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Public Health "*Always Working for a Safer and Healthier Chelan County and Douglas County*"

June 21, 2017

To: Linda Parlette, Executive Director, North Central ACH
From: Barry Kling, Administrator
Subject: NCACH Governing Board Questions on Hosting Agreement Draft

At our June 5, 2017 meeting the NCACH Governing Board discussed the draft agreement regarding CDHD's role as administrative host (or in HCA's terms the backbone organization) for NCACH. I recused myself from any Governing Board decision on the agreement, and was not present during this discussion, but John Schapman shared his notes on the questions involved. I am providing this memo for your use in discussing the questions with the NCACH attorney, and I will be sharing it with the Governing Board.

First, though, I am aware that we have several board members who were not involved when these issues came up before, and I want to provide some additional background.

How Did CDHD Become NCACH's Backbone?

In 2014 and 2015 there was considerable discussion about the NCACH backbone. There was consensus that we did not want the ACH to become another layer of administration or bureaucracy, or to duplicate existing capacity in our region. The idea was to use an existing organization's administrative structures to provide an administrative base for the ACH without unnecessary costs, so that ACH resources could be used to support community health improvement to the maximum possible extent.

In early July of 2015 the NCACH Leadership Group (which existed prior to establishment of a formal board) issued a request for letters of interest from organizations interested in serving as the backbone. It was widely distributed within the region. CDHD, Community Choice and Grant County Public Health indicated an interest. Grant County Public Health soon underwent a leadership change and withdrew its application. After creation of the NCACH Governing Board (but prior to incorporation of the ACH) there was a series of discussions with Community Choice, resulting in a mutual decision that it would be best for both parties if Community Choice did not serve as the backbone. This left Chelan-Douglas Health District.

CDHD's point of view was (and is) that although prevention services rather than treatment make up most of public health's work, the improvement of health care for Medicaid beneficiaries is also a public health improvement that falls within the statutory role of the Health District. And CDHD believed it could serve as a neutral host for all the counties in the region, so long as the

Governing Board and key partners agree that this is workable. At the same time, CDHD is a minimally funded public health department, and any hosting arrangement would have to provide good value to the ACH without creating a net cost to the Health District. In early 2016, the Chelan-Douglas Board of Health passed a hosting resolution (also reviewed and approved by the ACH Governing Board) setting out the terms of the relationship. Since then CDHD has worked to provide a solid base for the formation of the ACH, with special awareness of the need to operate in a neutral manner that did not favor Chelan and Douglas counties over the others in the region. CDHD contributed substantial in-kind support, mainly in the form of leadership and other staff time. Now that the ACH has become a state nonprofit corporation a legal agreement between the two entities is clearly needed if CDHD is to continue to serve as the NCACH administrative host. The first draft of the contract was modeled mainly on the CDHD hosting resolution.

Specific Questions from the Governing Board

The following material is based on notes from the Governing Board discussion of the draft contract at the June 5 meeting. My comments are in blue type. I responded to the questions for CDHD and also the questions for the NCACH attorney because I believe I have information relevant to both.

Any comments from Attorney (Jay Johnson), is included below in RED

Added by Attorney. This was not originally addressed at Board Retreat:

Section 8: The following statement was added to this section:

The CDHD shall maintain Commercial General Liability insurance written on an occurrence basis with an insurer acceptable to the NCACH with coverage of not less than $1,000,000 per occurrence. The policy of insurance shall name the NCACH as an additional insured.

Questions for Chelan – Douglas Health District:

Section 3.1 (Personnel)

- Can NCACH staff be CDHD employees and non-union?

  Not currently. Under the current contract only a few supervisory or "confidential" staff members can be excluded from union membership. It is conceivable that the union contract could be renegotiated to allow for this. I am willing to give that a try, but I would be surprised if the union accepted the idea. It is worth noting, though, that this would probably take a few months (based on the pace of past union negotiations) and that NCACH must make a decision sooner than that for HCA Certification purposes. If we do attempt this, it should probably be initiated once certification and project proposals are done in mid-November.

Comments from Attorney: If NCACH maintains the hosting agreement with CDHD, NCACH staff will be part of the union through the CDHD. Any management of staff will have to be followed in accordance with the labor agreement between the CDHD and the union.

- If NCACH Staff are union, how does the labor agreement affect our ability to manage staff (i.e. pay scale, job descriptions, and personal policies)

  The CDHD labor agreement is a very favorable one from management's point of view. Management has a great deal of freedom to define the agency's positions and assign work to them. When it comes to layoffs, seniority is one factor that must be considered, but it does not override other factors. Layoffs inconsistent with seniority must be explained, but this is not difficult when there is good reason not to follow seniority in a layoff situation. In hiring, we are required to advertise every position internally for a period of five working days before advertising externally, but we are not required to hire an internal applicant if we believe an external applicant is a better choice. In short, the management rigidity people sometimes associate with union contracts is not a part of our union contract.

  The union contract does, however, include our salary matrix, and any significant deviations would require contract changes. The Board of Health would also have to approve such changes, since the salary matrix is part of the CDHD budget which is passed each year by BOH and provides the financial authority under which CDHD operates. Changes in the benefits package would also require board and union approval. Our salary matrix is far from perfect, in part because it includes only 6 steps. Many new employees do not start on step 1 (because of their level of experience or the need to make an adequate salary offer). After a six-month probationary period there is a step increase, given acceptable performance. After that, step increases are annual, and it takes only a few years before employees reach step 6, after which raises occur only in the form of annual COLAs, which have been minimal in recent years.

  Salaries in public health are modest. Public Health Nurses, for example, are paid less than nurses who work at local hospitals and clinics. So far the position classifications available at CDHD have met NCACH's needs, but we may need to look at the creation of new classifications in the future. But there are some constraints. Creating new kinds of relatively well-paid positions requiring substantial credentials and experience will not be a problem. At the same time, ACH positions comparable in qualifications and experience to current CDHD positions must be consistent with current CDHD practices. For example, an ACH position requiring a bachelor's degree would have to provide a salary comparable to that of a bachelor's-level nursing or environmental health position; it would not be acceptable to have significantly higher salaries for ACH staff than for CDHD staff in comparable positions. That would undermine the morale and performance of staff members, and that is not acceptable to CDHD. But it does not appear so far that this is a significant problem in practice.

If NCACH should need staffing that does not fit well in our current system – one example might be a health IT specialist requiring an unusually high salary because of high salaries in that field -- at least two options exist. The first is that when we are talking about a type of position that does not yet exist at CDHD, it would be possible to create new position classifications (with Governing Board and Board of Health consent). Another possibility would be a contract rather than employment arrangement. I do not believe that the use of CDHD as backbone will prevent NCACH from hiring the staff it needs, one way or another.

We have a Personnel Guidelines document that sets forth most of our personnel policies.

No further comments where provided in this section

- Can NCACH have their staff be employees of the NCACH and contract with CDHD for the Fiscal services, IT Services, and Space? If so, what would need to be done to support the organization and what is the cost differences?

  I do not believe it is practical to split off staffing in this way, for a few reasons. If NCACH is an employer, that means it has accounts with money in them to pay staff. CDHD cannot open separate checking accounts for NCACH; by RCW, all of CDHD's funds must be handled through Chelan County, under the ultimate authority of the Health District's Board of Health (BOH). Of course CDHD's accounting system tracks NCACH money separately, and in the proposed agreement BOH gives the NCACH Governing Board the authority to determine how NCACH funds are used, but if NCACH employs staff separately from CDHD it would have to do that through checking accounts and monies owned by NCACH separately outside CDHD's financial system. Once NCACH receives and spends government funds separately, it must have the capacity to be accountable for those funds separately. If NCACH becomes an employer, even if CDHD handled other costs and administrative functions, NCACH would need (in addition to its own bank accounts) a payroll system that handles deductions and taxes appropriately. It would have to make its own arrangements for staff benefits. It would need its own accounting system to keep track of payroll funds, and probably a staff timekeeping system so that staff time can be allocated to different projects or funding sources. These systems must run on some sort of IT network (small nonprofits often use cloud-based applications accessible through the Web), which would require IT support for NCACH users. And it must keep the records needed, and establish the financial policies and procedures required, to pass financial audits separate from those done at CDHD. Once NCACH separately has the government money needed to pay staff, NCACH must create many of the administrative functions currently addressed by CDHD.

  These staff-related administrative services could be purchased from CDHD or some other source; I cannot tell you the cost without looking into it further, but the point of having a backbone organization is to avoid in the first place the need to set up separate administrative systems for the ACH. If CDHD staff were to set up and operate these administrative and IT systems for the ACH, it would take more staff time and be more costly than to simply add ACH staff to CDHD's existing system, as we are doing under

the backbone relationship. It would also be challenging – read, more expensive – to take the reports from the two different organizations and produce the unified financial reports HCA will be expecting. Attempting to separate personnel from all the other administrative functions would create a lot of unnecessary duplication and complication and does not seem like a very helpful approach to me.

If NCACH needs to be independent from CDHD's personnel system, it should look for a different host or become completely independent by developing or contracting for its own administrative capacity. But in suggesting that possibility, I want to point out that NCACH is going to need stable administrative arrangements within the next few weeks to succeed in the Certification process. Several million dollars are at stake. The proposed agreement gives both parties the right to cancel the agreement with reasonable notice. So there is no attempt here to permanently kidnap NCACH. But it seems to make sense to maintain the hosting relationship at least in the short run, rather than disrupting our capacity to attract HCA funding at this critical point.

No further comments were provided for this section

Section 5 (Fees)

- Specific to what the 15% of NCACH total expenditures, does it include all money spent directly by the CDHD for NCACH expenditures (up to 6 million dollars for certification dollars), or all money that is provided to the region through the Demonstration?

  The 15% fee would apply only to funds expended directly by CDHD on behalf of NCACH. It would not apply to the ~$42M or to any other funds distributed through the state's Financial Executor, even if that distribution is directed by NCACH.

  Comments from Attorney: An addition to the contract was placed in this section to specify that the money is only for funds that directly flow into the CDHD bank account for NCACH purposes. The added sentence states:

  For purposes of clarity, the Parties agree that the fee calculated pursuant to this section will only be based on funds that are deposited with the Chelan County Treasurer for the benefit of the NCACH.

  - i.e. NCACH will direct $42M to partner organizations through a Financial Executor assigned by the Washington State Health Care Authority. This money will be held in trust by the Financial Executor until NCACH submits request for these dollars to be released to their partnering agencies. Is this subject to the 15%

    Not subject to 15% fee. These funds will not be handled through CDHD accounts.

- Is the money only operating expenses of the NCACH Organization? If so, how are operating expenses identified. For example:
  - Does this include expenses related to equipment, furniture, and room rental
  - Does this include subcontracts such as the Coalitions for Health Improvement
  - Does in include incentive payments NCACH would provider directly through the CDHD (i.e. CDHD gives CVCH $100,000 to support their EMR system).

The 15% fee applies to all expenditures made by CDHD on NCACH's behalf, including any distribution of funds to partner organizations. If the money flows through CDHD accounts, the 15% fee applies. (The only exception would involve termination of the backbone arrangement. In that event CDHD would transfer uncommitted NCACH funds to whatever organization NCACH indicates, and that transfer would not be considered an expenditure subject to the 15% fee. This is addressed in the proposed agreement.)

The 15% fee covers the cost of space and the use of furniture already owned by CDHD and available for NCACH staff use. (So far, we have not had to buy any furniture for NCACH.) Any furniture (and anything else, such as computers) purchased by NCACH would be NCACH's property and would stay with NCACH if it stopped using CDHD as a host.

The point is not that it costs CDHD 15% for each and every NCACH expenditure, but that the 15% fee overall provides a modest level of support for the services provided by CDHD as the backbone. To put this in perspective, consider a year in which NCACH expends $1Million through CDHD, resulting in a hosting fee of $150,000. First, note that CDHD's audited state indirect cost rate is approximately 26%, so the 15% rate is low in those terms. Second, consider the alternative of NCACH independently purchasing the services provided by CDHD. Could NCACH rent space (largely furnished) with paid utilities for several staff members, purchase accounting and payroll services, handle the administrative work associated with HCA and partner contracts and the Federal requirements related to those contracts, operate and support a computer network including IT support for individual users, operate and support a phone system, and support annual audits by the State Auditor's office (including the Federal component) for $150,000 a year? I doubt it, but if it can be done elsewhere for that cost perhaps NCACH should do so. The proposed backbone agreement provides a way for NCACH to terminate the agreement if the time comes when it wishes

to do that. But in the meantime, the creation of a new organization with these capacities would be a distraction from the already-heavy workload involved in getting Demonstration projects off the ground.

Though not mentioned in these notes, I understand the question of extra audit expenses for NCACH was mentioned. The proposed agreement states that NCACH would pay for any extra audit fees that resulted from CDHD's handling of NCACH funds. These are fees charged by the State Auditor's Office (SAO) for our annual audits. The cost of CDHD staff time involved in the audit is covered by the 15% hosting fee. The fee discussed here is an extra charge for the more extensive audit NCACH funds would involve. SAO usually charges between $10K and $14K for its audits, based on the time their staff takes to do the audit, so any increase due to NCACH funds would probably involve only a few thousand dollars. I believe this is a reasonable request. In a sense, the extra audit cost is something CDHD is paying on behalf of NCACH, just as it might lease a printer for NCACH's use. But I do not see this as a deal-breaker if NCACH objects to it.

Questions for NCACH Attorney:

Section 3.1 (Personnel)

- Do we need any specific section that outlines the reporting structure/evaluation process of the Executive Director? Currently Senator Parlette is a CDHD employee. Does that impact the reporting structure/evaluation between the Executive Director, Administrative Organization, and NCACH Board?

  CDHD is governed by the Board of Health (BOH), which in turn hires/fires the Administrator to operate the Health District. The CDHD Health Officer, who must be a physician, is also hired directly by BOH. Otherwise, all CDHD employees report (directly or indirectly) to the Administrator. The NCACH Executive Director reports directly to the administrator. But through the proposed agreement BOH would modify reporting relationships as follows:

  Section 3.1 in the draft agreement already provides that:

  > The NCACH Board shall be responsible, through its Executive Director, for the selection, oversight and management of the NCACH staff, including the establishment and evaluation of said staff members' services and deliverables.

  I suggest that the following sentence be added to 3.1 in the draft agreement, just before the sentence quoted above:

  > The NCACH Board shall be responsible for the selection, oversight and evaluation of the NCACH Executive Director.

Comments from Jay Johnson: This section was amended in the contract to state the following:

The NCACH Board shall be responsible, through its Executive Director, for the selection, oversight and management of the NCACH staff, including the establishment and evaluation of said staff members' services and deliverables, and the firing or discipline of said staff. The NCACH Board shall be responsible for the selection, oversight and evaluation of the NCACH Executive Director. The NCACH Executive Director shall report to the NCACH Board and not the Administrator.

Section 3.3 (IT and Phone Services) & 4 (Office Space and Furniture)

- When the NCACH dissolves, does the contract explain how the organization's assets will be handled so that they can be appropriately distributed according to NCACH Bylaws and contracts (i.e. HCA contract)? Who is responsible for tracking the assets of the NCACH?

I believe the proposed agreement addresses this in Chapter 6, but I am open to discussing it further as needed.

No further discussion occurred in this section

Section 5.1 (Unanticipated Costs)

- How are any unanticipated costs classified? Does this statement put the NCACH at risk for any large expenditures we would be unaware of?

This was included in the original hosting resolution at a time when NCACH activities and funding were much less clear than they are today. The point was just to protect CDHD from any unexpected obligations. But I do not think this is needed now and would have no problem dropping this language from the agreement.

No comments needed. This was removed from the contract

Section 7 (Indemnification)

- This section should go both directions. CDHD should hold NCACH harmless.

Agreed.

Comments from Attorney: Added to the contract under Section 7, is the following paragraph.

The CDHD shall hold harmless, indemnify and defend the NCACH, its officers, agents and employees, from and against any and all claims, losses, or liability, for injuries, sickness or death of persons, or damage to property, arising out of or in connection with

the performance of this Agreement, except for injuries or damages caused by the sole negligence of NCACH.

Section 12: Governmental Regulations

- Check to ensure they are appropriate and allow us to operate as needed.
- Issues with public disclosure. We will be receiving information/data from both HCA and partner organizations that are proprietary and sensitive. How will public disclosure laws that the CDHD are held accountable to affect our ability to protect the data if someone does a public disclosure request to obtain that information.

  Almost any document in CDHD's possession – with very few exemptions for documents such as medical records – must be disclosed if requested under the state's open records law. That includes electronic as well as hard copy documents. This would also apply to any information shared with HCA or any other governmental unit. HCA is pushing ACHs to operate in a transparent manner, but a private nonprofit organization could protect information to a greater degree than a public entity such as CDHD.

  I do not believe NCACH meetings would be subject to the public meetings law, though Board of Health meetings are considered public meetings so any NCACH business discussed there would be exposed during an open meeting.

  I doubt NCACH's work will involve much information that partner organizations would be willing to disclose to all of the other partners, but not in a public records request. Or to put it another way, if it is too sensitive to become a publically accessible record, it is also probably too sensitive to disclose to all the other provider organizations in the region through the ACH. In my opinion, the greater exposure created by the open records act will not really add significantly to whatever reluctance there may be to share information among our many ACH partners. But it is certainly true that any CDHD record (other than health records) is likely to be a publicly disclosable record.

  Comments from Attorney: NCACH as an organization is not subject to governmental regulations (i.e. open meeting rules) since it is a non-profit corporation in Washington State. NCACH staff are CDHD employees and are subject to public records request just like any other employee and therefore any work done through them is disclosable.