responses to ACH level and project level questions, as well as the number of projects selected.

Section I: ACH Level	+	Section II: Project Level	=	Project Plan Score
30%		*70%*		

- Each section out of 100 points (minimum of 60) required per section
- Each project level section averaged together

Score	% Max Project Valuation for DY 1
60-69%	60%
70-79%	70%
80-89%	80%
90%+	90%

Project Selection Bonus

Projects	Additional % max project valuation for DY 1
4	0%
5	5%
6*	10% + possible unearned funds
7*	15% + possible unearned funds
8*	20% + possible unearned funds

* The maximum an ACH will receive is 100% of project valuation for DY 1, plus the possibility for funds that are unearned by ACHs that achieve less than 100%. Unearned funds will be distributed based on Project Plan quality, project selection, and attribution.

Project Plan Scoring Framework: Examples

For example: An ACH scoring a combined 80% on its Section I & II Project Plan and selecting 6 projects would receive 90% of its Year 1 Project Incentive maximum potential funding amount, and would be eligible to receive a portion of the funds unearned across all ACHs.

Section I & II Score	# Projects Selected	Valuation	Eligible to Receive Portion of Unearned Funds?
60%	4	60%	No
	6	70%	Yes
	8	80%	Yes
80%	4	80%	No
	6	90%	Yes
	8	100%	Yes
100%	4	90%	No
	6	100%	Yes
	8	100%	Yes

What Has Changed?

Adjustments to Medicaid Transformation Demonstration Project Plan Scoring Methodology

Background

The Medicaid Transformation Demonstration is a collaborative, performance-based way of funding health system transformation. It is a contract with the federal government that establishes conditions under which up to $1.5 billion over five years may be expected. That funding is dependent on the federal government matching funds to two sources made available by the state:

- Intergovernmental Transfers (IGT)
- Designated State Health Programs (DSHP)

Recent analysis of Demonstration funding reflects a lower than originally calculated amount in Demonstration Year 1. This affects how much money Accountable Communities of Health will receive to carry out their planned transformation projects under Initiative 1. It has implications for ACHs as they continue forming their Project Plans, which are due to the Independent Assessor by November 16, 2017.

Implications for CPAA Project Portfolio?

- HCAs project plan scoring protocol sets up a *dynamic* funding system where the portfolio size and project plan valuation of every ACH impacts the revenue estimates for each ACH.
- Given this dynamic system, simple across-the-board averages of plan valuations can be misleading and inaccurate.
- In order to produce reasonable estimates of project plan awards, one has to evaluate a larger number of possible results based on a *random* assignment of project plan valuations and awards for all ACHs.
- The CPAA analysis is based a random assignment of project plan valuations for each ACH, repeated 1,000 times.

Funds Flow Impacts of Portfolio Size and Project Plan Award (CPAA)

Table 1 - Impact of Project Portfolio on **Project Plan Award** (Millions)

Project Plan Awards	Average	Change	% Change
Sticking with 6 Projects	$9.85		
Going to 4 Projects	$8.19	-$1.87	-17%
Maximum Award (6 Projects)	$10.52		
Minimum Award (4 Projects)	$7.51	**-$3.01**	-29%

Table 2 - **P4P** Revenue (Millions)

	Average	Change from High Estimate	
Achievement Levels	P4P Revenue	Amount	% Change
High - P4P at 75%	$11.94		
Medium - P4P at 50%	$7.96	-$3.98	-33%
Low - P4P at 25%	$3.98	-$7.96	-67%

Table 3 - Project Plan & **P4R** Revenue (Millions)

	P4R	Project Plan Award*		Total Plan & P4R Revenue	
Achievement Levels	Revenue	6 Projects	4 Projects	6 Projects	4 Projects
Low - P4R = 85%	$25.04	$9.05	$7.51	$34.09	$32.55
Medium - P4R = 90%	$26.50	$9.85	$8.19	$36.35	$34.69
High - P4R = 95%	$28.00	$10.52	$8.83	$38.52	$36.83
Dropping from 95% to 90% on P4R	-$1.50				
Dropping from 90% to 85% on P4R	-$1.46				
Dropping from 95% to 85% on P4R	-$2.96				

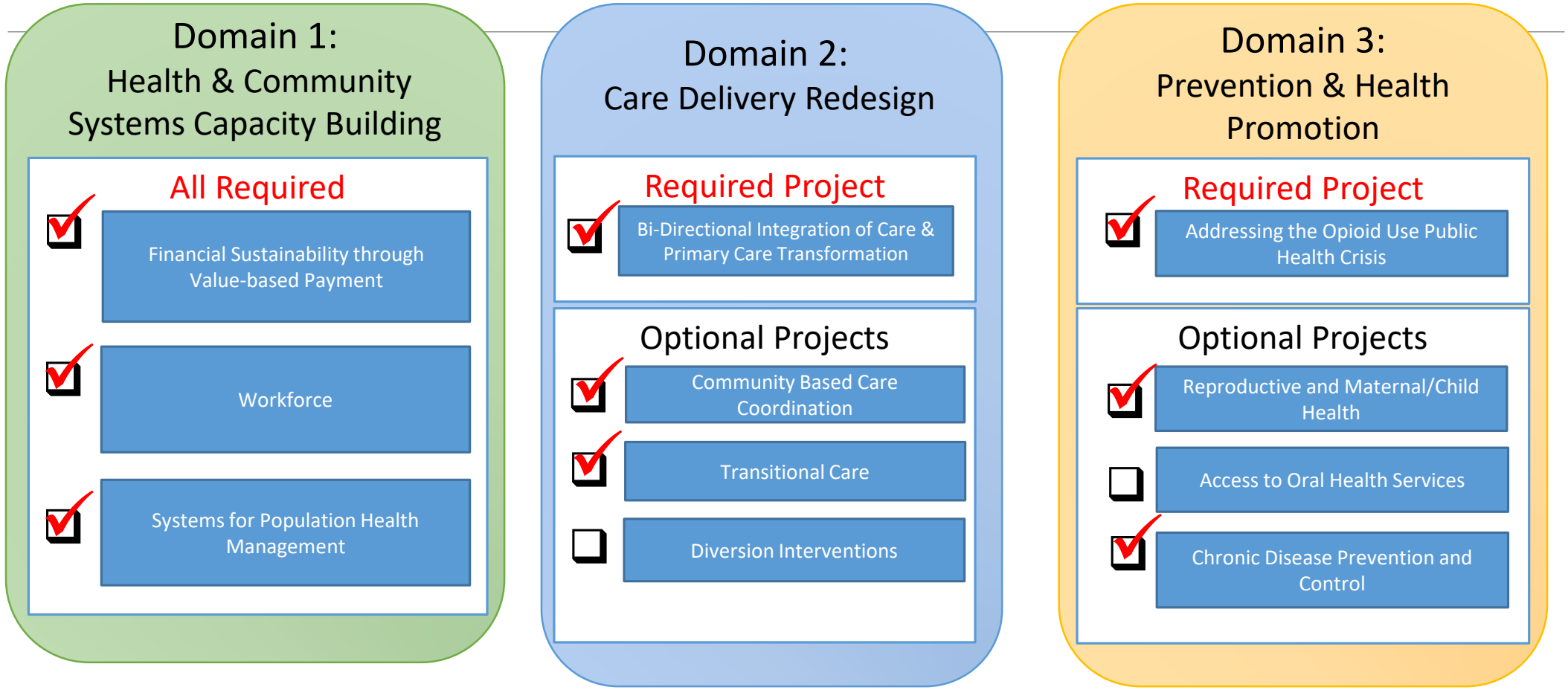
Combined Potential Loss of Poor P4R and P4P: -$10.92

* Project Plan Awards - Low = Minimum Estimate, Medium = Average Estimate, High = Maximum Estimate

Project Portfolio Selection

- Not just a financial decision, but also a *normative* question: What does our community need and value?
- Provider Capacity: What are our providers able to achieve?
- Management Capacity: How many projects can we realistically manage?
- Risk Tolerance: How confident are we that we will reach outcome metrics (P4P)?

Medicaid Transformation Project Toolkit



So How Much Money Can We Earn? – Really?! (6-Project Portfolio)

Select ACH:	*Cascade Pacific Action Alliance*	*10%*	*Estimated Medicaid Attribution % for Selected ACH*

	2017 Year 1	2018 Year 2	2019 Year 3	2020 Year 4	2021 Year 5	Revenue Estimate	
Project Plan Q-Score	90%					$8,830,000	**<<< Based on the original scoring method, assuming no added bonus.**
Pay for Reporting		90%	90%	90%	90%	$26,532,000	
Pay for Performance			75%	75%	75%	$11,947,500	
Total DSRIP Estimate						**$47,309,500**	<< does not include Design and FIMC funds

Revenue Breakdown (6-Project Portfolio)

ESTIMATED PERFORMANCE-ADJUSTED PROJECT INCENTIVES DSRIP REVENUE BY PROJECT (MILLIONS)

PP-P4R-P4P: 90-90-75						
	Calendar Year	2017	2018	2019	2020	2021
	Program Year	Y1	Y2	Y3	Y4	Y5
2A: Bi-Directional Integration of Care		$3.36	$4.24	$3.98	$3.52	$2.92
2B: Community-Based Care Coordination		$2.31	$2.92	$2.73	$2.42	$2.01
2C: Transitional Care		$1.37	$1.72	$1.61	$1.43	$1.19
N/A		$0.00	$0.00	$0.00	$0.00	$0.00
3A: Addressing the Opioid Use Crisis		$0.42	$0.53	$0.50	$0.44	$0.36
3B: Maternal and Child Health		$0.53	$0.67	$0.62	$0.55	$0.46
N/A		$0.00	$0.00	$0.00	$0.00	$0.00
3D: Chronic Disease Prevention / Control		$0.84	$1.06	$0.99	$0.88	$0.73
Total Estimated Performance-Adjusted Project Incentives	**$47.31**	**$8.83**	**$11.13**	**$10.44**	**$9.24**	**$7.67**
Total Estimated Project Incentives Not Earned	**$6.93**	**$0.00**	**$1.24**	**$1.66**	**$1.96**	**$2.07**
Eligible for Potential Additional Funds?		**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

So How Much Money Can We Earn? (4-Project Portfolio)

Select ACH:	*Cascade Pacific Action Alliance*	*10%*	*Estimated Medicaid Attribution % for Selected ACH*

	2017 Year 1	2018 Year 2	2019 Year 3	2020 Year 4	2021 Year 5	Revenue Estimate	
Project Plan Q-Score	90%					$7,950,000	**<<< Based on the original scoring method, assuming no added bonus.**
Pay for Reporting		90%	90%	90%	90%	$26,514,000	
Pay for Performance			75%	75%	75%	$11,940,000	
Total DSRIP Estimate						**$46,404,000**	<< does not include Design and FIMC funds

Revenue Breakdown (4-Project Portfolio)

ESTIMATED PERFORMANCE-ADJUSTED PROJECT INCENTIVES DSRIP REVENUE BY PROJECT (MILLIONS)

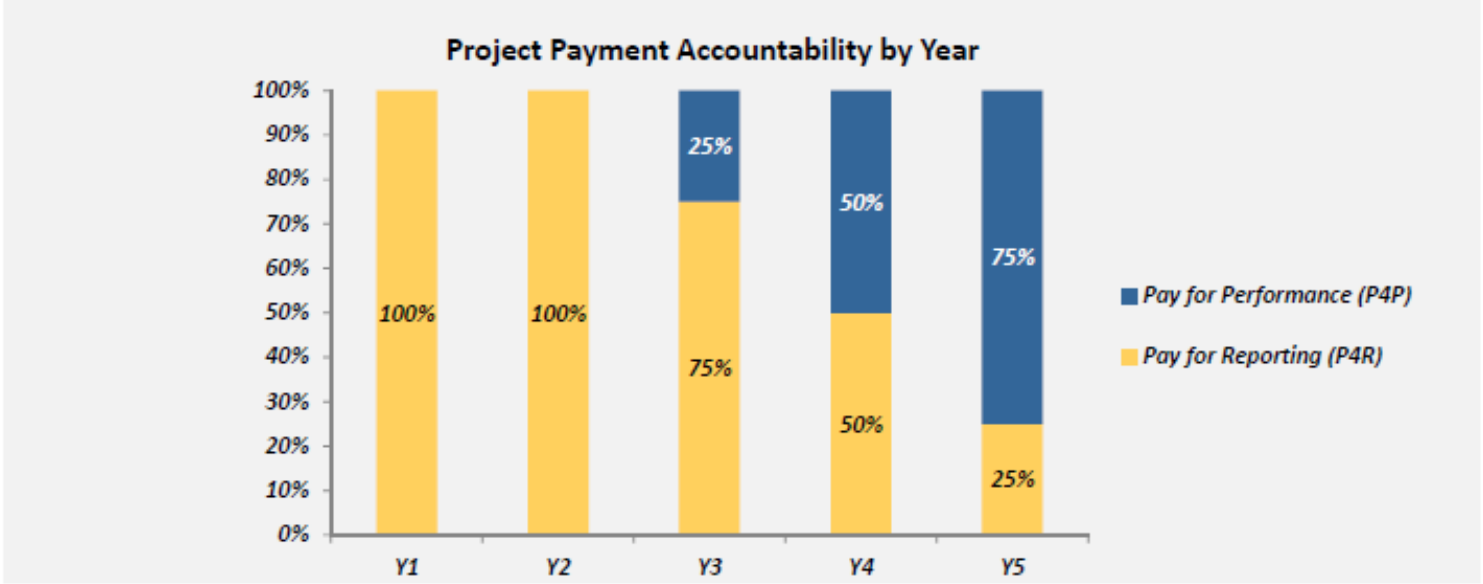
PP-P4R-P4P: 90-90-75	**Calendar Year**	2017	2018	2019	2020	2021
	Program Year	Y1	Y2	Y3	Y4	Y5
2A: Bi-Directional Integration of Care		$3.85	$5.39	$5.05	$4.48	$3.72
2B: Community-Based Care Coordination		$2.65	$3.71	$3.48	$3.08	$2.55
~~2C: Transitional Care~~		$0.00	$0.00	$0.00	$0.00	$0.00
N/A		$0.00	$0.00	$0.00	$0.00	$0.00
3A: Addressing the Opioid Use Crisis		$0.49	$0.68	$0.63	$0.56	$0.46
~~3B: Maternal and Child Health~~		$0.00	$0.00	$0.00	$0.00	$0.00
N/A		$0.00	$0.00	$0.00	$0.00	$0.00
3D: Chronic Disease Prevention / Control		$0.96	$1.35	$1.27	$1.12	$0.93
Total Estimated Performance-Adjusted Project Incentives	**$46.40**	**$7.95**	**$11.12**	**$10.43**	**$9.24**	**$7.66**
Total Estimated Project Incentives Not Earned	**$7.81**	***$0.88***	***$1.24***	***$1.66***	***$1.96***	***$2.07***
Eligible for Potential Additional Funds?		***No***	***Yes***	***Yes***	***Yes***	***Yes***

So What Does This All Mean?

- **Max. 5-yr. earning potential: ≤ $47.31M, not ≤ $85M** (assumes 90-90-75% achievement)
- **Sliding scale scoring** instead of tiered scoring **increases DY1 earned funds**
- **~$1M-$3M swing** b/w 6 and 4-project scenario (DY1 only):
  - Fewer projects = More dollars per project = Greater Impact/Goal Achievement? = More P4P $$$ + More High Performance Pool $$$, **OR**
  - Fewer start-up $$$ = Reduced provider readiness = Lesser Impact/Goal Achievement? = Fewer P4P $$$ + Fewer High Performance Pool $$$
- **6 projects provide:**
  - Access to unknown unearned funds pool (*dynamic* relationship!)
  - 10% score bump = 10% more money (up to 110% of DY1 funds); important if scoring low (start-up $$$!)
  - Access to unknown other funds?
  - Maintains community priorities (MCH/ACEs/SDH)
- **But wait, what if we had to drop a project?**

ACH Project Funds Adjusted Based on Performance

- Performance metrics will be used to monitor progress toward achieving the overall waiver vision. Project Pool incentive payments in Years 2 -5 will be **adjusted based on level of performance** against these metrics
- **ACHs will report semi-annually** on progress and, starting in Y3, on their outcomes to date for selected projects
- Accountability emphasis shifts from **process** metrics to **outcome** metrics and from **reporting** to **performance** thresholds over the course of the 5-year program



Conclusions / Recommendation

1. There are a number of unknowns.
2. It's still a lot of money, but not as much as we initially thought.
3. Adjust project portfolio scope = **Reduced P4P $$$ potential?**
4. Think integrated project initiatives, not stand-alone projects.
5. Leverage existing provider investments and infrastructure to greatest extent possible.
6. It's not all about the money: Be guided by community needs and provider capacity.
7. **Wait and See about final project selection.**

Finances: FIMC Funds

- Joint letter sent to Health Care Authority from CPAA and Olympic ACH
- HCA response: No money, but TA
- Next steps

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Updates

- Workgroups
- Consumer Advisory Committee
- Clinical Provider Advisory Committee

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Building Equity into the CPAA workflow

MICHAEL O'NEILL - PATHWAYS PROGRAM MANAGER

CHOICE REGIONAL HEALTH NETWORK

Assumptions

We need to improve authentic engagement with consumers and the community at large in the work of the CPAA

We need tools that lead us to equity driven habits of thought

We need to consider equity at multiple points along the way, not just when weighing final decisions

1st Tool, 1st Draft

Adapted from similar tools

- Equity Impact Assessment Tool – *Healthy King County Coalition*
- Equity and Empowerment Lens – *Multnomah County, Office of Diversity & Inclusion*

Created as resource for CPAA Board decisions

- May require pre-work from staff to be useful
- Possibly too late in the process for major concerns to be addressed

Questions & Comments

Test the Tool

Individually:

- Read the “Handout for DRAFT Equity Lens Test”
- Apply the questions on the Equity Lens to the Handout

With your table:

- Decide on Equity Lens scoring as a group
- Discuss possible improvements to the Public Engagement Process
- Discuss your experience using the Equity Lens

Feedback

PUBLIC ENGAGEMENT PROCESS

- Any recommended changes?

EQUITY LENS

- What worked?
- What could be better?
- Is this tool well suited for the CPAA Board?

Equity Workflow Next Steps

- Improve DRAFT Equity Lens based on feedback
- Map out CPAA workflow for additional places to emphasize equity
- Develop additional tools as needed

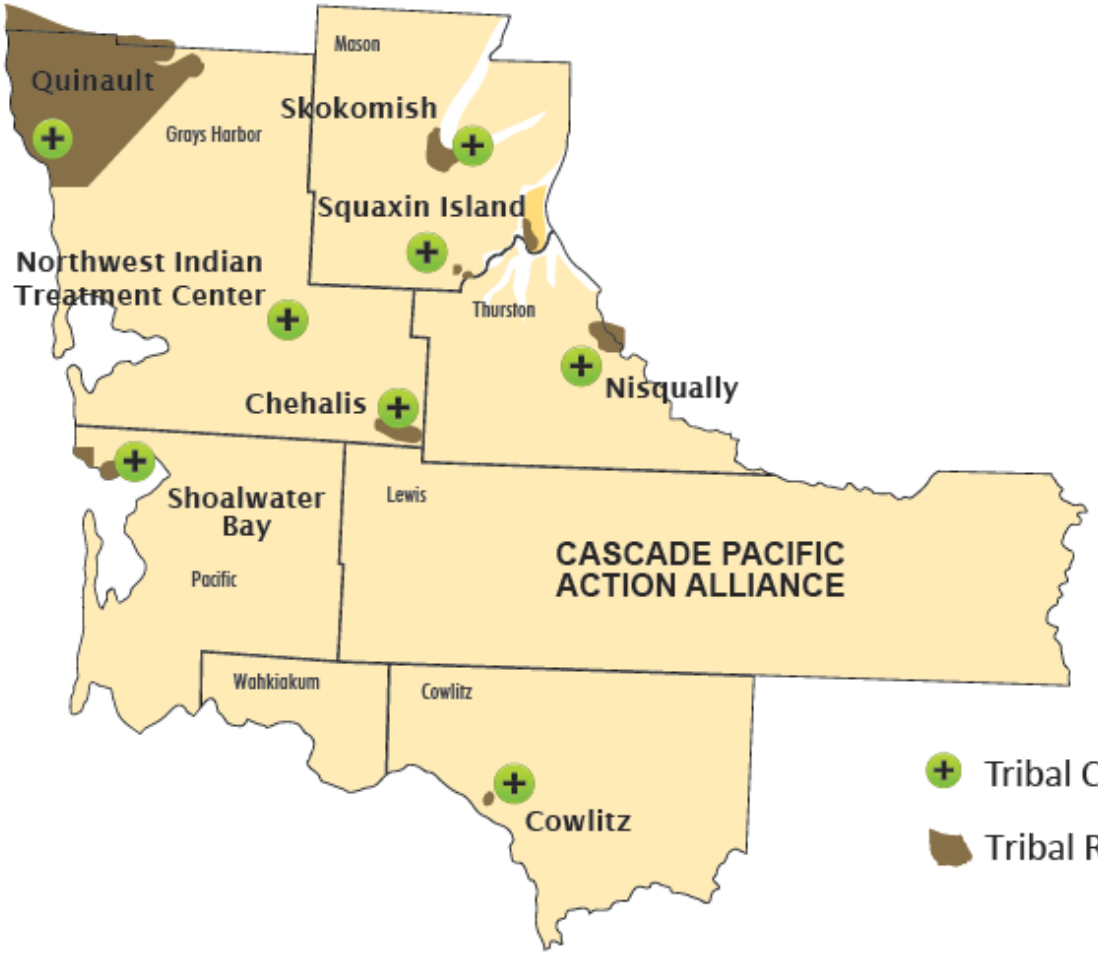
Actions speak louder than words

Tribal Health Priorities

JUSTIN WAGAMAN, COMMUNITY AND TRIBAL LIAISON

CHOICE REGIONAL HEALTH NETWORK

Tribes and Tribal Health Clinics



- 7 Tribes within the CPAA's geographic region
- 8 Tribe Operated Clinics
- 1 in 50 people who live in the region are a tribal member

Tribal Health Priorities

DENISE WALKER, WELLNESS CENTER DIRECTOR

CONFEDERATED TRIBES OF THE CHEHALIS RESERVATION

Small Group Break-out Session

Please get into small groups at each table of about 4 to 8 people. Using the 2 handouts at the tables, discuss the following questions. After discussion we will have a report out with the large group.

1. Where do the Tribe's Health Priorities overlap with the Medicaid Transformation Project work?
2. Where do the Tribe's Health Priorities overlap with the CPAA's Shared Regional Health Priorities in the RHIP Compass?

Large Group Session

1. Report out on questions from Small Group
2. Knowing where there is overlap or not, how and in which areas might we better align with our region's Tribes and Tribal Health Systems?

Questions from Small Group:

1. Where do the Tribe's Health Priorities overlap with the Medicaid Transformation Project work?
2. Where do the Tribe's Health Priorities overlap with the CPAA's Shared Regional Health Priorities in the RHIP Compass Document?

Summary and Next Steps

- What worked? What can we do better next time? What do we need to bring to our local forums?
- Next Council Meeting:

  Thursday, December 14, 2017, 12:00-3:00 PM

  Summit Pacific Medical Center

  600 E Main St, Elma, WA

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