COUNCIL MEETING

FEBRUARY 8, 2018

Welcome and Introductions

Introduce yourself: Name, organization, and county

WELCOME

Review Proposed Agenda Items

- ✓ FY 2017-18 Q1 Financial Update
- ✓ Check in with Committees and Workgroups
- ✓ CPAA Board elections: Medicaid beneficiary and Wahkiakum non-clinical
- ✓ Continue IGT strategy discussion and recommend approval of funding mechanism to board
- ✓ Shared Learning: Bi-Directional Integration of Care

CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

Financial Update

- FY 2017-18 Quarter 1 Financial Summary

CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

Work Group Check-in

- ACEs
- Care Coordination/Pathways
- Oral Health

Work Group Check-in

- Bi-Directional Care Integration
- Care Transitions
- Chronic Disease
- Opioid Response

- Met January 30th and 31st
- Discussed:
  - State Capacity Assessment
  - Target Populations
  - Integration of Projects
  - Upcoming Milestones
- Next work group meetings:
  - February 27th and 28th
    - webinar

Advisory Committee Check-in

- Clinical Provider Advisory Committee
  - Met January 16th
  - Dr. Federico Cruz-Uribe selected as Co-Chair
  - Convene every other month
- Consumer Advisory Committee
  - February 13th at Centralia College

CPAA Board Vacancies

- **Medicaid Beneficiary Board Seat**
  - All Council members may vote (in-person only)
  - Applicants:
    - Erin Oly, Thurston County
    - DJ Lindberg, Thurston County
    - Michelle Richburg, Thurston County
- **Wahkiakum County Non-clinical Board Seat**
  - Appointed by Council members who serve Wahkiakum County (in-person only)
  - Applicant:
    - Chris Bischoff, Director, Wahkiakum Health & Human Services

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IMPROVING COMMUNITY HEALTH & SAFETY

Intergovernmental Transfers (IGT)

MARC PROVENCE, WA HEALTH CARE AUTHORITY

What is an Intergovernmental Transfer (IGT)?

- A transfer of public funds between governmental entities, such as from a county or a public hospital to the state.
- The source of funding for each IGT that is proposed by a governmental entity must be reviewed to ensure that it meets state and federal requirements for permissible transfers.

DSRIP IGT Funding Assumptions

- ACHs do not need to find IGT contributors. The state has identified IGT contributors and will handle the contractual requirements to operationalize the IGT financing mechanism.
- IGT contributors, like other provider partners, must have an opportunity to earn incentives.
- IGT contributors are well-positioned to provide Domain 1 services across all 9 ACHs.
- All incentive distributions must be approved by ACHs prior to payment.
- Less than full participation by ACHs in an IGT strategy reduces the total DSRIP incentive pool proportionally.

IGT Contributors

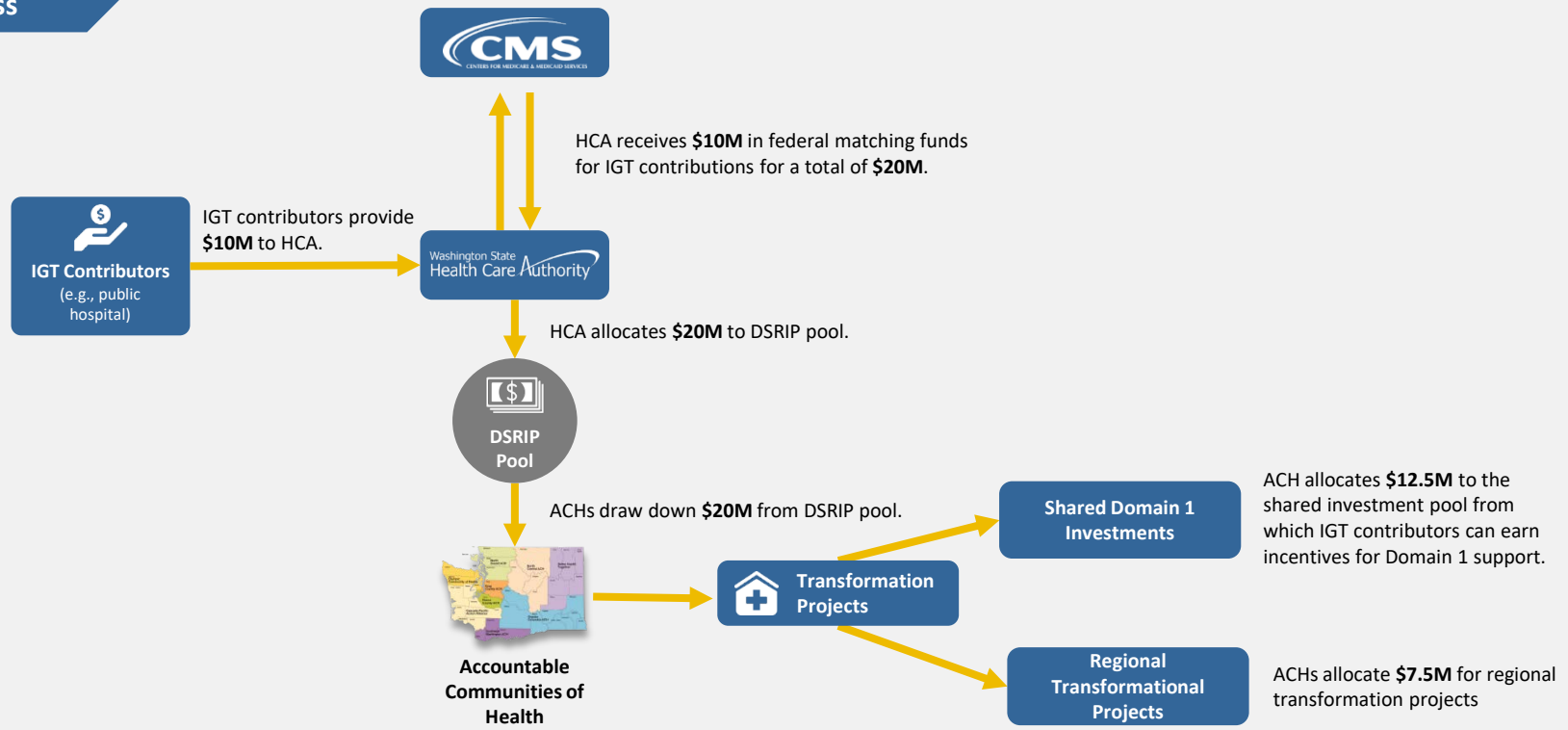
- Examples:
  - University of Washington – Seattle – King County
  - EvergreenHealth – Kirkland – King County
  - Valley Medical – Renton – King County
- An IGT contributor does not need to be located within your region to support the Shared Domain 1 Investments.
- Participation in Shared Domain 1 investments will increase the availability of regional project incentives.

DSRIP IGT Approach
Shared Domain 1 Investments

- **"Shared Domain 1 Investments"** is a term representing pooled incentive funds for specific (to be defined) Domain 1 services from designated providers across all nine regions.
- **Shared Domain 1 Investments neither preclude nor replace other ACH allocations for Domain 1.**
- ACHs must still approve incentive payments made from the Shared Domain 1 Investment pool.
- Shared Domain 1 Investments supports the use of intergovernmental transfers **as a funding mechanism for DSRIP**.

How IGT works

***Illustrative* IGT Process**



Expected DY 1 funding amounts communicated to ACHs already take into account remaining dollars after payments to IGT contributors.

Note: Rounded funding amounts are provided as examples.

Source: 42 CFR 433.51 - Public Funds as the State share of financial participation.

What this means for CPAA ACH incentives?

ACH Project Incentives (funded by DSHP)	ACH Project Incentives (funded by IGT)	Shared Domain 1 Investments (Optional)	VBP Incentives (Reinvestment Pool)	Total Incentives
$29,221,000	$22,184,000	$41,852,000	$2,200,000	$95,457,000

ACH approval of Shared Domain 1 Investments funds $22.2m in regional project incentives over the five years.

If one or more ACHs select to not participate in the Shared Domain 1 Investments, this will reduce the total available funding available for ACH project incentives.

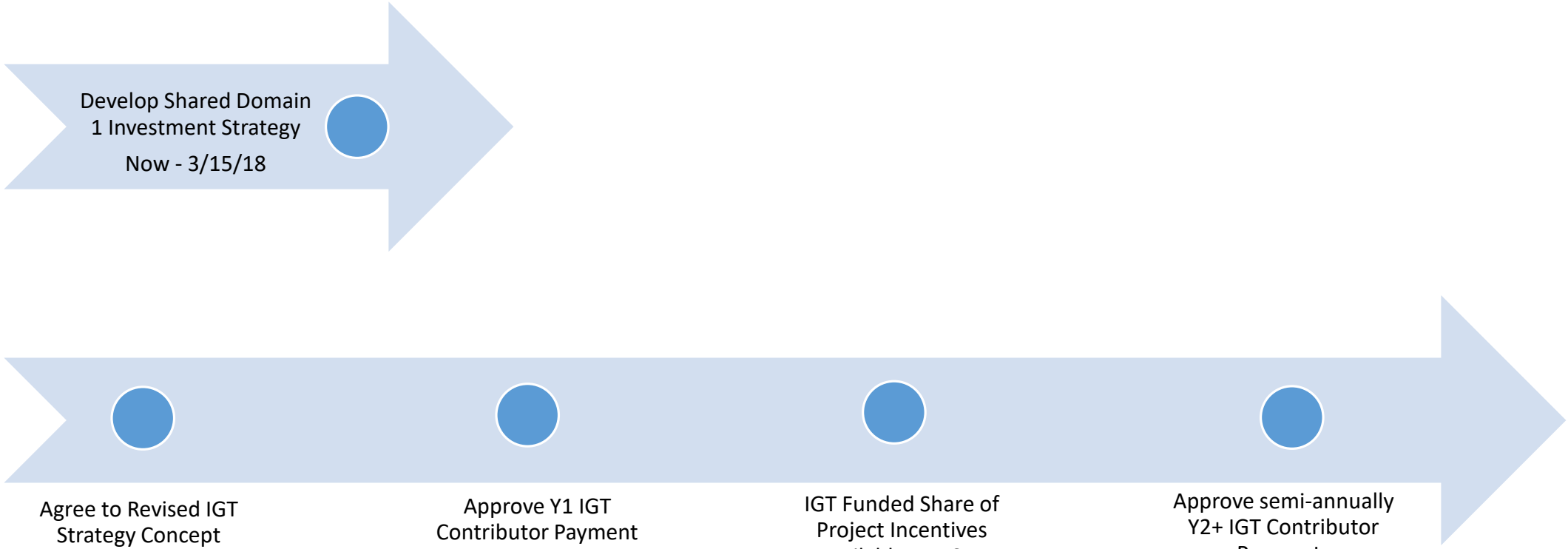
Shared Domain 1 Investments

- The Shared Domain 1 Investments (optional) are the incentives to be earned by IGT contributors.
- **ACHs** will determine when a Shared Domain 1 Partnering Provider has met their deliverables statewide, which would then trigger payments from the Shared Domain 1 Investments.
- The **ACH will approve any disbursements** to the Shared Domain 1 Partnering Providers.

ACH's Role

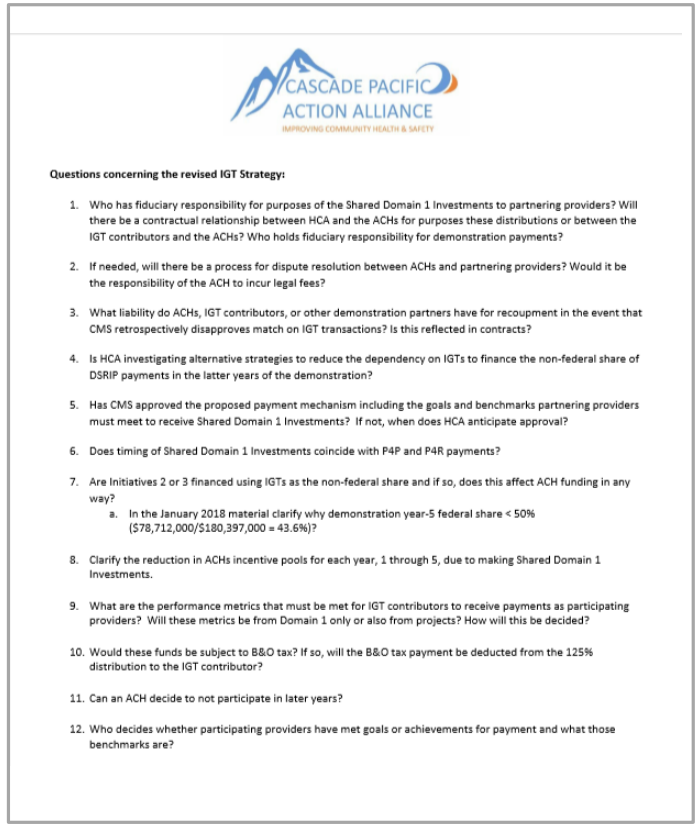
1. Register and approve Shared Domain 1 Partnering Providers
2. Authorize disbursements to Shared Domain 1 Partnering Providers

IGT Timeline



IGT Q&A

"HCA's responsibilities to CMS regarding IGT financing are governed by our Special Terms and Conditions and by our approved IGT protocol. CMS requires us to fund a designated portion of the non-federal financing through IGT. The state therefore cannot "reduce the dependence" on IGT as a source of funds. We are, however, exploring whether there are alternative IGT financing strategies that would create more budget "room" relative to our DSRIP cap (as we explained in an earlier session with the ACHs). We have also committed to using IGT funding for Initiative 1 and not for Initiatives 2 or 3. Our STCs establish the terms under which we are allowed to claim federal funds; and conditions, if any, under which the federal government could seek to recoup any payments."



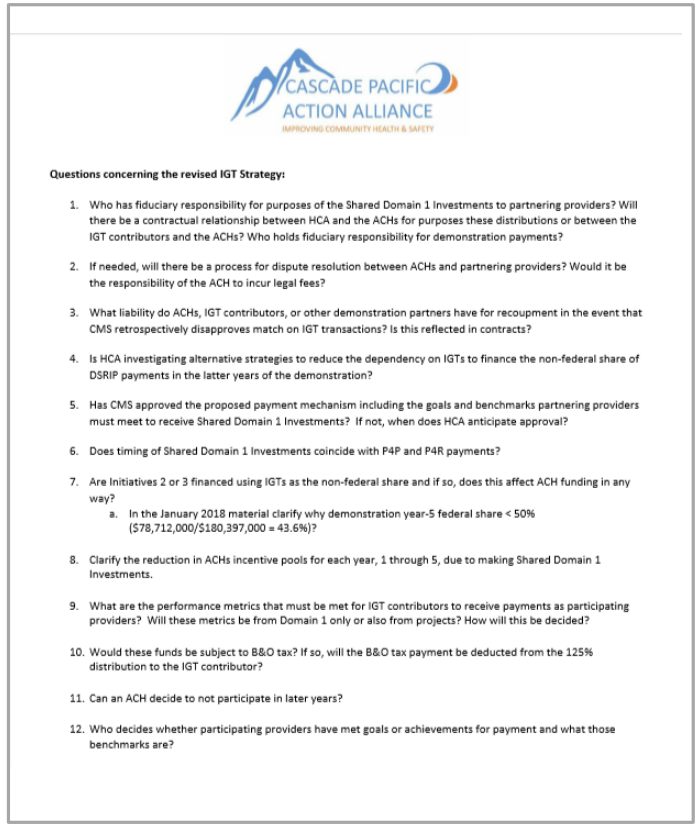
CASCADE PACIFIC ACTION ALLIANCE
IMPROVING COMMUNITY HEALTH & SAFETY

Questions concerning the revised IGT Strategy:

1. Who has fiduciary responsibility for purposes of the Shared Domain 1 Investments to partnering providers? Will there be a contractual relationship between HCA and the ACHs for purposes these distributions or between the IGT contributors and the ACHs? Who holds fiduciary responsibility for demonstration payments?
2. If needed, will there be a process for dispute resolution between ACHs and partnering providers? Would it be the responsibility of the ACH to incur legal fees?
3. What liability do ACHs, IGT contributors, or other demonstration partners have for recoupment in the event that CMS retrospectively disapproves match on IGT transactions? Is this reflected in contracts?
4. Is HCA investigating alternative strategies to reduce the dependency on IGTs to finance the non-federal share of DSRIP payments in the latter years of the demonstration?
5. Has CMS approved the proposed payment mechanism including the goals and benchmarks partnering providers must meet to receive Shared Domain 1 Investments? If not, when does HCA anticipate approval?
6. Does timing of Shared Domain 1 Investments coincide with P4P and P4R payments?
7. Are Initiatives 2 or 3 financed using IGTs as the non-federal share and if so, does this affect ACH funding in any way?
   a. In the January 2018 material clarify why demonstration year-5 federal share < 50% ($78,712,000/$180,397,000 = 43.6%)?
8. Clarify the reduction in ACHs incentive pools for each year, 1 through 5, due to making Shared Domain 1 Investments.
9. What are the performance metrics that must be met for IGT contributors to receive payments as participating providers? Will these metrics be from Domain 1 only or also from projects? How will this be decided?
10. Would these funds be subject to B&O tax? If so, will the B&O tax payment be deducted from the 125% distribution to the IGT contributor?
11. Can an ACH decide to not participate in later years?
12. Who decides whether participating providers have met goals or achievements for payment and what those benchmarks are?

IGT Q&A cont.

"Obtaining IGT financing is HCA's responsibility. This includes identifying and securing necessary agreements with IGT contributors in order to establish the mechanism whereby contributions are made. Similarly, it is HCA's responsibility to claim federal funds, whether based on DSHP or IGT."



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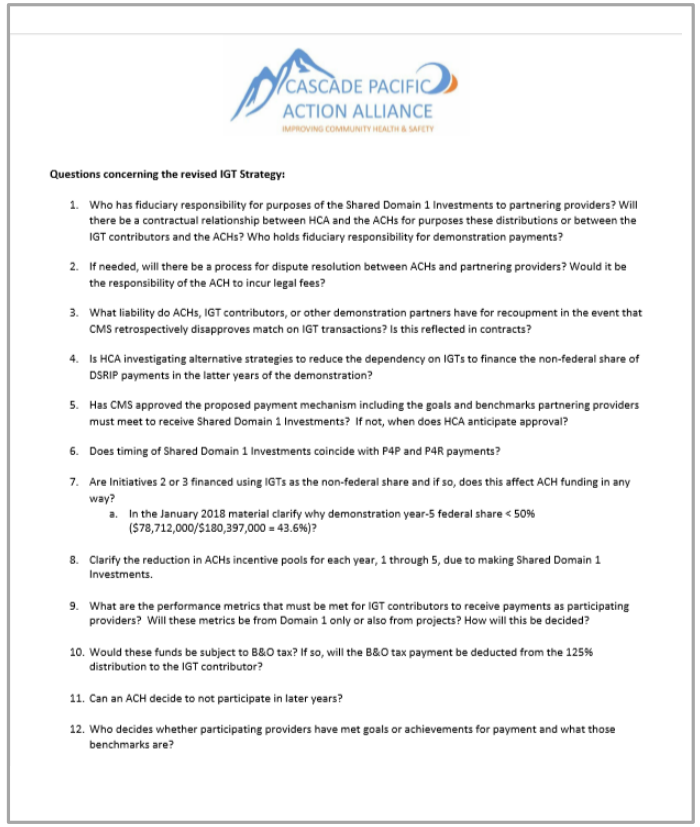
IGT Q&A cont.

"Incentives are intended to recognize and encourage provider activity that advances the ACH's delivery system reform goals. Incentive payments to those partners providing Domain 1 support services are, like all DSRIP payments, governed by our CMS approved protocols. Those protocols do not distinguish between providers of Domain 1 supports and any other providers with respect to how incentives are allocated by an ACH. Allocation decisions are made by each ACH, and each has the option to participate or not with respect to incentive payments for Domain 1 shared services. Under the proposed strategy, IGT contributors will, when registered as partnering providers, be given an opportunity to receive DSRIP incentives by supporting Domain 1 shared services (value-based payment, workforce, population health management) as authorized by the ACHs."



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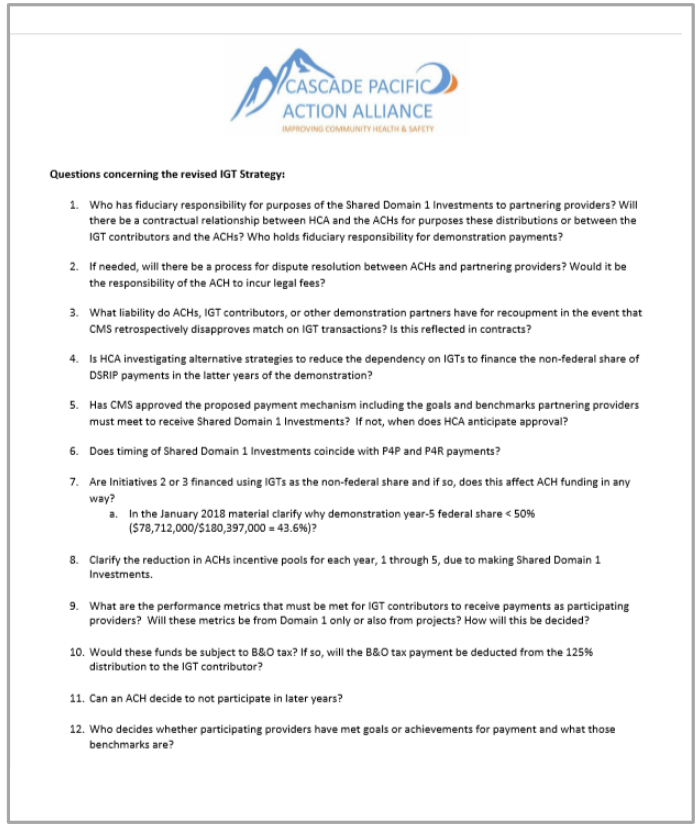
IGT Q&A cont.

"As with any other partnering provider, those providing Domain 1 supports must have an agreement with the ACHs. All providers receiving incentive payments will be required to sign the standard agreement through the Financial Executor portal. This agreement establishes the basic terms and conditions with which any provider must comply. This does not preclude a given provider from entering into a separate agreement with an ACH to partner in support of specific DSRIP projects."



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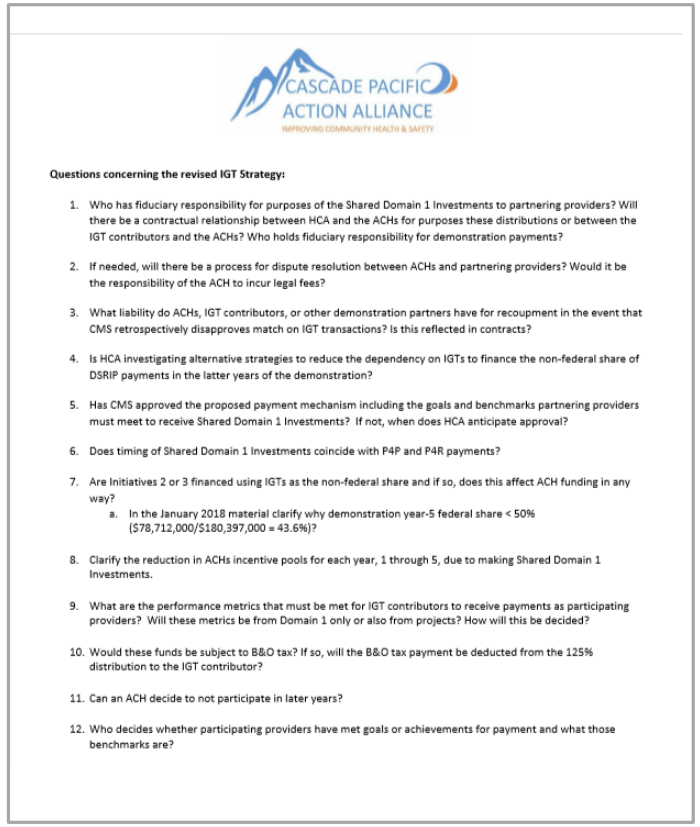
IGT Q&A cont.

"You have requested the opportunity for active engagement with HCA as we continue to develop the IGT strategy and chart its impact on the budget for Medicaid Transformation. We are committed to ongoing partnership with CPAA and all the ACHs in exploring Domain 1 shared services opportunities and monitoring their success in advancing the goals of Initiative 1. We will seek ways in which to minimize the administrative burden, especially by keeping requirements consistent across providers, projects and Domain 1 services. As always, we welcome your feedback and suggestions."



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Conditional Yes?

1. Indemnify ACHs against potential claims
2. Provide ACHs with influence over Shared Domain 1 investment selection
3. Clear process (funds flow, fiduciary responsibilities and authorizations, etc.)

Election Results

- Consumer/Medicaid Beneficiary
- Wahkiakum County Non-clinical

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INTEGRATED SYSTEMS OF CARE

FEBRUARY 8TH , 2018

Agenda

- General overview of Project 2A: Bi-Directional Integration of Care
- Group Discussion on care integration
- Discuss potential of creating Natural Care Communities
- Identify tools needed by partners to be successful in the Transformation

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As Described in the Project Toolkit

Objective: Through a whole person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, better coordinated care, and better access to services

Target Population: All Medicaid beneficiaries, adults and children, with or at-risk for behavioral health conditions

Evidence-Based Approaches: Collaborative Care Model (CoCM), Bree Collaborative BHI Recommendations; off-site, enhanced collaboration; co-located or integrated care

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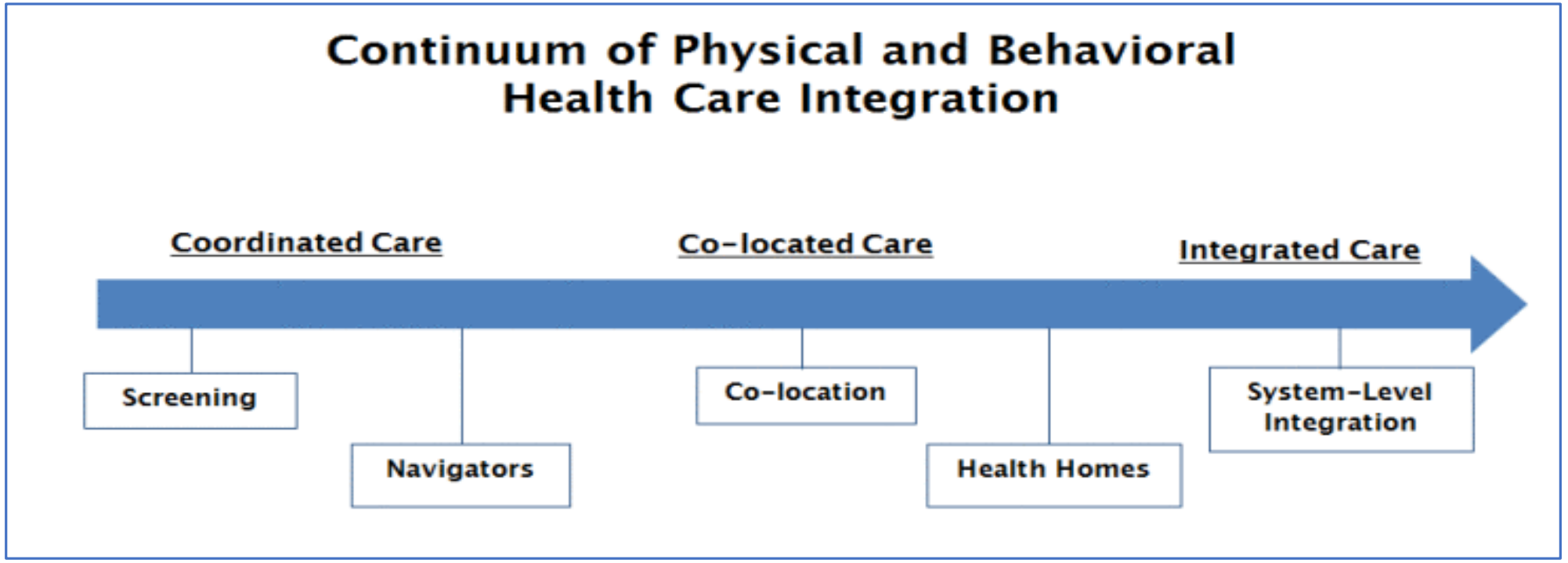
Moving Towards an Integrated System

Moving away from silos of care to an integrated team of physical and behavioral health providers working collaboratively



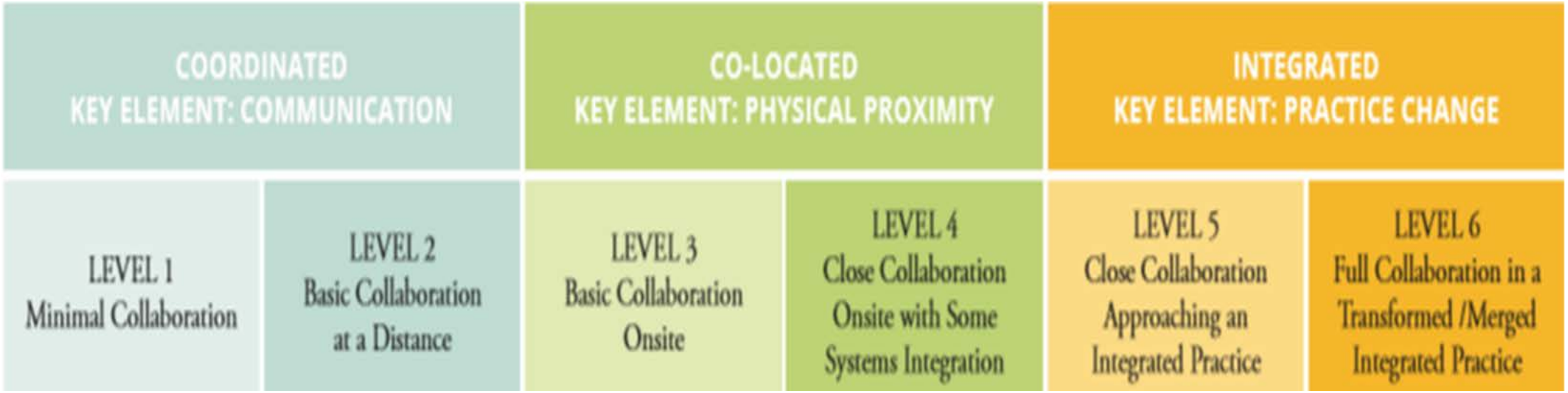
*A Standard Framework for Levels of Integrated Care. SAMSHA.

6 Levels of Integrations

Behavioral Health Integration ⟷ **Primary Care Integration**

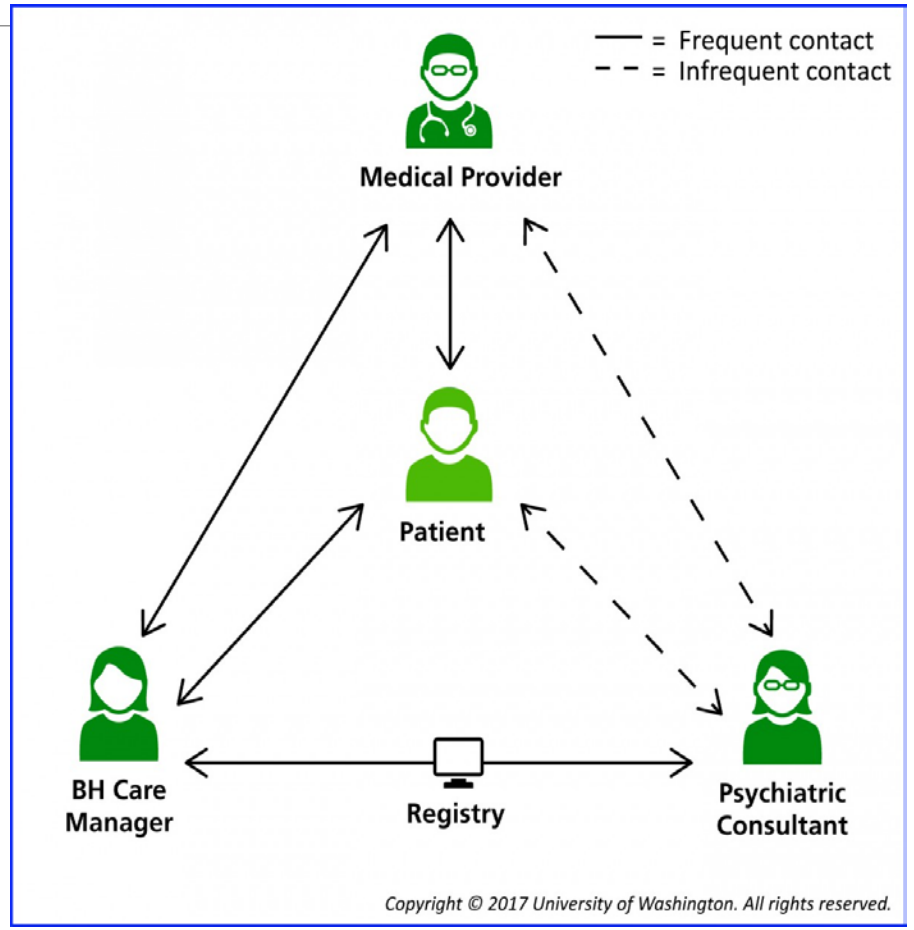
Implement collaborative care principles by following guidance from the CoCM (AIMS Center) and Bree Recommendations for BHI

SAMSHA 6 Levels of Integrated Care. A Standard Framework for Levels of Integrated Care.



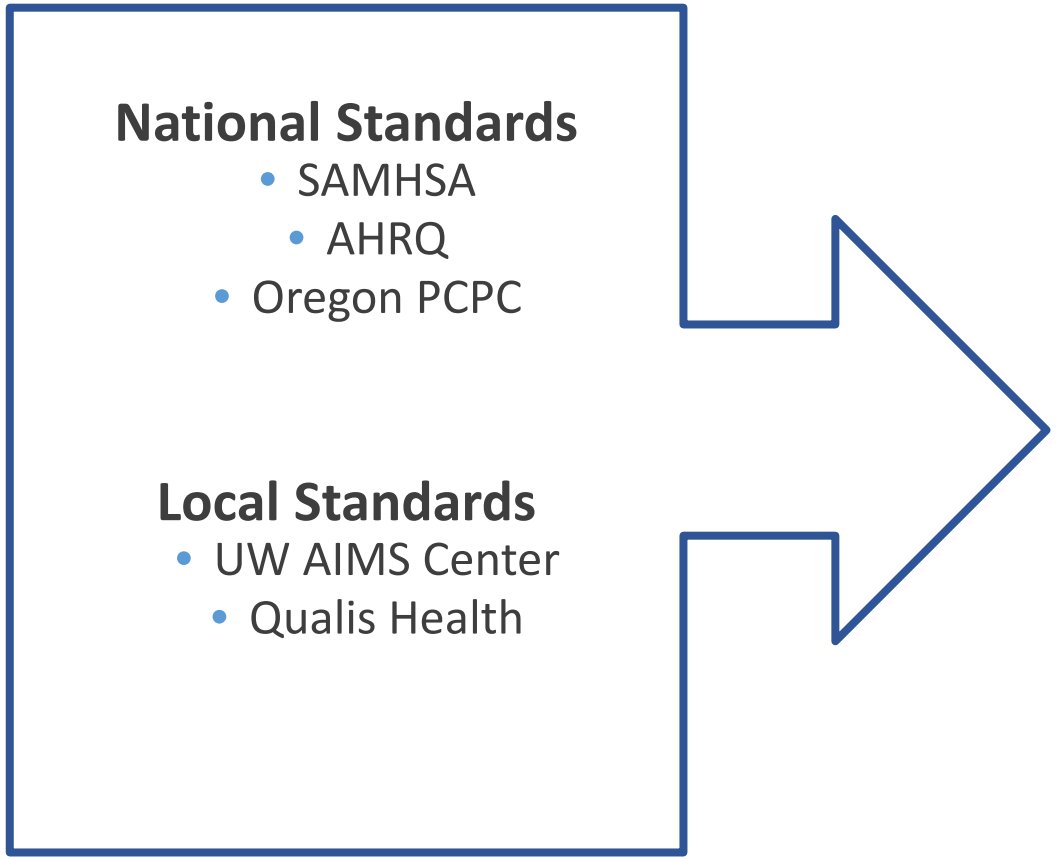
Collaborative Care Model (CoCM)

- Patient-centered team care
  - Shared care plans incorporating patient goals
- Population-based care
  - Defined group of patients tracked in a registry
- Measurement-based treatment to target
  - Articulates clinical outcomes measured by evidence-based tools (e.g., PHQ-9)
- Evidence-based care
  - Implementing psychotherapy and counseling methods
- Accountable care
  - Providers accountable and reimbursed for quality of care and clinical outcomes



*Used with approval from the AIMS Center

Bree Collaborative BHI Recommendations



2016-2017 Bree Collaborative BHI Recommendations

8 Common Elements of Integrated Care

1. Integrated care team
2. Patient access to BH
3. Accessibility and sharing of patient information
4. Practice access to psychiatric services
5. Systems & work flows to support population-based care
6. Evidence-based treatments
7. Patient involvement in care
8. Data for QI

Common Elements Between CoCM & Bree

- ✓BH provider is part of the primary care team
- ✓Systematic BH screening
- ✓Measurement-based care
- ✓Access to psychiatric services
- ✓Population-based care; treatment to target
- ✓Tracking and follow-up
- ✓Evidence-based treatment
- ✓Virtual or in-person psychiatric services

*Main difference between CoCM & Bree: approach to psychiatric services

Different Approach to Psychiatric Services

- **Bree**
  - Specialty services available and coordinated with primary care
  - Psychiatric provider is responsible for the care of individual patients
  - Prescribes psychiatric medications and provides treatment
- **CoCM**
  - Weekly systematic case review, usually in addition to direct services
  - Psychiatric provider is responsible for an assigned caseload of patients
  - Recommends treatment and psychiatric medications to PCP

*Used with approval from the AIMS Center

Behavioral Health Integration Strategies

Primary Care Setting Including Pediatrics

- Potential new team roles
  - BH Care Managers
  - Onsite BH Specialists
  - Psychiatric Consultants
- Implement PHQ-9, GAD-7, SBIRT, DAST, AUDIT, etc. with follow-up
- Clinical outcomes routinely measured in patient registry. Treatment altered until effective.
- Accountable for BH quality measures
- Medication adherence, including BH medications

Primary Care Integration Strategies

Behavioral Health and Chemical Dependency Settings

- Potential new team roles
  - PC Consultants
  - PC RN Care Managers
  - Onsite PCP provider (MD or ARNP)
- Metabolic screening: BMI, BP, tobacco screening, lab results
- Routine preventative care: immunizations, mammograms, annual checkups, etc.
- Cardiovascular and diabetes care (e.g., BP; A1C)
- Accountable for medical quality measures
- Medication adherence for physical health conditions

Funding Start up and Sustainability

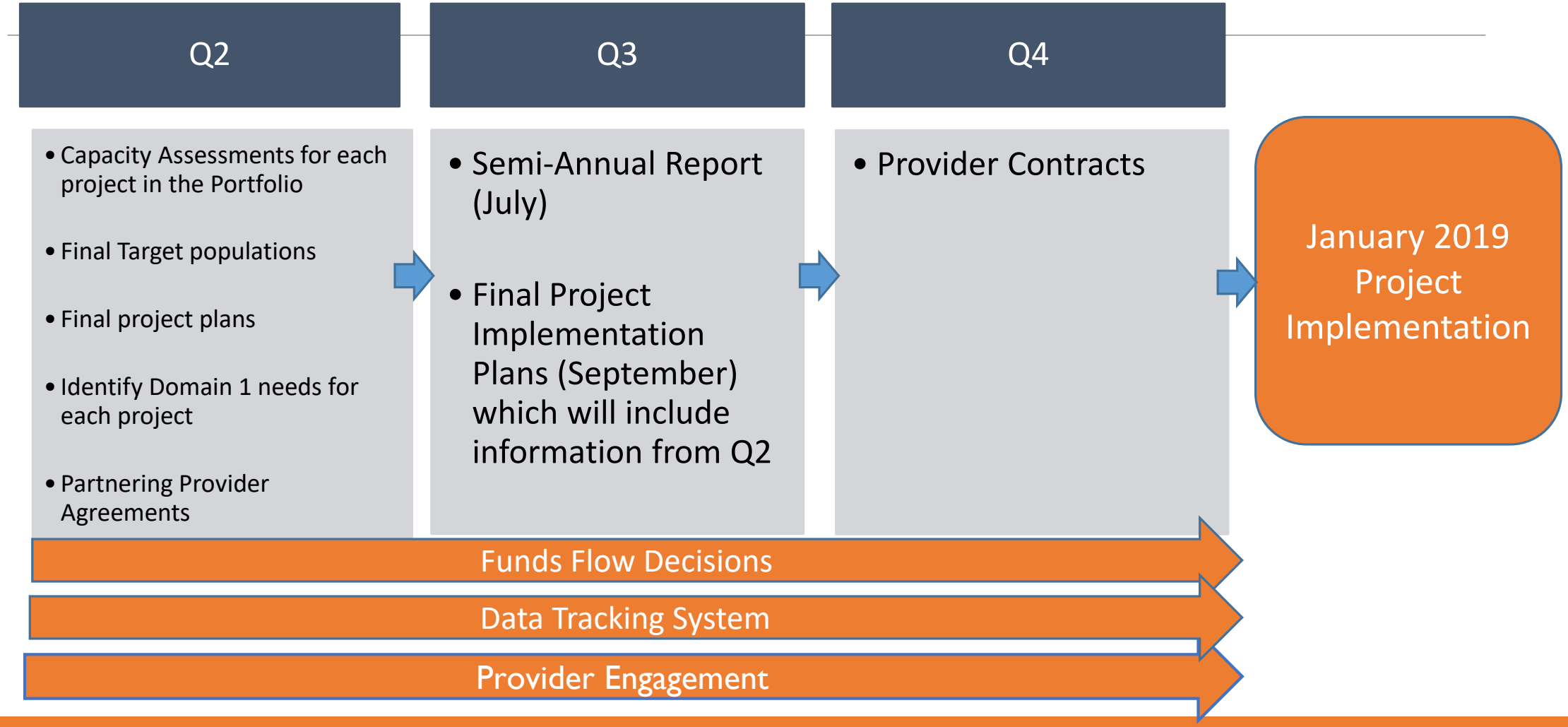
- **Startup**
  - Medicaid Transformation funds
  - Grants and other funding
  - AIMS Center Financial modeling workbook

- **Sustainability**
  - Value-based payment
  - New G-codes cover costs of PCP, care manager and psychiatric consultation
    - Specific to behavioral health integration and CoCM
  - CPT codes for behavioral health integration activities
  - HCA Phase 1-4 billing codes

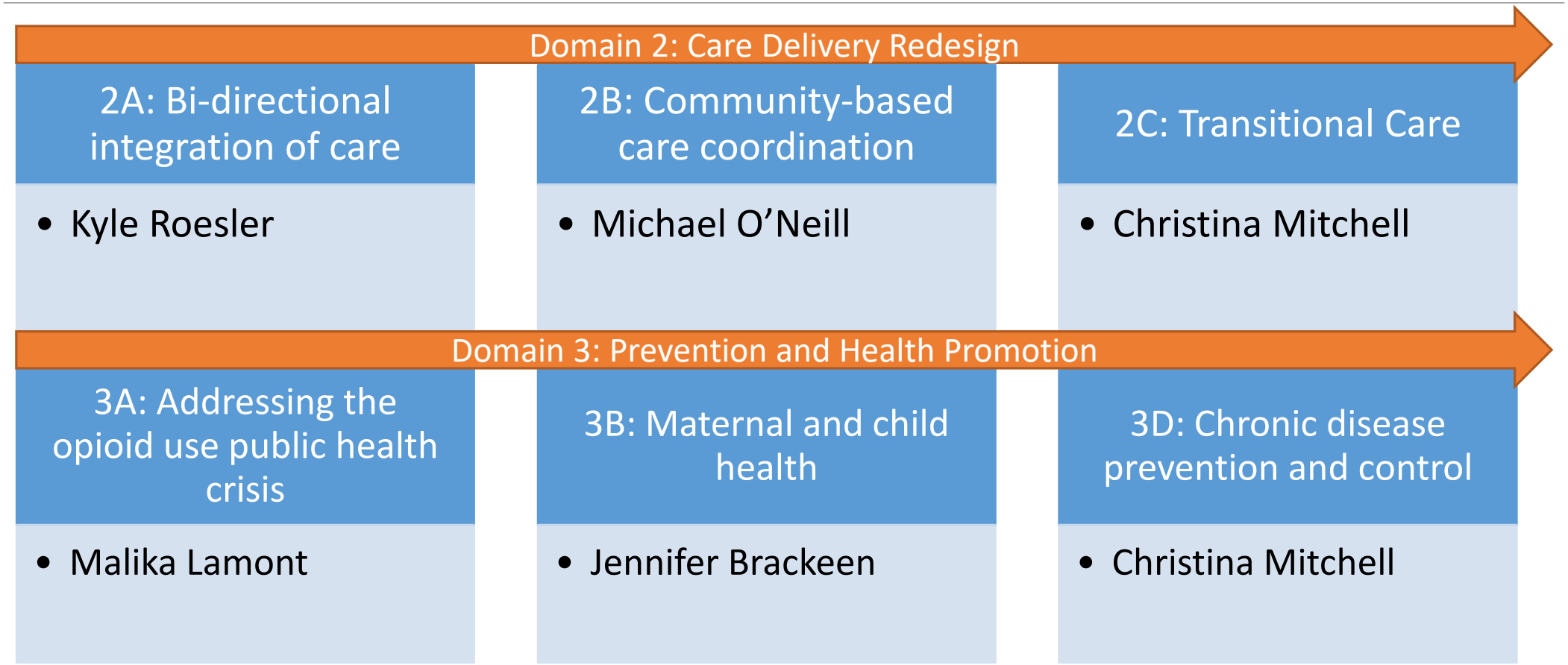
Top Metrics for Improvement

What Metrics Need to Improve for Project 2A?		
Antidepressant Medication Management	Outpatient Emergency Department Visits per 1000 Member Months	Plan All-Cause Readmission Rate (30 days)
Child and Adolescent' Access to Primary Care Practioners (all ages)	Inpatient Hospitalization	Substance Use Disorder Treatment Penetration
Comprehensive Diabetes Care: Eye Exam performed	Percent Homeless	Medication Management for People with Asthma (5-64 years)
Comprehensive Diabetes Care: HbA1c Testing	Mental Health Treatment Penetration (Broad version)	Depression Screening and Follow-up for Adolescents and Adults
Comprehensive Diabetes Care: Medical attention for nephropathy	Follow-up After Hospitalization for Mental Illness	Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence

Summary and Next Steps



Systems of Integrated Care



Care Integration

Challenges

- Several payers
- Data sharing
- Numerous Project Managers

Opportunities

- Address several areas in one visit
- Overlapping target populations
- Shared metrics

Shared Project Metrics (1/1)

October 2017 Medicaid Transformation Project Toolkit Metrics (updated Dec 19, 2017)						
Measure Name	2a: Integration	2b: Care Coordination	2c: Transitional Care	3a: Opioids	3b: Reproductive / MCH	3d: chronic disease prevention
Follow-up After Hospitalization for Mental Illness	x	x	x			
Inpatient Hospital Utilization	x	x	x	x		x
Mental Health Treatment Penetration (broad)	x	x			x	
Outpatient Emergency Department Visits per 1000 Member Months	x	x	x	x	x	x
Plan All-Cause Readmission Rate (30 Days)	x	x	x			
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	x	x	x			
Substance Use Disorder Treatment Penetration	x	x			x	
Percent Homeless (Narrow Definition)		x	x			
Comprehensive Diabetes Care: Eye Exam (retinal) performed	x					x
Child and Adolescents' Access to Primary Care Practitioners	x					x
Medication Management for People with Asthma (5 – 64 Years)	x					x
Comprehensive Diabetes Care: HbA1c Testing	x					x
Comprehensive Diabetes Care: Medical attention for nephropathy	x					x

Single Project Metrics (2/2)

October 2017 Medicaid Transformation Project Toolkit Metrics (updated Dec 19, 2017)						
Measure Name	**2a: Integration**	**2b: Care Coordination**	**2c: Transitional Care**	**3a: Opioids**	**3b: Reproductive / MCH**	**3d: chronic disease prevention**
Antidepressant Medication Management	x					
Childhood Immunization Status					x	
Chlamydia Screening in Women Ages 16 to 24					x	
Contraceptive Care – Most & Moderately Effective Methods					x	
Prenatal care in the first trimester of pregnancy					x	
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)						x
Patients on high-dose chronic opioid therapy by varying thresholds (Measure specification in development)				x		
Patients with concurrent sedatives prescriptions (Measure specification in development)				x		
Substance Use Disorder Treatment Penetration (Opioid) (Measure specification in development)				x		
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life					x	
Well-Child Visits in the First 15 Months of Life					x	

Small Group Discussions

- How are projects connected?
  - ✓ Work flow
  - ✓ Shared metrics
  - ✓ Target Population

2A: Bi-Directional Integration of Care
2B: Community-Based Organizations
2C: Transitional Care
3A: Opioid Response
3B: Maternal and Child Health
3D: Chronic Disease

- What opportunities do you see?
- How can you mitigate challenges?
- Who will you need to partner with to be successful?
- What support will you need from CPAA to be successful

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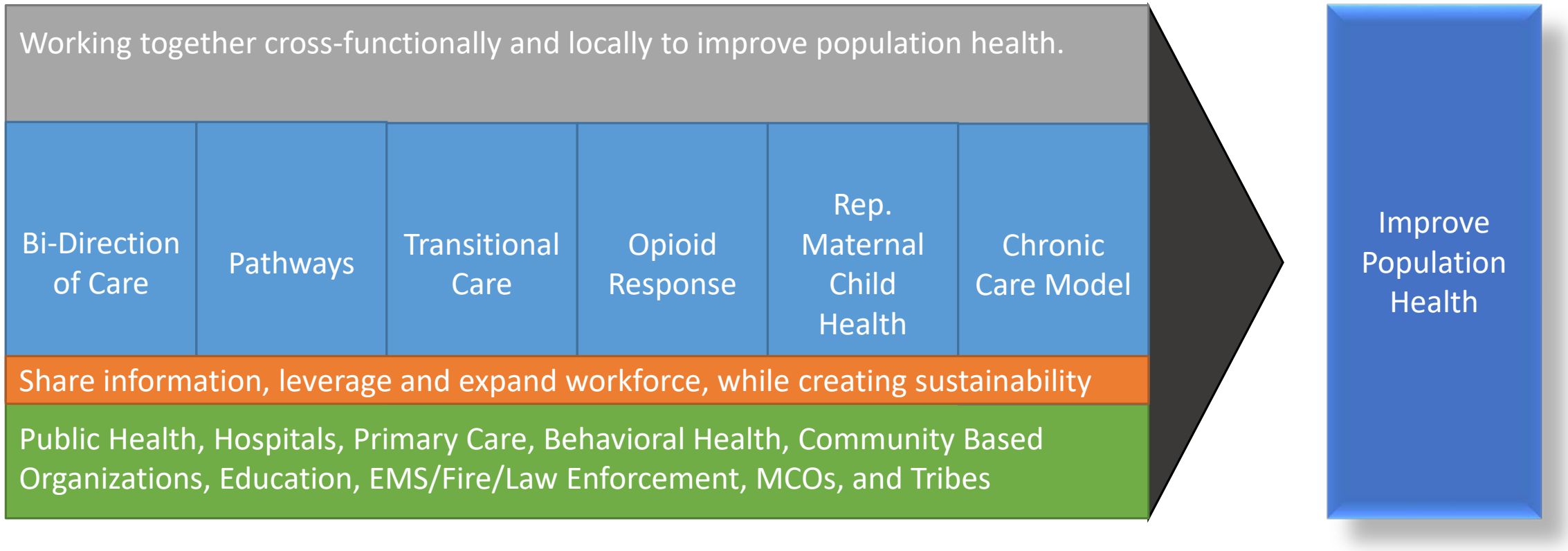
Natural Communities of Care

How do we work together collaboratively to develop an integrated system of care that improves population health outcomes?



Portal Development

Performance Dashboard

Real Time Date

Forums

EHR Integration

Community Resources

Document Management

Small Group Discussion

What are your priorities?

- ✓EHR Integration
- ✓Performance Dashboard
- ✓Document Management
- ✓Real Time Data
- ✓Forums
- ✓Community Forum

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Review of Shared Learning

- General overview of Project 2A: Bi-Directional Integration of Care
- Group Discussion on care integration
- Discuss potential of creating Natural Communities of Care
- Identify tools needed by partnering to be successful in the Transformation

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Questions?
Comments?

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Summary and Next Steps

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

Thursday, March 8, 2018, 12:00-3:00 PM

Great Wolf Lodge Conference Center

20500 Old Hwy 99 SW, Grand Mound, WA 98531

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