**NCACH Governing Board**

**MEETING NOTES**

12:30 – 2:30PM June 05, 2017

Confluence Technology Center

Wenatchee, WA

### Attendance:

**Board Members onsite:** Tim Hoekstra, Rick Hourigan, Doug Wilson, Kevin Abel, Sheila Chilson, Winnie Adams, Barry Kling, Bruce Buckles, Kat Latet, Jesus Hernandez.

**Board Members via phone:** Theresa Sullivan, Senator Warnick, Ray Eickmeyer; **Absent:** Nancy Nash-Mendoza

**Public attendees onsite:** Ruth Bush, Courtney Ward, Gwen Cox, Megan Guffie, Tessa Timmons, Torrie Canda, John Doyle, Chris Tippen, Kris Davis, Tim Anderson, Christine Mikkelson, Andrea Bennett, Christine Quinata, Jackie Weber, Bill Hinkle, Tory Gildred, Dave Olson, Caitlin Safford, Kayla Down

**Public attendees via phone:** Samantha Zimmerman, Lisa Apple, James Novelly, Lorna Randall, Kim Frickey,

**NCACH Staff onsite:** Linda Parlette, John Schapman, Christal Eshelman, Peter Morgan

**Minutes:** Teresa Davis

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Welcome &amp; Conflict of Interest Disclosure</td>
<td>No conflicts of interest disclosed</td>
</tr>
<tr>
<td>Approval of Minutes</td>
<td><strong>Tim Hoekstra motioned to approve the May 2017 minutes as written, Bruce Buckles seconded, no further discussion, motion passed</strong></td>
</tr>
</tbody>
</table>
| Executive Directors report         | See attached written Executive Director’s report from Linda Parlette: Additional Information:  
- Molly Morris from the Colville Tribe and Coulee Medical Center has agreed to fill the Tribal Seat on the NCACH Board. She will get us a bio and we will present to the board at the next meeting.  
- Thanked Gwen Cox for her continued efforts with the assessments.  
- Presented Kat Latet with flowers and thanked her for serving on our board for the last year. |
| Governing Board Update            | **Sheila Chilson motioned and Rick Hourigan seconded to update the By-Laws including the following changes...**  
- Restructuring Community Engagement – CHIs w/o Regional Council, voting board seats for each CHI, remove Regional Council seats.  
- Add one “Consumer Seat”  
- Add one “At Large Seat”  
*No further discussion, motion passed unanimously.* |
|                                   | **Bruce Buckles motioned and Kevin Abel seconded the nomination of Jesus Hernandez for the “At Large Seat” on the NCACH Board. No further discussion, motion passed.** |
|                                   | **Legal Representation for Backbone Organization:** Now that the ACH is a non-profit organization we need to have a legal contract in place. CDHD is working with their attorneys to draft the agreement. Davis, Arneil Law Firm was recommended to us. We will need to sign a conflict of interest. Linda’s husband has retired from this firm but is still of Council. Contract will be emailed out to the board for review.** |
See attached presentation:

- North Central has already earned a portion of this money for being a mid-adopter. Challenge funds only flow to MCO’s the rest of the money can be used to the partners.
- NC earned $1m in design funds for passing phase 1. Certification money will not be released until a contract between HCA & NCACH has been signed. Up to $5M more will be earned with phase 2. The amount will be based on the strength of our phase 2 certification submission.
- Project incentives will be held by a financial executor that will disperse upon requests from the ACH. Financial executor will disperse money based on information that is received from the ACH. Which means that checks can be written directly to providers.
- Reporting cycle July 31 for 1st half of year, January 31st for second half. It could take a few months for the money to get to the executor. Request for draws on money already earned can occur anytime.
- Barry discussed the attached DSRIP Estimated Project Pool Funds form to give everyone an idea of the funds and how the funds are reweighted. Will email this out with minutes, Andrea Bennett clarified that this is still in draft form.
- Year 2 is a very important year because it is a milestone reporting year. Critical time to create and strengthen projects so that we get the outcomes we are hoping for.

Retreat Agenda

- Contract, CHI Guidance, Certification Next Steps, Funds Distribution, Project Proposal Planning, Whole Person Care Collaborative (want to make sure that agencies are participating in order to receive funding).

FIMC Update

See attached report from Christal Eshelman:
- Barry announced that Christal has now joined the NCACH team full-time as Project Coordinator.

BHO Update

Courtney Ward gave the BHO Update.
- They have been in contact with the HCA and ACH for the knowledge transfer. In the process of completing the closeout. Will do a presentation on that at the next FIMC Meeting on June 21st.
- Parkside is in the final stages of permitting. Will be advertising for construction bids by the end of this week. It will be a 4-6 week process to have a decision.
- BHO is going to re-release the RFP for operating Parkside. They think that they will get more bids after the ASO has been announced because companies will know the funding source.
- Still waiting on State contracts. State is planning on releasing 3 months of funding for now. The BHO has executed all contracts with providers knowing that there will be a lot of amendments.
- The BHO has been actively participating on all of the NCACH committees.

ACH Phase 1 Certification Feedback

NCACH received a score of 25.5 out of 30. Overall HCA thought the proposal was strong. Areas that were noted for improvement...
North Central
Accountable Community of Health

| Theory and action: Looking for more info on expanding work beyond Medicaid population and how we are extending over 5 years |
| Governance: Need data sharing agreements signed. |
| Tribal: Very happy with approval of tribal policy. Need board education and tribal rep on board |
| Communication: Need meaningful consumer engagement specifically targeting the Medicaid population. |

**Items to look for in Phase 2 Certification:**
- Approval of the budget
- Need to purchase Directors and Officers Liability coverage. John is currently obtaining quotes and will present for board approval at a later meeting.

**Governing Board Roundtable Discussion**
- Sheila asked for more board education and that we get a presentation on the Early Warning System.
- Need to schedule more regular calls for officers.
- Linda updated on the search for second program development specialist, we are in the process of offering the position, will know more soon.
- Theresa wants to work on communication—how do we prepare brief messages that can go out to people.

**Action Items:**
- Send out Phase 2 Certification Template to board (John)
- Teresa to get in contact with John Doyle about a possible time to present at the board retreat
- Email out Funds Flow Presentation (once it has been corrected by Mannat) and DSRIP Estimated Project Pool Funds form (draft)
- Add public comment section to future agendas (Teresa)
- Arrange and add monthly board education to the meeting agenda (Teresa)
- Schedule regular officer calls (Teresa will send doodle poll and schedule)

**Next Meeting**
- Next meeting July 10th, 2017 12:30 PM – 2:30 PM, Samaritan Healthcare Room 407, Moses Lake, WA

Meeting adjourned at 2:30 by Barry Kling
NCACH Certification Phase I

The exciting news of the month is that we received notification on Friday, May 26th, that we passed the first phase of certification. Phase 2 is due on August 14th. Kudos to John Schapman for doing the majority of the writing and to Christal for helping with data collection. The average score was 4.25 out of 5. That is fantastic!

Yesterday, on June 1st, the total document was reviewed with Manatt, the Health Care Authority, and Andrea Bennett, our regional Coordinator(RC) followed by a call with Andrea later in the day. John will expand on this discussion at the board meeting.

May Outreach:

- Vice Chair Tribal Council member, Mel Tonasket,
- Dr. Ann Diamond
- Healthcare Panelist – see attached article
- Okanogan Board of Health at the request of Lori Jones—all three Okanogan county commissioners present
- Cascade Medical Center Clinic Quality Improvement Focus Group with John
- NCW Regional Hospital meeting/ Brewster, with John. Shared tool kit and metrics sheet
- Coulee Medical Center with CEO Johnathan Owens and staff

Communication:

- Wenatchee World interview- KC Mehaffey – see attached article
- Interview with KOHO radio—Chris Hanson prior to panel occurring on May 8, 7-9 PM, Cashmere
Meetings:

- There are a variety of meetings related to the full integration of Medicaid contracts in Chelan, Douglas, and Grant counties by January 1, 2018. Several of the Fully Integrated Medicaid Contracting (FIMC) meetings met in May including the Advisory Committee, Early Warning System Workgroup, Managed Care Rates Workgroup, IT Workgroup and Consumer Engagement Workgroup. I attend these meetings when I can because the work done by those participating should help prepare us for the “Bi-directional Integration of Physical and Behavioral Health through Care Transformation” —the required Demonstration project that we are calling “Whole Person Care.” These meetings are at least monthly and led by Christal Eshelman. I will not reference them in future reports.

- John and I attended a presentation on the Care Coordination Pathways Hub in Spokane—an over and back meeting along with several other ACHs.

- The Washington State Hospital Association (WSHA) has monthly meetings which John and I listen to. This month there was discussion from Opioid Stakeholders from across the state, including Glenn Adams, Confluence Health.
EAST WENATCHEE — A local organization working to transform Medicaid has picked six projects to focus on over the next four and a half years.

The North Central Accountable Community of Health says as much as $50 million will come to Chelan, Douglas, Grant and Okanogan counties — mostly to medical providers and community organizations — as it guides drastic changes in how care is delivered, and billed.

The funds are part of a $1.5 billion investment of new funds from the federal Centers for Medicare & Medicaid Services that the state applied for seeking to demonstrate how whole-person care could reduce Medicaid costs. They are not tied to the Affordable Care Act.

Nine ACHs across the state are each picking at least four demonstration projects to help them figure out ways to give Medicaid patients higher-quality services at a lower cost. The goal is to show how Medicaid patients can be healthier by developing self-sustaining changes to the health care system that do not require continued funding.

ACHs will work with health care providers to treat the “whole person,” and offer financial incentives if specific care standards are met, instead of being paid on a per-visit basis.

Before selecting the projects to focus on, the North Central ACH held meetings throughout the region, gathering input from those involved in all forms of health care and social services.

“There’s a whole bunch of work to do. But just the fact that we have chosen our projects is a big step,” said Linda Evans Parlette, executive director of the North Central ACH.

She said the six projects have a strong focus on promoting whole person care, improving health care by strengthening partnerships, and enabling care givers to help address social barriers — such as a lack of housing or transportation.

Parlette said the process will also help a separate effort by the region’s Behavioral Health Organization to fully integrate mental health care with physical health and substance abuse by Jan. 1 — two years earlier than most other regions.

She said now that the projects have been selected, the ACH will determine how those projects will be implemented. After the planning phase this year, the ACH will have four years to implement the projects.

Here are the projects:

- **Integration of Physical and Behavioral Health**: Address physical and behavioral health needs in one system, through an integrated network of providers who offer better coordinated care for patients, and easy access to the services they need.
- **Community-Based Care Coordination**: Ensure that patients with complex health needs are connected to the interventions and services that will help them manage their health. This develops infrastructure to coordinate the care coordinators.
- **Transitional Care**: Reduce hospitalizations by ensuring patients continue to get the care they need after being discharged from a hospital, a mental health facility, or a prison or jail.
- **Diversion Interventions**: Promote better use of emergency care services through increased access to primary care and social services. It includes diverting patients to the appropriate service when they come to an emergency room or call an ambulance with a non-emergency need, or come into contact with law enforcement.
- **Addressing Opioid Use**: Reduce opioid misuse and abuse through treatment, overdose prevention, long-term recovery and whole-person care.
• **Chronic Disease Prevention and Control**: Improve chronic disease management in the primary care setting. It encourages using the community, the health care system, self-management support, delivery system design, decision support, and clinical information systems.

Reach K.C. Mehaffey at 509-997-2512 or mehaffey@wenatcheeworld.com. Read her blog *An Apple a Day*. follow her on Twitter at @KCMehaffeyWW.
Proposed health care law worrisome, panelists say

by Nevonne McDaniels | May 9, 2017, 4:46 p.m.

CASHMERE — The Affordable Care Act is not perfect, but it's working in Washington state, says Gov. Jay Inslee’s senior health care adviser.

More people have insurance, uncompensated care costs to hospitals have been reduced by half and insurance premiums are starting to stabilize, said Dr. Bob Crittenden, the governor’s health policy adviser.

“The Affordable Care Act is not broken here,” he said at Monday’s “Healthcare at a Crossroads” forum at the Cashmere Riverside Center, attended by about 200 people.

Crittenden was one of six panelists at the event hosted by NCW United, an activist group that formed in December, and AARP to talk about what’s in store for health care, whether the ACA (Obamacare) remains the law of the land or is repealed and replaced by the proposed American Health Care Act.

The AHCA passed the U.S. House of Representatives last week and is now being discussed in the Senate. The new legislation reduces the number of people who would be covered by Medicaid, drops the mandate for insurance and allows insurance companies to charge more for people with pre-existing conditions.

Panelists at Monday’s meeting said all of those pieces have helped make Obamacare doable, despite its flaws.

“The ACA is not perfect. Social change takes time,” said Cathleen MacCaul, AARP’s advocacy director for the state. AARP opposes the AHCA, which MacCaul described as “essentially an age tax that allows insurance companies to charge older Americans five times — or even more — for their health coverage.”

Other speakers included Linda Evans Parlette, a former state senator and now executive director of North Central Accountable Community of Health; Dr. Malcolm Butler, chief medical officer at Columbia Valley Community Health; Dr. Peter Rutherford, chief executive officer at Confluence Health; and Jillian Danley, community outreach manager of Planned Parenthood of Greater Washington and North Idaho.

Rutherford said Confluence Health doctors have noted a change in patient attitude since Obamacare was implemented.

“It’s much easier to talk to patients about getting a mammogram or colonoscopy when it is covered as part of preventive care under the ACA,” he said.

On the downside, despite having insurance, patients with high deductibles are still struggling when faced with ongoing medical conditions such as diabetes, which means hospitals continue to provide uncompensated care, though the amount has been reduced.

That's also been the case at Columbia Valley, which, as a federally qualified community health center, provides services regardless of the ability to pay.
“Until 2010, our mission was to serve the underserved,” Butler said.

Before the ACA, 40 percent of the health center’s 25,000 patients did not have insurance. Now, about 20 percent are uninsured.

“People are coming in earlier for health care. We are now doing all those things we hoped we could do. When an acutely psychotic patient comes into our office, we can prescribe the medication, they can buy the medication and we can treat them. We have diabetic patients who can afford insulin,” he said. “For us, the Affordable Care Act has been massive.”

It also created a mission shift.

“What do you do when suddenly everyone has insurance?” he said. “We’ve had to redefine what we do, so we are the better choice, not the only choice.”

The result has allowed Columbia Valley to “serve patients in new and more effective ways,” including team-based care, working between primary care physicians and mental health providers, Butler said.

Parlette said treating the whole person is likely to be part of the discussion of future health care whether under ACA or AHCA. She is heading up the new Accountable Community of Health in an effort to integrate all aspects of health into the delivery system and do it for less money.

The program uses a whole-person approach to health care, where a patient’s medical condition is treated with attention to behavioral health, social health (education, housing, transportation), employment as well as the environment (presence of lead or pollution).

Parlette said she doesn’t see the AHCA passing the Senate without some changes.

She referred to the state’s private insurance market collapse in 1999, when insurers fled the state. She worked with then-Gov. Gary Locke, insurers and providers to draft legislation to bring insurance companies back into the market. A similar approach is needed in Washington, D.C., she said.

“What they should do is bring together Democrats, Republicans, medical organizations, hospital groups — everyone affected — and improve upon what was started with the ACA,” she said.

“If you’re going to enact huge social change, it takes people from both sides of the aisle willing to roll up their sleeves.”

Reach Nevonne McDaniels at 509-664-7151 or mcdaniels@wenatcheeworld.com.
North Central
Accountable Community of Health

Fully-Integrated Medicaid Contracting Advisory Committee
Report for the North Central Accountable Community of Health Governing Board
June 5th, 2017

Completed Meetings
Two Fully-Integrated Medicaid Contracting Advisory Committee meetings were held in May. The details of that meeting are below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Topic</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 3rd</td>
<td>Confluence Technology Center</td>
<td>Group discussion on measuring FIMC success. Morning session: Included a presentation by guest speakers on the sufficiency of the state monitoring resources to measure FIMC success in NC ACH and discussed additional metrics needed/possible? Guest Speakers: David Mancuso, PhD, Director of the Research and Data Analysis Division of the Washington State Department of Social and Health Services Kirsta Glenn, Director of Analytics, Interoperability, and Measurement at the Washington State Health Care Authority Afternoon session:</td>
<td>49</td>
</tr>
<tr>
<td>May 31st</td>
<td>Confluence Technology Center</td>
<td>MCO RFP update, Qualis Behavioral Health IT Assessment Report Presentation, Workgroup Reports, FIMC Next Steps Work Plan – June-December</td>
<td>44</td>
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Workgroups of the Advisory Committee

Early Warning System
The Early Warning System (EWS) workgroup met on May 31st. We are continuing to identify indicators and delegating who will be responsible for reporting that data, both pre- and post-FIMC. The draft indicator matrix is continuing to be populated throughout this process. The target date for the EWS to be operational is still July 1, 2017 in order to collect 6 months of baseline data. A subgroup of the Early Warning System consisting of the Jail Systems in Grant, Chelan, and Okanogan Counties met on May 11th to discuss criminal justice indicators to be used and work to identify protocols for collecting data for HCA. Two indicators were unanimously agreed on by the group. The draft indicator matrix is available on the Early Warning System Workgroup webpage. A charter for this workgroup was adopted on May 31st.

Managed Care Rates
The Managed Care Rates workgroup met on May 31st. Most Behavioral Health providers completed the template provided by Milliman to collect data that is potentially not accounted for in the current rates. Milliman is requesting additional information on staffing models (vacancies, average salaries, growth plans, etc.) from each Behavioral Health Provider. In addition, the BHO will supply updated financial information. Milliman and HCA will research incident rate of crisis services NCW compared to other regions. A charter for this workgroup was adopted on May 31st.

IT/EHR
The IT/EHR workgroup met on May 24th which included a presentation by Diane Vrenios on the results of the Behavioral Health Provider IT Assessment that Qualis performed. The aggregate
North Central
Accountable Community of Health

The report is still draft form but the final report will be available soon. In addition, Qualis is providing individualized reports to each Behavioral Health Agency with more detailed recommendations. HCA will review the reports for individual agencies to determine where there are commonalities in recommendations that Technical Assistance can be focused.

Consumer Engagement
The Consumer Engagement workgroup met on May 24th. We will be working with HCA to review and update their client communications (postcard, mailed Sept 1; flyer, mailed Oct 1; booklet, mailed Nov 1). We are continuing to develop a comprehensive communications plan for August-December. Assignments were made for developing key message by audience type (care coordinators etc, providers, and beneficiaries). Delivery method/forums for message delivery were brainstormed and will be incorporated into the communications plan.

Full meeting notes and materials from all Advisory Committee and Workgroup meetings are available on the FIMC webpage on the NC ACH website at: [http://www.mydocvault.us/fimc-advisory-committee.html](http://www.mydocvault.us/fimc-advisory-committee.html)

Upcoming Meetings

**Advisory Committee meetings dates and tentative topics:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Topic</th>
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<tbody>
<tr>
<td>June 21</td>
<td>Confluence Technology Center</td>
<td>TBD</td>
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<tr>
<td>10:00 – 11:30 AM</td>
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<tr>
<td>July 12</td>
<td>Confluence Technology Center</td>
<td>TBD</td>
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<td>10:00 – 11:30 AM</td>
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**Workgroup meeting dates:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Workgroup</th>
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<tbody>
<tr>
<td>June 20</td>
<td>Chelan-Douglas Health District, 2nd Floor Conference Room</td>
<td>Early Warning System</td>
</tr>
<tr>
<td>11:00 AM – 12:30 PM</td>
<td></td>
<td></td>
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<tr>
<td>June 21st</td>
<td>Chelan-Douglas Health District, 2nd Floor Conference Room</td>
<td>Managed Care Rates</td>
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<tr>
<td>2:00 – 3:30 PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 21st</td>
<td>Chelan-Douglas Health District, 2nd Floor Conference Room</td>
<td>Consumer Engagement</td>
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<tr>
<td>2:30 PM – 4:00 PM</td>
<td></td>
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</tr>
<tr>
<td>TBD (Last week of June)</td>
<td>Chelan-Douglas Health District, 2nd Floor Conference Room</td>
<td>IT/EHR</td>
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Each workgroup meeting will have a call-in option – email Christal.eshelman@cdhd.wa.gov to request those details.

**HCA Request for Proposals**

- **MCO:** The Apparenty Successful Bidders have been announced – they are: Molina, Coordinated Care, and Amerigroup. There is a formal protest period that we are currently in. HCA will have time to respond to any protests as well.
- **ASO:** The Administrative Service Organization RFP is currently being scored. The Apparently Successful Bidder will be announced around June 15th.
Delivery System Reform Incentive Payment (DSRIP) Program: “Funds Flow 101”

Technical Assistance Resource
North Central ACH – June 5, 2017
This presentation provides a high-level overview of DSRIP Program funding:

- Federal Medicaid Demonstration Funding
- Delivery System Reform Incentive Payment (DSRIP) Program
- Potential DSRIP Funding Snapshot for North Central
- Earning DSRIP Incentives Process
- Sustainability Considerations
Federal Medicaid Demonstration - 5 Years of Funding

$1.5 BILLION OVER 5 YEARS (2017 – 2021)

 initiative 1: Apple Health delivery system transformation investments to enable adoption of value-based purchasing (VBP):
  - Delivery System Reform Incentive Payment (DSRIP)
  - Projects to be coordinated by regional Accountable Communities of Health (ACHs)

 initiative 2: Alternative options for long-term services and supports (LTSS) benefits and eligibility

 initiative 3: New “foundational community support services,” including housing and employment supports

**Focus of this Deck**

Note: Investments are intended to be sustainable without additional federal support by the end of five years

DSRIP Program Structure: Transformation Incentives

Total Initiative 1 DSRIP Transformation Incentives ($1.12 billion)

State Administration Funding ($52M)

- VBP Incentives ($169M Max)
- Design Funds (Y1 Only) ($54M Max)
- Project Incentives ($847M Max)
- Reinvestment Pool (Partnering Providers) ($113M Max* + Un-earned Funds)
- Challenge Pool (MCOs) ($56M Max*)

Integration Incentives ($70M Max)

Subject to Change: Under Negotiation with CMS

* Max only applicable if no regions secure Integration Incentives for integrated managed care; otherwise VBP incentive pool funds remaining after Integration Incentives will be distributed 1/3 to the Challenge Pool (for MCOs) and 2/3 for ACH-specified “Participating Providers”

Source: 1115 Waiver Special Terms and Conditions; Working DSRIP Funding and Mechanics Protocol; Discussion with HCA
DSRIP Funds Flow to ACHs & Partnering Providers

Total Initiative 1 DSRIP Transformation Incentives ($1.12 billion)

- VBP Incentives
- Design Funds (Y1 Only)
- Project Incentives

Coordination & Funds Allocation

Accountable Communities of Health

Project Selection, Coordination, & Allocation

Sample Partnering Provider Organizations for Transformation Projects

- MCO Partner*
- BHO Partner
- BH Provider
- Primary Care Provider
- Indian Health Care Providers
- Hospital Health Center
- County Govt
- Community Based Orgs
- Tribal Govt
- ACH Admin.

* Note that though MCOs are critical project partners, they are only eligible for Challenge Pool funds

Source: 1115 Waiver Special Terms and Conditions; Working DSRIP Funding and Mechanics Protocol; Discussion with HCA

Subject to Change: Under Negotiation with CMS
# Maximum Potential DSRIP Funding for North Central

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Calendar Year – Est. Potential Funding Earned ($m)</th>
<th>Total ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>Design Funds</td>
<td>$6</td>
<td></td>
</tr>
<tr>
<td>Project Incentives</td>
<td>$7</td>
<td>$10</td>
</tr>
<tr>
<td>Integration Incentives*</td>
<td>$2.19</td>
<td>3.29</td>
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**Key Takeaways:**

- Funding amounts are planning estimates, and subject to change.
- The only guaranteed amount is $1 million in Design Funds, awarded when North Central ACH achieves Phase I certification. Up to $5 million of the remaining Design Funds will be awarded based on the ACH’s certification submission score.
- Project Pool funding in Year 1 is earned and adjusted based on the ACH’s Project Plan application score. Project Pool funds for later years are adjusted based on progress and outcome performance.
- Integration Incentives are earned in two phase: (1) when LOIs are submitted, and (2) when integrated manage care is implemented (prior to January 1, 2019). NC has achieved the first phase for all but Okanogan County.
- “Partnering Providers” can also earn DSRIP High Performance and Value-Based Payment (VBP) incentives, in addition to the funds described in this table.

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*The amounts reported here do not include potential additional incentives if Okanogan County signs a LOI by Sept 15, 2017, and launches integrated managed care by Jan 1, 2019.*

**Source:** OHSU/Manatt analysis of 1115 Waiver Special Terms and Conditions, working DSRIP Funding and Mechanics Protocol & discussion with HCA

**Subject to Change:** Under Negotiation with CMS
2017 Design Funds Based on ACH Certification

<table>
<thead>
<tr>
<th>2017</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
</tr>
</thead>
</table>

Submit Phase I Certification Application by May 15

Phase 1 ACH Certification Awarded

ACH Contract with HCA Signed

$1m Phase 1 Project Design Payment

Submit Phase II Certification Application by August 14

Phase 2 Certification Awarded & Application Score Assigned

Up to $5m Phase 2 Project Design Payment, Adjusted Based on Application Score

* Pending DSHP claiming protocol process
Source: Working DSRIP Funding and Mechanics Protocol; Discussion with HCA

Subject to Change: Under Negotiation with CMS
**Design Funds Are Intended to Support ACH Capacity**

**Design Pool Funds** are to be used to support ACH-level investments on tools, technology and human resources for coordination of Medicaid transformation projects.

**Examples of potential Design Pool focus areas:**

- **Development of an ACH Project Plan:** Convening meetings of partner organizations; reviewing data, clinical evidence, and research; drafting, reviewing, and revising a Project Plan.
- **Support for community engagement efforts:** Holding community engagement meetings; facilitating participation of community stakeholders on ACH boards and committees.
- **Support for tribal consultation:** Engaging and collaborating with tribes, including training of board members.
- **Support for ACH administrative/project management infrastructure:** Supporting key ACH leadership roles (e.g., ACH Executive Director) and other support staff; hosting/maintaining ACH website.
- **Support for ACH data capacity:** Supporting data-driven decision-making, including regional data collection, asset mapping, and analyzing State data.
- **Health IT/Population health management:** Investments in EMR/electronic health record systems, registry capacity, and linkages to community-based care models.
- **Capacity building for direct care or services provision workforce:** Recruiting/hiring, retention, and training of staff.

*Pending DSHP claiming protocol process*

**Source:** Working DSRIP Funding and Mechanics Protocol; Discussion with HCA

**Subject to Change: Under Negotiation with CMS**

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*Pending DSHP claiming protocol process*
**DSRIP Project and VBP Incentives Earning Process**

1. **Partnering Providers Apply Funds at Their Discretion**
2. **ACH & Partnering Providers Undertake Transformation Initiatives**
3. **Financial Executor Distributes Funds to ACH & Partnering Providers**
4. **Independent Assessor Determines ACH Hits Progress & Outcomes Targets**
5. **Financial Executor Holds DSRIP Funds for Distribution**
6. **ACH Provides Payment Distribution Direction to Financial Executor**
7. **HCA Releases DSRIP Funds to Financial Executor**

*Pending DSHP claiming protocol process*
Source: Working DSRIP Funding and Mechanics Protocol; Discussion with HCA

Subject to Change: Under Negotiation with CMS
Sustainability Requires Health System Transformation

Existing Health Care System
Fee-for-Service & Largely uncoordinated

DSRIP Incentive Payments Support Health System Transformation

Provider, Member and Community Partnerships & Investments in Population Health Management Capabilities

Transformed System of Health & Wellness
Value-Based Payments with Coordinated Care
More to Come...

Several funds flow program design areas are still in development, including:

- **Design Funds:**
  - ACH Phase 2 Certification criteria
  - Phase 2 scoring methodology and application to Design Pool funding calculation

- **Year 1 Project Incentives:**
  - Project Plan review criteria
  - Project Plan scoring methodology and application to Y1 Project Pool funding calculation

- **Year 2 – 5 Project Incentives:**
  - Timing of progress metric stages
  - Measure weighting methodology

- **Integration Incentives:**
  - Funding distribution parameters

- **Reinvestment Pool:** Distribution methodology and spending parameters

- **Challenge Pool:** Distribution methodology and spending parameters
Please contact your Regional Coordinators with questions, or submit to HCA at: medicaidtransformation@hca.wa.gov

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