Meeting Title: Title XIX Advisory Committee

Minutes: Meeting Date: 11/15/19
Meeting Time: 8:30 am – 12:00 pm

Meeting Location: Emerald Queen Conference Center | 5580 Pacific Hwy E Fife, WA 98424
Meeting Called By: Claudia St. Clair, Chair
Minutes: Catherine Georg | Meetings may be recorded for transcription RCW 9.73.040 (3)

Title XIX Advisory Committee Online:

Attendees:

Members:
- Christian, Ann
- Delecki, Chris
- Gil, Sylvia
- Hannemann, Barbara
- Hendrickson, Wes
- Lester, Litonya
- Marsalli, Bob
- Milliren, Heather
- Sawyckyj, Kristina
- St. Clair, Claudia
- Tufte, Janice
- Yorioka, Gerald ‘Jerry’

HCA Staff:
- Georg, Catherine
- McGill, Jason
- Lindeblad, MaryAnne
- Linke, Taylor
- Kramer, Karin
- Claycamp, Teresa
- Pazolt, Melodie
- Venuto, Liz
- Worrell, Dennis
- Swan, Gary

Members Review | Bring | Discuss
Review/bring/discuss
- Current agenda and minutes from previous meeting(s)
- Changes in minutes may be emailed to: catherine.georg@hca.wa.gov

This public meeting may be recorded in order to produce a transitory audio record for transcription purposes.

RCW 9.73.030 (3) Intercepting, recording, or divulging private communication (3) Where consent by all parties is needed... consent shall be considered obtained whenever one party has announced to all other parties engaged in the communication or conversation, in any reasonably effective manner, that such communication or conversation is about to be recorded or transmitted: PROVIDED, That if the conversation is to be recorded that said announcement shall also be recorded.

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<tr>
<th>Date</th>
<th>Time</th>
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<tr>
<td>January 18, 2019</td>
<td>8:30-9:30 am</td>
<td>Conference Call</td>
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<tr>
<td>March 22, 2019</td>
<td>8:30-12:00 pm</td>
<td>In-Person Emerald Queen Conference Center - Fife</td>
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<tr>
<td>May 17, 2019</td>
<td>8:30-9:30 am</td>
<td>Conference Call</td>
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<tr>
<td>July 12, 2019</td>
<td>8:30-12:00 pm</td>
<td>In-Person Emerald Queen Conference Center - Fife</td>
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<tr>
<td>September 20, 2019</td>
<td>8:30-9:30 am</td>
<td>Conference Call</td>
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<tr>
<td>November 15, 2019</td>
<td>8:30-12:00 pm</td>
<td>In-Person Emerald Queen Conference Center - Fife</td>
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**AGENDA**

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<th>Allotted Time</th>
<th>Agenda Items</th>
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<tr>
<td>8:30-8:45</td>
<td><strong>Call to Order</strong></td>
<td>Claudia St. Clair</td>
<td>Informational</td>
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<td>15 min</td>
<td><strong>Announcement</strong></td>
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<td><strong>Introductions &amp; New Member</strong></td>
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<td>[Kristina Sawyckyj]</td>
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<td><strong>Approval of Agenda - Action Items (Members Only)</strong></td>
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<td><strong>Review Action Items</strong></td>
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<td>8:45-9:15</td>
<td>Integrated Managed Care update</td>
<td>Teresa Claycamp, HCA</td>
<td>Informational</td>
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<td>9:15-10:00</td>
<td>Homelessness in Youth</td>
<td>Liz Venuto, HCA &amp;</td>
<td>Informational</td>
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<td>45 min</td>
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<td>Regina McDougal, COM</td>
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<td>10:00-10:30</td>
<td>Clinical Data Repository update</td>
<td>Dennis Worrell, HCA</td>
<td>Informational</td>
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<td>10:30-10:40</td>
<td>Break</td>
<td>All</td>
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<td>10:40-11:05</td>
<td>Alternative Payment Methodology 4</td>
<td>Gary Swan, HCA</td>
<td>Informational</td>
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<td>11:05-11:35</td>
<td>Social Determinants of Health</td>
<td>Melodie Pazolt, HCA</td>
<td>Informational</td>
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<td>11:35-11:45</td>
<td>Reports to the Legislature</td>
<td>Taylor Linke, HCA</td>
<td>Informational</td>
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<td>11:45-11:55</td>
<td>2020 Meeting Dates &amp; Agenda Items</td>
<td>Catherine Georg, HCA</td>
<td>Decision</td>
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<td>11:55-12:00</td>
<td>Open Platform, Announcements, Closing</td>
<td>Claudia St. Clair, All</td>
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**ACTION ITEMS & DECISIONS**

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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Title XIX Membership &amp; Bylaws Refresh:</strong> In progress; Refresh for 2020</td>
<td>Complete: No Date:</td>
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**MINUTES**

<table>
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<td>6. Review Action Items</td>
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<td>8:45-9:15</td>
<td>7. Integrated Managed Care Update [materials attached]</td>
<td>Teresa Claycamp, HCA</td>
<td>Informational</td>
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<td>30 min</td>
<td>Behavioral Health Integration Update 2019</td>
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<td>Teresa Claycamp introduced for Integrated Managed Care Update; was a licensed mental health counselor prior to beginning state service in 2016</td>
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<td>Provided an overview, status update, and explained the roles of Managed Care Organizations (MCOs), Behavioral Health Administrative Service Organizations (BH-ASOs), processes to monitor integration, ensure successful transition, including work streams to do so</td>
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<td>See Document/handout titled: Behavioral Health Integration</td>
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<td>Substitute Senate Bill (SSB) 6312 passed in 2014; changed how the State purchases mental health and substance use disorder services in the Medicaid program</td>
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<td>Directed the State to fully integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care by 2020</td>
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<td>Directed the State to integrate mental health and substance use disorder services through Behavioral Health Organizations (BHOs) as an interim step to 2020</td>
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<td>Created a pathway for regions to fully integrate early (Early Adopters), starting in April 2016</td>
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<td>This meant taking a fragmented tri-furcated system and making it more streamlined</td>
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**Why Integrate?**

- No single entity with accountability, nor with the data and information necessary to manage the whole person
- Consumers with co-occurring disorders navigating disparate systems with no single point of contact
- Care coordination is duplicated
- Access to Care standards set an arbitrary barrier to higher-level services
- Tri-furcated funding streams make it challenging for providers to move to integrated care models.

**Integrated System**

- One managed care plan is accountable for keeping people healthy, both mind and body
- Individuals have 1 point of contact for questions and information
- Individuals have 1 Care Coordinator
- Access to care standards eliminated – care is based on level of care guidelines
- Over time, providers and MCOs can work together to establish new payment methodologies and integrated care models.

**Tri-furcated System**

1. **MH System** – Administered by DSHS - Regional Service Networks for people with Serious Mental Illness (SMI)
2. **SUD System** - County-administered outpatient Substance Use Disorder (SUD) treatment system (including methadone); State agency administers inpatient/residential SUD treatment system
3. **Physical Health** - Health Care Authority (HCA) Washington’s single state Medicaid agency
   - Outpatient mental health benefit for persons not meeting SMI criteria
   - All mental health medications, regardless of prescriber
   - Other medication assisted treatment (mainly buprenorphine for Opiate Use Disorder)
Bob Perna: How do the dollars flow? Directly to the care delivery organizations, or through the MCOs?

Teresa Claycamp: With integration, the dollars flow to the MCOs and then to the providers; general fund dollars go to the BH-ASOs; those folks are the ones who administer the crisis systems; MCOs do get some GF state dollars (for specific purpose)

What has changed? Medicaid benefits and state plan are the same; the MCOs provide all the physical, MH, SUD, services, and also receive general fund dollars to be prioritize for medically necessary services and support no covered by Medicaid

Examples include: room and board for mental health residential settings or freestanding evaluation and treatment centers, rehabilitation case management to those in hospitals or jails, non-Medicaid UA’s, non-Medicaid PACT team costs, etc.

MCOs also cover crisis services for their enrollees; contract with the BH-ASO

Also page 4; this is where we begin to see what is in the BH-ASO contracts; on the hook for full deployment of ITA designated crisis responders, involuntary treatment provider assessments;

Snap shot of where things stand; the phasing in of integration began in 2016

Of the 10 regions in our state, 7 have implemented to integrated managed care with 3 regions remaining (see map)

North Sound was scheduled to integrate in January of 2019, but this was moved to July 2019 to ensure readiness within the region; Three 3 remaining regions, Great Rivers, Thurston Mason, and Salish, are on track to integrate January 2020

Integrated whole person care will not happen overnight; implementation of integration is a journey and process

Initial phase was about integrating to a single payer system; now the real work begins to integrate systems and care coordination to ensure whole person care, mind and body

Some counties have some county dollars 1/10th of 1%; ASO also oversees the ombudsman systems, Wraparound with Intensive Services (Wise), and Family Youth System Partner Round Tables (FYSPRT)

Handout, page 5: Hones in on the BH-ASO; BHOs are shifting to this function

HCA contracts with MCOs, the MCOs contract with ASO for Medicaid

Bob Perna: Is there a split for how much is state money, how much is Medicaid; are there mechanisms for crisis services for non-covered (ER)?

Teresa Claycamp: Part of the ASOs job is to check the service encounters, then bill MCOs accordingly; idea is to make sure funding for non-Medicaid is truly non-Medicaid

Bob Perna: How much is (split) retro and open enrollment?

Taylor Linke: Somehow through the process, we can see that they would be retro enrolled; if we go back and see they had services in past 90 days, then would be paid through fee for service (FFS)

Native American Alaska Natives; can opt into managed care; with implementation, this has not changed

Successful transition and readiness; there are a lot of efforts to make sure they are ready, including a great deal of technical assistance; provider readiness is big

Once go live, will have rapid response calls 3x week, with MCOs, ASOs and Providers; this will reveal whether there are eligibility, care coordinator issues, early warning system (metrics) in the regions, set indicators, claims processing, wanting to make sure there are no trends that integration may be impacting services

MCOs Per Region

This is a snapshot of the managed care organization per region

Coordinated Care Washington (CCW) is in every region for Foster Care Population

Larger regions, such as King and North Sound have all 5 MCOs

Smaller regions have a minimum of three plans
• Teresa Claycamp: Contracts and Research and Data Analysis (RDA): Looking at data; analyzing Southwest and close to analyzing North Central
• Bob Marsalli: What is happening with this (RDA) and Clinical Data Repository (CDR)?
• Teresa Claycamp: Let’s save CDR questions for Dennis Worrell
• Bob Marsalli: Klickitat and Okanagan Counties – what is with the slashes on the map?
• Both were previous regions, now early adopters with other regions
• Taylor Linke: Over the next 3-6 months the new Data Officer (Chris Chen) will be on board; then it will make more sense what it looks like going forward
• Bob Perna: In analyzing, what?
• Teresa Claycamp: Early comparisons (2015) with first year of implementation, look at 29 measures and compare with what is going on across the state; correlation does not mean causation; we look at areas that may need fixed
• Bob Perna: Were the 29 measures instituted across the state?
• Taylor Linke: There was a workgroup under Bree, that compiled the 29 measures
• Bob Perna: Do the 29 measures draw from that?
• Teresa Claycamp: Blend; some are access measures, some are HEDIS, hospitalization trends, readmission trends, a lot of social determinants of health, etc.
• Bob Perna: There may be an overlap, over time it would be interesting to see where they end up
• Jerry Yorioka: Designated Crisis Responders are they the same as what was called MHPs (designated Mental Health Professionals)? Are they generally the same people?
• Teresa Claycamp: Yes, the same; the BH-ASOs contract for those services; in contracts, there are a lot of time requirements; part of our job is to monitor that

9:15 - 10:00
45 min
8. Homelessness in Youth
Liz Venuto, HCA & Regina McDougal, COM
Informational

• Regina McDougal: Commerce (COM), Department of Homeless Youth and Prevention
• Regina McDougal: Would like to hear from you about your experiences, see where the issues intersect, in order to make our systems work better; like to work with people that have direct experiences
• Regina McDougal: Would like to talk about who we are, what we do, initiatives and what we’ve been doing over the last year
  o Q1: Are there indicators in your work that give you a sense that additional housing services are needed?
  o Q2: What do you do in those instances?
• Liz Venuto: HCA - Children, Youth & Family Behavioral Health Section Supervisor Division of Behavioral Health and Recovery; will talk about two programs in particular today
• New Journeys: Coordinated specialty; individuals with psychosis; typically 20% have experience with psychosis; similar to Oregon’s program; program is currently (King, Yakima, Thurston, SW); by 2020 will have services in every region across the state; about 80% are housed; if intervention in the first 2 years of onset, there is opportunity to reverse
• WISE: Wrap around intensive services; target youth and family; community based; one of the advantages is that this population is not best served in tan office setting; services are youth and family driven; that drives and keeps folks engaged; unconditional; change is incremental; hard to go from being homeless formalized services; can be referred as many times as need to
• Bob Marsalli: Sad that Ann Christian isn’t here today, have been working together on psychosis (SB5903 or 5923)
• Liz Venuto: Ann was fundamental in bringing this program and expansion together; why we have four new programs this year, and expanded coverage are a result of legislation
• Bob Marsalli: Would like to have an off-line conversation regarding the school based services and training for physicians
• Liz Venuto: Would love to work with you
• Jerry Yorioka: Question(s) around human trafficking
• Regina McDougal: Rep Tina Orwell has interest, and we have been interacting with her on this; there is work being done; has some contacts for us (Safe Harbors) she would like to have more advocacy, it would be a good time (legislation has been proposed at least the last ¾ years
• Jerry Yorioka: Is there a current task force?
• Regina McDougal: Children and Youth Justice
• Regina McDougal: Like to invite people to share a story relative to the topic we are talking about and help center the conversation; working on a bill to help stabilize housing for formerly involved individuals
• Young man, over 18, was releasing form JRA facility; tried to set him up to live on own, but quickly found he was couch surfing again; tried to figure out why; the issue was wrap around services; he was institutionalized and lonely; what are your stories?
• Jerry Yorioka: This was 20 years ago already, a lady had a 16 year old son; sometimes not at home and at the mall, friends started shop lifting then started sharing the goods; he was pressured to begin stealing too; went from shoplifting to stealing cars; this later involved him in a police chase and he died when he lost control
Taylor Linke: With my own children, last year was first exposure their school district; learned that 1 in 25 children are homeless (K-12); teacher shared that support services are brought in to help kids

Regina McDougal: This is a fairly new office in state government, created in 2015; interestingly housed with Commerce, which in itself is a unique agency; acts as an independent office in the larger agency, with 2 major books of business; half of the staff work on contracts with shelter providers; how do we coordinate in a way to get better response and advocate for system change; look at trends, gaps, challenges, adding capacity, change operations, change gaps in system

Interagency work group has a lot of responsibility for implementation; does not have regulatory authority, but have peer influence for improvement; 6560 by 2021 no young person in care will be released into unstable housing; juvenile justice in county and state through JRA, residential programs, shelter programs; there has been an investment in crisis shelters, have not made an equal investments in other areas

Child Welfare includes the foster system

Taylor Linke: Are you claiming draw down matches for connecting services; federal draw down could help with some of the work you are doing

Gary Swann: Seems like there are some opportunities under Section 2 of the Waiver, which links back to potential financing for housing, break cycle on investments

Regina McDougal: 6560 recommendation(s) due to the legislature at the end of Dec

Look at number of kids released to fosters and population of un-stably housed; 85% of un-stably housed is young adults

Have taken a three pillar strategy; host of strategies to modify systems for transition planning; second pillar, how to prepare and support community better as released to be successful (improved referral process); third pillar, housing models, in order to meet various levels, have to look at various housing levels

Jerry Yorioka: Is there a designation for run-aways?

Regina McDougal: Good question, there isn’t one answer; there’s a population of kids that aren’t in the system or court involved; typically a lot of the kids we work with are system involved; prompting questions; do any you currently see patients (in this demographic)

Bob Perna: When responsible for intersection of clinical care and administrative operations, seems to have place in both sides of the Venn Diagram; making this more tangible and viable, there has to be a connection; don’t know how to funnel them out into the community for services; how do get channel into services; are there tools that facilitate this and lead to successful interventions?

Liz Venuto: How would you recognize the need; how would you connect when it is a challenge to screen for everything

Regina McDougal: May be a good prompting question for our remaining time, given the audience; suspect there are missed opportunities that we need to know more about

Bob Perna: Looking at the other Bob (Marsalli); this is part of what integration is about; there is no warm hand out; no clinical information to provide; needs to be some channel

Claudia St. Clair: One of the managed care plans is integrating services, but this is not my area of expertise; do have a team of community connectors that help clients get directed to the right place (there are 100 community connecters)

Regina McDougal: What does that look like?

Taylor Linke: Another resource - Within Reach; provides connectors to housing, child care, etc.; HCA contracts with them on multiple services

Better Health Together: putting together a new model

Dennis Worrell: Next Within Reach quarterly meeting is Dec 13

Bob Perna: Claudia represents one MCO, does your area have any connectors to the different MCOs to solicit stories?

Regina McDougal: Work with DBHR all the time; may work on youth, family, veteran homelessness

As APCD moves to HCA, what are we missing to connect?

Bob Perna: Data may be helpful

Lis Venuto: Not an oversight body like there are for certain services; doesn’t have the same structure; collecting data is difficult

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<th>Clinical Data Repository Update</th>
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<td>Dennis Worrell, HCA</td>
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Dennis Worrell presenting; PowerPoint attached

Clinical Data Repository (CDR), Improving care at the point of care; secure, cloud database supported by HCA’s vendor, OneHealthPort, storing Apple Health (Medicaid) clinical and claims information

Clinical information is submitted by participating providers, claims info comes from HCA

Providers with a trust framework agreement with OneHealthPort may view CDR data

About 2.2 million Apple Health (Medicaid) clients’ eligibility data (non-Fee For Service clients)
Approx. 1.8 million active clients; data is piped from ProviderOne
Over 95% have claims data (dental, pharmacy, encounter, no costs)
Over 10 million Continuity of Care Documents (CCDs)

- CDR collects CCDs
  - Based on a Meaningful Use requirement
  - HCA and OHP are exploring Fast Healthcare Interoperability Resources (FHIR) APIs
  - Processes in place to keep sensitive data out

Bob Perna: Know the enumerator; what is the denominator?

Dennis Worrell: This will not answer your question, but – but transmit continuity of care documents; spectrum of technical readiness; probably 100s being able to transmit, but not ready to transmit

Bob Perna: No hard data to test it against?

Dennis Worrell: Unable to answer that question at this time

Taylor Linke: The MCOs have been paying; there has some real progress; 1.8 million represents the whole Medicaid population, so it must be working

Dennis Worrell: There is a later slide; web portal access is the only way to access the information; working on query functionality; at this point OneHealthPort is working with a provider to pilot; using the data in the normal workflow; all the provider knows is that they have it

Jerry Yorioka: Is this in MS Access, or some type of “relational data base?”

Dennis Worrell: Do not have that level of granularity

Jerry Yorioka: What systems do need to access electronic health records?

Dennis Worrell: Value is that any provider can add the data and others may query it; CCD is a standard method of transmitting

In order for the information to seat in the CDR, there has to be file to load & identify Medicaid clients; to find them right now, can only search name and/or by wildcard

Claudia St. Clair: From an MCO perspective, hoping will be able to run reports to use with HEDIS

Bob Marsalli: MCOs are paying, providers are sponsors; how much is this costing? Will the MCO, since not clinicians, managing networks, there are others like my association would like to query in a non-patient manner, to form hypothesis, can load on the CCD homelessness, food insecurity, domestic abuse (term?); what is HCA strategy around this data lake asset for clinician and point of care, but in the larger picture for future data strategy

Dennis Worrell: Can speak to how person can access it now, provider, trust entity agreement

Bob Marsalli: To the extent that others may be able to influence the development, there are a lot of folks that are excited, overwhelmed, overburdened, would like to provide input on development

Taylor Linke: Including PEB/SEB side too, looking at this in a holistic way, think Mich’l Needham would welcome the idea that other stakeholders would like to participate in that

Dennis Worrell: Piloting the query capability; query functionality; e-consent management includes things like including sensitive needs of the tribes, making sure HIPAA compliant; CDR has over 10M continuity of care documents in it; have multiples on same client; included a notes section for clinician; some development in using AI to increase value of Continuity of Care document, that will search notes for keywords; social determinants of health, etc.

Taylor Linke: Looking at integration, an RX program regarding Medicaid clients only would be helpful; does CDR have accumulative cost information?

Dennis Worrell: The web portal view; RX story; prescribed, not filled; lab results, etc.

Claudia St. Clair: Cost is $500-600K more per year per MCO; cost may be different, based on enrollment

10:30-10:40 10 min
10. Break All

10:40-11:05 25 min
11. Alternative Payment Methodology 4 [materials attached] Gary Swan, HCA Informational

- Begin 10:45 – Gary Swan  See PowerPoint titled: APM4 Overview (attached)
- Have worked on various payment models; Federally Qualified Health Centers (FQHCs) get enhanced rates; set rates on the FFS side, used the MCOs to help inform; After 2006 CMS audit, adopted three APM models (see slide 1)
- APM 1: January 1, 2009 – April 6, 2011; Based on cost reports, average of 1999 and 2000 PPS rates; Encounter rates inflated by a Washington-specific healthcare index
- APM 2: April 7, 2011 – June 30, 2011; PPS rate inflated by 5 percent
• APM 3: July 1, 2011 to Present; 2008 rates as calculated under APM 1 inflated by Medicare Economic Index (MEI) from 2009-2010
• Gary Swan: Encounter rate is created under feds to ensure delivery of rural services
• Bob Perna: Recollection was that the categories is that one is facility based, the other is not (see slide 3- bubbles)
• Gary Swan: Payment is the same, they get the encounter based rate
• Under Sim and move to value, implemented APM3 in 2011, since then there has been new legislation
• Slide 4: By virtue of the PMPM, paid out prospectively throughout the year, within federal regulations
• Bob Perna: Annual reconciliation, issues with retroactive payback; what is happening with that or is the wound still healing?
• Gary Swan: Legislature 2011-2013 outstanding, essentially forgave the over/under, proposing legislation to bring people current to 2017; front load payment to MCOs, then reimburse MCOs opposed to RHCs
• Jerry Yorioka: Native American Encounter Rate was set every year by Congress
• Gary Swan: Native American Alaska native is separate from this
• RHCs by and large have taken a different approach, addressed to get their encounter rate, in the works to resolve past due payments
• Slide 5: Generally what we see in APM3 to PPS and APM4 rates; APM4 starts to replace billable encounters with non-billable encounters (telemedicine, etc.)
• Trying to align with HEDIS measures
• If able to measure down some of the provider encounters, it (Link to Quality slide)
• Seven measures; HB1c blood pressure toll; childcare issues; antidepressant management; asthma
• Tie quality improvement to subset of the Washington State Common Measure set
  o Clinics that demonstrate quality improvement will continue to receive their full PMPM rate
  o Non-performance will result in reduced PMPM rate through prospective adjustment, but never less than APM 3
• Upon meeting quality improvement targets
  o Clinics can earn back the full benefit of the PMPM rate in future years
• Slide 8 –Rewards attainment and improvement based on targets, means and weighting
• Clinics are compared against their own quality performance baseline (prior performance year); for the first year, CY2016 is the prior performance year and CY2017 is the performance year
• MCO reported member months (assignment rosters) are used for payment and quality performance calculations
• The quality improvement model compares multiple measures to establish a composite score, the Quality Improvement Score (QIS); the QIS is used to prospectively adjust the PMPM rate
• Slide 12: Early outcomes
  o Positive signs, but more time is needed
    ▪ Quality appears to be headed in the right direction
    ▪ Anecdotally, the model is allowing for clinical transformation
  o There is a culture of change
    ▪ Executives are carrying the messages within their organization
    ▪ Participants are investing in performance
  o Further evaluation is required
• Slide 13: Status and Future Work
  o Continuing implementation
    ▪ Seeking out opportunities to improve our processes and ensure success
  o Working with the Washington Association for Community Health to:
    ▪ Ensure long-term sustainability of the program
    ▪ Demonstrate care transformation outcomes
  o Engaging now through early 2020
• Bob Perna: RHC association of Washington, have you engaged with them?
• Taylor Linke: Every time you present Gary, I am amazed at the complexity and learn something new every time, thank you
• Health Care Authority has a range of activities with SDH, including:
  o Medicaid Transformation Project (MTP) Waiver – Accountable Communities of Health activities in each region
  o Examining opportunities to link SDOH with Medicaid Managed Care purchasing and employee benefit purchasing, but still in research and development
  o MTP – Foundational Community Supports (FCS) – targeted federal dollars to provide supportive housing and supported employment to high need Medicaid clients
• Today we will provide an introduction to the FCS and the active program focus on these critical needs that help address client’s health needs
• Services are delivered through third-party administrator, Amerigroup, with contracted community providers (see attached map)
• Robert Wood Johnson Foundation has been promoting that you are more likely to experience healthier life with stable work; laid off workers are 54% more likely to have poor or fair health, compared to the unemployed; 83% of those unemployed are more likely to have heart disease, depression, substance abuse
• There are over 90 epidemiological studies on conditions related to long term unemployment
• 5732 & 1519 directed BH system and long term system to start down track of common measures
• 1115 Demonstration for FCS models have been fully vetted and evidence based nationally
• Marrying services with housing helps people to be successful; that is the number one driver; more funding trickles (vs streams) for housing, with varying eligibility, six continuums of care, section 8 vouchers, most communities don’t have vouchers to give; it gets complicated to follow these funding trickles; if you are homeless with health issues, it’s complicated and difficult
• When developing 1115 FCS, we found in research and data analysis (report in 2010) 50% of exiting and 30% existing hospitals are homeless within a year
• Models are based on fidelity score tool; are providers following the models, are there successful outcomes?
• These are services that cannot use Medicaid for services; we are really doing two demonstrations, using non-traditional agencies to provide services
• We likely provided technical assistance to Minnesota; a lot of services have used our model
• Not just about getting somebody housed; still can only pay for services
• Need to be 18 and up; go a lot of questions; because have to be 18 to sign lease
• FCS services can be 16; there has to be necessity, health condition, on Medicaid, send third party administrator files; it’s an enhancement; do not need to leave MCO; can still access FCS
• Jerry Yorioka: Regarding New York, they are relocating people to other cities; is there an ethical reason for doing that?
• Melodie Pazolt: We have been able to do that (through housing/homeless specialist) if reconnecting them to families in other cities; however, cannot pay for bus passes
• Jerry Yorioka: Can legally do it?
• Melodie Pazolt: Perhaps a religious entity can pay for the bus pass, then we can connect to family and they can relocate
• Right now partners at Commerce have good data on what causes homelessness; mostly rents; as incomes go up, rents go up; people on SSI or SSDI, rates are flat; there are disadvantages in rents, the steep incline affects their ability to remain housed; we have not kept up on construction; number of individuals needing housing vs construction of AFFORDABLE housing, there are gaps; we will never will our way out of the affordable housing crisis; need to work with landlords, etc. to make affordable housing available
• Businesses: Housing Trust Fund; there was about 130M in pledges, including set asides for BH population; can get tax credits for units set aside for certain income group, etc.; various strategies to help housing shortage; there is no system to access it in one place; sprinkled and difficult
• Jerry Yorioka: How much is Section 8?
• Melodie Pazolt: That’s through HUD; there are many types of public housing authorities for different populations (TANF for families, etc.), there are Section 8 projects, and Section 8 vouchers (not part of the tax credit)
• Bob Perna: Why isn’t there one stop shopping?
• Melodie Pazolt: There are county, state and city, coordinated entries; Commerce has list; the question is, how do we get them discharge information?
• What is in your packet was launched in 2018; have over 7K enrolled in supported housing and other supports
• Who do we have enrolled vs. who do we have enrolled
• Bob Perna will send Melodie Pazolt WSMA ambulatory site info
• Jerry Yorioka: Is there a reason health literacy is not a SDH?
• Melodie Pazolt: World Health Organization (WHO) sends out SDH and leads work on global plan of action
  https://www.who.int/social_determinants/sdh_definition/en/
Potential Future Agenda Items

1. 7/27/18: Core Measurements Adult/Child Medicaid - there is a work group through the Governor’s office that oversees the measures and suggested that Laura Pennington attend a future in-person meeting to discuss the common set of measures, process and structure. [7/8/19 - Laura Pennington, Dr. Zerzan both on vacation] [Has been on list

2. 7/12/19: Bob Marsalli – Dental Managed Care report to legislature [posted on hca.wa.gov; expand, or?]

3. 7/12/19: Bob Marsalli – PI – how it dovetails VBP role; MAL could do update [brief on call or detailed in-person?]

4. 11/13/19: Kristina Sawyckyj - Housing Stabilization Services

5. 11/13/19: Trueblood update [Michael Brown]

6. 11/13/19: 1115 Demonstration Waiver [Chase Napier]

7. 11/13/19: HEP C Eradication [Mary Fliss]

8. 11/13/19: Partnership Access Line for Schools (PALS) [Mary Fliss]
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<td>11/15/19: Research &amp; Data Analysis (RDA) (for in-person)</td>
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<td>11/15/19: Medicaid &amp; Justice Population (for phone) – Dave Mancuso; how much of Medicaid population is involved in the justice system; FEDs just proposed new rule for 30 day discharge planning</td>
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<td>11/15/19: Ongoing Medicaid rule for 2020, leveling payment rates, outpatient; independent ambulatory practices; does Medicare policy impact Medicaid (discontinuation of hospital facility fee); would HCA consider it a policy change [Initiated by Bob Perna: not clear if it was/is a potential agenda item since he asked it during the agenda solicitation segment, or if it’s really responding to question]</td>
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### Other Partners / Participants / Presenters

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