North Sound Accountable Community of Health

Governing Body Meeting

August 21, 2015: 1pm – 3pm

Skagit Station Meeting Room

MINUTES

Present	Present	Apologies	Guests
Joe Valentine, Chair		Linda McCarthy	Nathan Johnson, HCA
Tim Key		Regina Delahunt	Joanne Roberts, PRMCE
John Miller		Justin Iwasaki	Mike Whatson, LWC
Robin Fenn, PhD		Scott Forslund	Mark Raaka, Skagit EMS
Stephen Gockley, JD		Suzanne Pak	Katy Hetterle, Molina
David Kincheloe, PhD		Gary Goldbaum	Duncan West, MIN-NS
Jason Smith		Federico Cruz-Uribe	Meitra Williams, Tulalip Tribes
Greg Winter		Bob Burden	Murray Laidley, MIN-NS
Kim Williams		Barbara LaBrash	Eric Jensen, Evergreen Health
Glenn Puckett		Carl Bruner	Rose Ness, SI4BH
Allan Fisher, UHC		Keith Higman	Chase Napier, HCA
Chris Phillips: 1:05		Marilyn Scott	Dr. Chao-Ying Wu, FCN
Connie Davis, MD: 110	**Staff**	Linda Gipson, PhD	MJ Brell-Vujovic, Snohomish HS
Dan Murphy: 1:15	Elya Moore, PhD	Jennifer Johnson	Judy Ziels, Whatcom Health Dist.
Alisha Fehrenbacher: 1:25	Lee Che Leong	John Stephens	Kayla Down, HCA
Debra Lancaster, 2:30	Veronica Smith		Gary Waters, PeaceHealth Island

Topic	Action
1. Welcome and review	Approve agenda

2. Medicaid Transformation 1115 Waiver
• **Nathan Johnson provided an overview** of Healthier Washington, 2014 Legislation, SIM grant and:
• Waiver goals:
  ○ Reduce avoidable use of intensive service
  ○ Improve population health
  ○ Accelerate value-based purchasing
  ○ Ensure Medicaid grown is 2% below national trends
• Three initiatives
  ○ Transformation via ACHs to address 80/20 proposition; ACHs are 100% solution.
  ○ Targeted LTSS for at risk (3.4b per biennium)
  ○ Supportive housing
• Expedited process: governor grant in November 2014; 2015: May 30 concept paper, July 24 draft, August 24 application submission
• **Answers to initial Governing Body governing body related to Application Draft:**
  ○ Slide 15 lists coordinating entity duties; multi sector collaborations key to tasks including *Organizing members and partners, Coordinating applications, Distributing funds to partners carrying out transformation activities* and *Work with state and partners toward sustainability*
  ○ Timelines for ACHs and the waiver are different: *for the waiver, April 1 implementation with 8 months of ramp up with January 1, 2016 start*
  ○ Broader discussion across payers is necessary; don't want to focus solely on Medicaid but we spend $8B yearly and has grown by 43% so start there
  ○ Anticipate statewide workgroups as negotiations are underway; later this fall/early winter start
  ○ Toolkit: menu of options under initiative 1 with a 5 year demo in mind: rely on evidence based criteria though intent is not to focus only on evidence based practices, especially for populations where evidence doesn't exist. 5 year period for ROI
  ○ May also have initiative 2 and 3 activities that require ACH
  ○ There will be opportunities for regional priorities; envision a balance of strong state priorities and regionally undertaken efforts informed by RHNI
  ○ Menu development will follow later in the autumn with a statewide workgroup and several sub-
	Presentation from and questions for Nathan Johnson of the HCA from the North Sound ACH governing body and members of the public

groups that will be stakeholder-ing forums not statewide activities. Will work closely with pilots
  - The opportunity to undertake projects with multiple payers is key
  - Medicaid funding will need to be documented for Medicaid populations but CMS understand that providers see patients beyond Medicaid so see impact beyond Medicaid population
  - Not sure will have menu activities until long after January 2016; hope to not overly encumber. We need to work with you closely.
- **Robin Fenn: What kind of infrastructure, data, and support are planned?**
  - CMS has strong evaluation expectation. Will leverage SIM and will incorporate capacity building and rapid cycle improvements. Will not build 9 separate infrastructures. WA has done considerable work to develop a common measure set; will not build many additional measures.
- **Chris Phillips: what will MCO and shared reinvestments look like?**
  - Shared contribution needs more work before we incorporate into undertaking. The hope was 10% shared investment by year 3 and 50% by year 5. We wanted to draw reinvestment strategies, but a theory. Reinvestment is one of the most exciting things but also one of the most challenging which is why we put in less of the theoretical.
  - CMS is currently engaging with states with long term reinvestments but they have been very clear that they do not intend to continue that moving forward
- **Dr. Yu, family physician in Whatcom: I see a problem with adequate providers for wrap around mental health**
  - With expanded Medicaid, we are keenly aware of need. Something that can be supported by the waiver: UW telemedicine capacity helps PCP provide MH. Necessary but not sufficient; now sure we can pay for slots as that's not a 5 year return but in-depth gap assessments and expanding workforce capacity. Community health workforce won't fill the need but can be an asset. There will be room in initiative 1 for workforce capacity. Projects require a return.
- **Kim Williams: you spoke about keeping patients out of hospitals but in Everett our challenge is being unable to discharge 30-35 patients with delays in assessments or nowhere to place**
  - Slide 14: transitional care is a key area – not just ER but LTC, psychiatric, etc. sucks workforce capacity and we can do better for people. Not just hospital, provider or LTC but a perfect example of ACH leveraging partners to develop project
- **(unidentified): you won't pay rent for people but will you pay for counselors?**
  - A lot is spent on supportive housing but I suspect that if we can free up money from supportive services, they can build housing. We want to keep people out of LTC. We want to leverage what we've done and keep people housed with additional supports
- **Dan Murphy:** We need improvements all along the continuum. The ability to support family care givers rather than making a deeper investment in workforce have led to the efficiencies
- **Gary Waters, Peace Island: San Juan has twice as many eligible vets than any other county. Why aren't they accessing care at the same rate as civilians? Prevention is rarely mentioned. Also, any discussion of dual eligible?**
  - Population health includes targeted opportunities for certain populations including peer supports. Chiefly reliant on managed care but ongoing discussions to better manage people.
  - Managing in subclinical setting is massive cost savings.
  - Veteran access to care is huge issue in every community
  - WA has demonstrated integrated care models can lead to significant cost avoidance.
- **Judy Zeals. Whatcom Health Department: how can we optimize child health?**
  - This is the #1 public comment. The tension between 5 year ROI and investment upstream, 5 year return is the focus but not the exclusive focus.
- **(unidentified): How will the budget flow be determined?**
  - Too early to try to answer that though models in NY as well other places. This will be a balanced portfolio approach
- **Meitra Williams, Tulalip Tribes: How will tribes be involved?**
- There are tribal clinics around the state demonstrating what we are aiming for. The largest disparities are among the Native American population. There will need to be tribal-centric strategies. We can do great in PCP but don't have hospitals or specialists so that's a quandary and a question. Very pleased to see active tribal participation at this table.
- **Joe Valentine:** All 8 tribes in the region have a seat at the North Sound ACH table
- **Group Health:** what are you really talking about when you say "bidirectional integration"?
  - Need more access virtually or colocation in CHC. Many can and should be served in PCP. If serious BH issues, can bring PCP to that setting.
- **[unidentified] If elderly person cared for in the home, if private insurance costs are reduced, what is the mechanism for keeping those savings in the community? Is the insurance**

commissioner involved? Or will the state provide a public option? ○ Waiver is Medicaid exclusive but I've been impressed by early thinking. Pay for success in supportive housing has early promise. That would be in the legislative purview. Anyone in this room would be better than anyone in my neck of the woods in this conversation **Joe Valentine: if local ACH decided not to take that responsibility, what happens?** ○ We are not talking about applying insurance risk to ACHs; no accountability for outcomes that will impact finances. If not ACHs, then who? The 80/20 proposition requires everyone at this table. ACHs are the only present entities that cross health and social service domains. ○ We've discussed contracting out other functions in a conflict of interest free manner; performing provider systems in NY were led by hospitals. We won't want to form new orgs for the sake of it but hospitals themselves have considerable concerns. **1: Want to role in tool kit** **2: Want to partner in determining requirements of coordinating entity** **3: State must provide adequate resources**	
4. Public Comment Period	*No additional comments offered*
3. Proposed North Sound ACH feedback to Waiver • HCA deadline for feedback is Sunday, August 23 at 5pm • Short term impact must be balanced with long term upstream investments • Fear that the Medicaid waiver is capturing all the health transformation air in the room. All this is driven by 5 year savings while most of us are committed to real transformation. • We could slot in short, medium and long term strategies; can we utilize some waiver funds to provide a proof of concept or spread outside of the time horizon • Strategies could carve out a % for prevention; alternately ACHs could create a business plan • There's a risk of stampede to the short term which is why building in protections are key. In the longer term, must carve out sufficient portion of funding. Also drop list from #3. • Propose cutting 4 and 5 • Without discussion of data from the outset, too easily dropped • No word count limit so should include • Footnote cites reason for concern the state would not provide data in an accessible format • Take off last 2 bullets in 5 • Request for notes from April 30 convening; put all on canvas • Our main statement is there are many details to work out	Governing Body discussed concerns and amendments as indicated by underlined text to the left Consensus on document amendments indicated by underlined text to the left
5. North Sound ACH Resolution on waiver feedback • Approve amended comments on the waiver	Consensus for submitting amended comments to HCA
6. Next Steps • Minutes: approved • Updates: ○ Senator Murray's staffer met with WAHA, as a part of that ACH was discussed ○ Backbone staff requested to address health care lobbyist meeting re: ACH ○ HCA TA meeting 2 days next week for backbone staff • Governing Body: Sept 18, Nov 6, Dec 11	Comments will be circulated to all attendees who signed in Meeting notes to be shared on Canvas
7. Adjourn	