Washington State Health Care Authority

Consultation

April 17, 2015

Agenda

10:00A	Blessing & Welcome Introductions: Tribal Leaders & HCA Leadership Team Opening Statements
10:30A	Planning for Two-Day Joint Agency Summit on State Health Reform
11:30A	Topic 1: Global 1115 Waiver for Healthier Washington (Update)
Noon	Lunch
1:00P	Topic 2: Draft Early Adopter Managed Care Organization (MCO) Contract • Apple Health Contracts for Managed Care • Apple Health – Fully Integrated Managed Care • Tribal Concerns/Issues with MCOs • Tribal Concerns/Issues with RSNs
3:00P	Closing Statements
3:30P	Closing

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Blessing & Welcome

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Introductions: Tribal Leaders & HCA Leadership Team

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Opening Statements

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Planning for Two-Day Summit

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Topic 1: Global 1115 Waiver (Update)

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Working Together for a Healthier Washington

Tribal Consultation

Healthier WASHINGTON

Better Health, Better Care, Lower Costs

Health System Transformation

Current System	Transformed System
Fragmented clinical and financial approaches to care delivery	**Integrated** systems that deliver whole person care
Disjointed care and transitions	**Coordinated** care and transitions
Disengaged clients	**Activated** clients
Capacity limits in critical service areas	**Optimal access** to **appropriate** services
Individuals impoverish themselves to access needed LTSS	**Timely supports** delay or divert need for Medicaid LTSS
Inconsistent measurement of delivery system performance	**Standardized performance measurement** with **accountability** for improved health outcomes
Volume-based payment	**Value-based** payment

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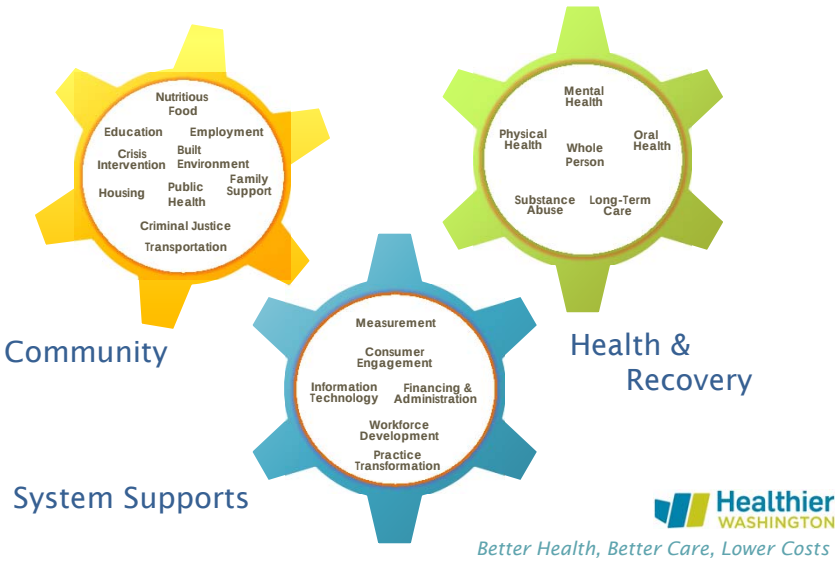
Because health is more than health care



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The Plan for a Healthier Washington

Build healthier communities through a collaborative regional approach

Ensure health care focuses on the whole person

Improve how we pay for services

Implementation tools:
State Innovation Models grant, state funding, potential federal waiver, philanthropic support
Legislative support: HB 2572, SB 6312

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The Vision for Medicaid Transformation

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Vision for Transforming Medicaid

Washington State Medicaid will actively engage and support individuals, providers and communities in achieving improved health, better care and lower costs through:

- Fully integrated managed care systems for **physical and behavioral health services** that more effectively provide whole person care
- Clinical-community linkages address **social and community-based service** needs that are critical to meaningfully engaging Medicaid clients in improving their health across the life course
- Cost-effective systems of care & supports that enable individuals to delay or avoid the need for Medicaid-financed services, including **long-term services and supports**
- **Sustainable funding streams** for a transformed health system through value-based purchasing, with 80% of payments to providers on the value-based continuum by 2019

A **waiver** enables Medicaid sustainability by guaranteeing a reduced growth rate in health costs.

Why does Washington need a Global 1115 Demonstration Waiver?

- Flexibility to use past and anticipated future federal savings for strategic, targeted investments
- Further transformation of LTSS systems in preparation for growing aging population
- Opportunity to achieve administrative simplification and standardized performance measurement across systems
- Flexibility to fund non-traditional Medicaid services for targeted populations
- Flexibility to phase-in innovations with demonstrated ROI

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Waiver Proposal Limitations

- Investments cannot fund business as usual—waiver funding must be linked to the implementation of the Medicaid Transformation vision.
- This is not a grant.
  Investments must result in sustainable savings.
- A waiver is not guaranteed.
  We will need to make a strong case to obtain federal approval to reinvest federal savings.
- There are several types of waiver authorities; this is a "Section 1115 waiver demonstration."

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Global (Comprehensive) Section 1115 Waiver Overview

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Global Section 1115 Waiver

- Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) the authority to approve experimental, pilot, or demonstration projects
- It provides flexibility and expenditure authority for states to design and improve Medicaid programs
- The purpose is to demonstrate and evaluate policy approaches, such as:
  - Changes in eligibility, benefits, cost sharing, and provider payments
  - Providing services not typically covered by Medicaid
  - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs

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Key Characteristics of an 1115 Waiver

- **Budget Neutrality**
  - Must result in federal expenditures for the five-year demonstration period that are no more than what would have been spent in the absence of the waiver.
- **Five-Year Demonstration**
  - Demonstrations are typically approved for 5 years.
  - Expected savings and performance outcome milestones must be achieved within 5 years.
  - The transformation is expected to be sustainable after the demonstration period ends.
- **Rigorous Evaluation**
  - Comprehensive evaluation is required to confirm or test the degree to which the program achieves the intended benefits.

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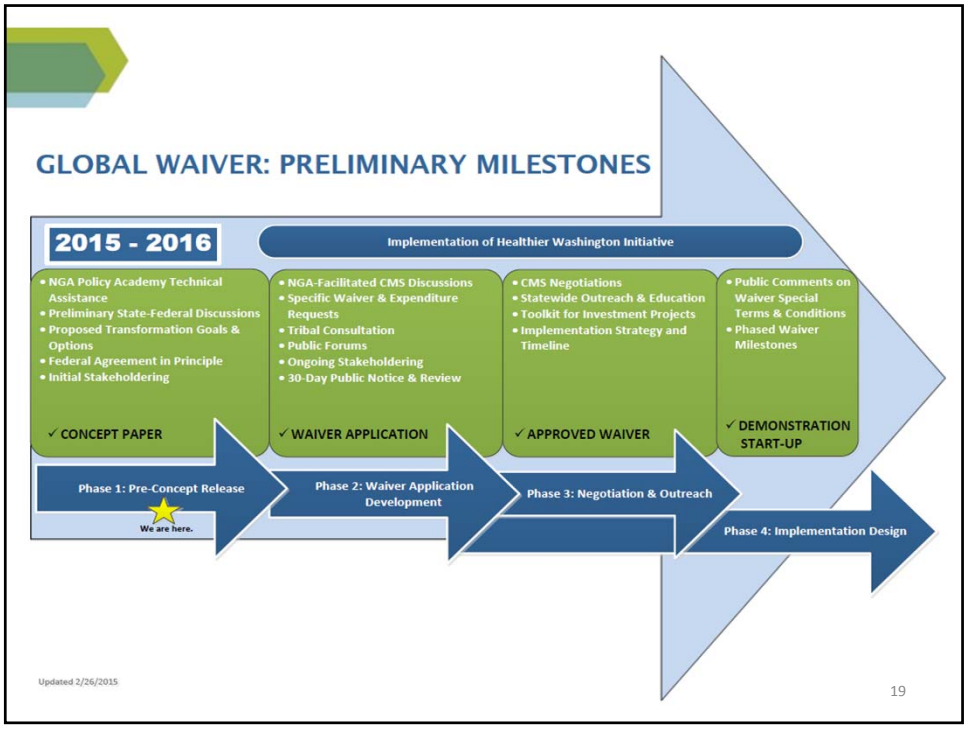

We need your feedback!

- **Medicaid Transformation:**
  - http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx
  - **Email:** medicaidtransformation@hca.wa.gov
- **Link to webinar recording:**
  https://attendee.gotowebinar.com/recording/4072587036299781890

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Join the Healthier Washington Feedback Network:

healthierwa@hca.wa.gov

Learn more:

www.hca.wa.gov/hw

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Topic 2: Apple Health & Fully Integrated Managed Care

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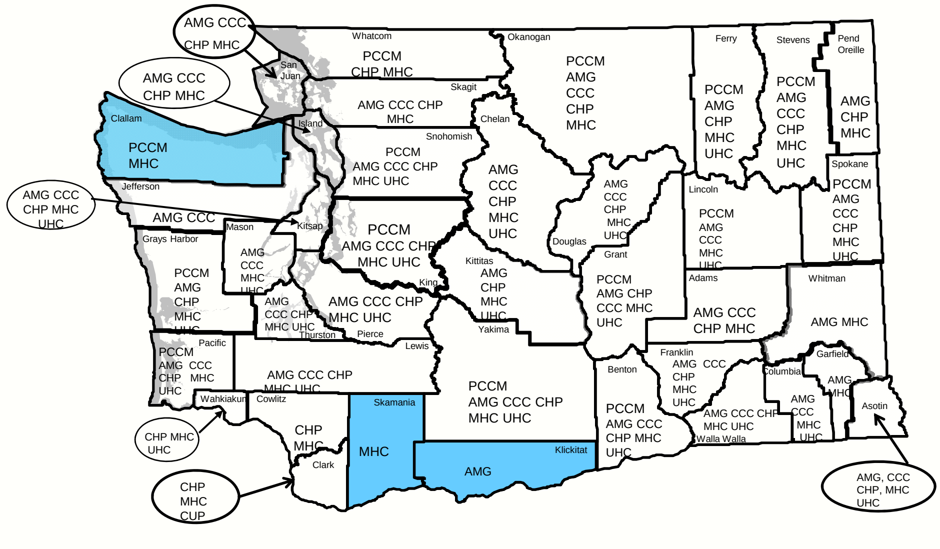
Managed Care: Apple Health and Fully Integrated Managed Care

Alice Lind, MPH, RN
Manager, Grants and Program Development
April 17, 2015

Presentation Overview

- Apple Health contracts for managed care:
  - Procurement of Apple Health
  - Contract overview
  - Contract monitoring
- Apple Health – Fully Integrated Managed Care:
  - Procurement timeline
  - Structure of contracting for Medicaid/non-Medicaid services in Early Adopter counties
  - Draft contract elements

Apple Health Managed Care Services Areas Effective 1-1-15



County enrollment in managed care is voluntary.

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Run Date: 12-8-14 Source: November ODS Data Warehouse 847.1 (most current) Total Population: 1,270,329

States Must Meet Certain Federal Requirements to Implement Medicaid Managed Care

- ✓ Implementation of quality programs
- ✓ Language access services (e.g., interpretation, translation)
- ✓ Network adequacy and timely access to care requirements
- ✓ Direct access for women's preventive and routine care
- ✓ Informing members on appeal and grievance rights, benefits, reasonable access to providers, and the right to change plans
- ✓ Acceptance of all enrollees during the enrollment period
- ✓ Marketing "guidelines" to avoid misleading, confusing or defrauding members

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Apple Health Contracts: Additional Requirements

- ✓ MCO's are required to have National Committee for Quality Assurance (NCQA) accreditation at a level of "accredited" or better by December 31, 2015.
- ✓ MCO's are required to report performance measures that meet "HEDIS" specifications: Healthcare Effectiveness Data and Information Set is a set of standardized performance measures designed to ensure that health care purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.
- ✓ MCO's help fund and participate in the design of the Clinical Data Repository.

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Apple Health Contracts: Additional Requirements

- ✓ Care Coordination requirements (Section 14):
  - Continuity of care provisions
  - Identification of clients with special needs
  - Initial health screen conducted for all; health assessment for those with special needs within 60 days
  - Care coordination plan in place for those who consent
  - Coordination of services and transitional care
  - Medication Therapy Management
- ✓ Health Home requirements (Exhibit C) for those identified by HCA as higher than average risk

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Federal Requirements for states: mandatory activities

- External Quality Review
  - Annual review of MCOs conducted by an external quality review (EQRO) organization (public report)
  - Annual validation of MCO performance measures (HEDIS audit by EQRO)
- Health Care Authority role
  - Structured monitoring of MCOs
  - Annual validation of MCO clinical and non-clinical performance improvement projects (PIP)
  - Day to day monitoring

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Structured Monitoring of MCOs

- Areas reviewed based on federal requirements and monitoring protocols:
  - Availability of services
  - Coordination and continuity of care
  - Program Integrity
  - Quality assessment and performance improvement
  - Coverage and authorization of services (Utilization Management)

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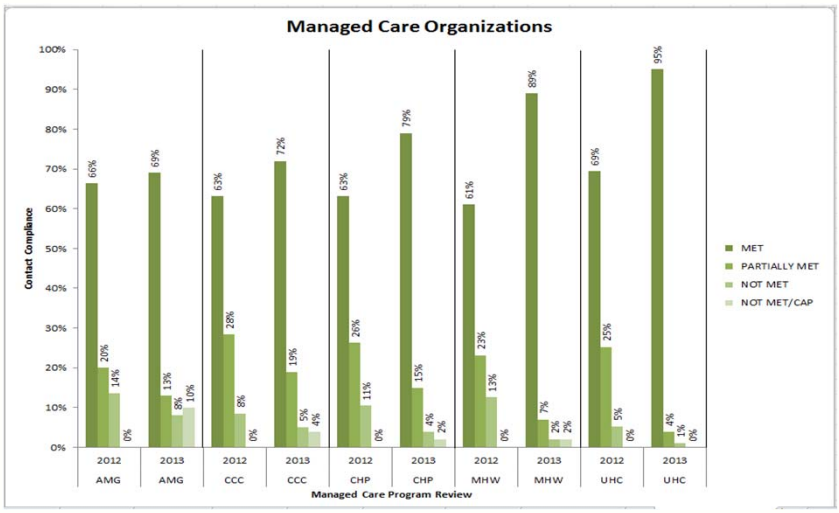
2014 Monitoring results



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Childhood Immunization Status (CIS)

Childhood Immunization Status (CIS)
2014 HEDIS Measures
Measurement Year 2013

	DTaP	IPV	MMR	HIB	Hepatitis B	VZV	Pneumococcal Conjugate	Hepatitis A	Rotavirus	Influenza	Combo 2
AMG	61.68%	77.84%	79.64%	82.63%	83.23%	77.84%	62.87%	67.07%	53.89%	38.92%	53.89%
CC	72.92%	83.33%	86.57%	85.65%	81.25%	86.11%	72.92%	82.41%	66.20%	55.79%	64.35%
CHPW	79.81%	91.24%	90.51%	91.73%	90.75%	89.05%	79.32%	83.45%	70.80%	58.88%	76.89%
MHW	74.17%	89.18%	88.96%	89.18%	87.20%	87.64%	75.28%	75.28%	68.43%	53.42%	67.77%
UHC	66.18%	80.05%	81.51%	80.29%	76.40%	82.48%	71.29%	71.78%	60.34%	53.28%	59.61%
2013 Statewide Averages	70.95%	84.33%	85.44%	85.90%	83.77%	84.62%	72.34%	76.00%	63.93%	52.06%	64.50%

GREEN - % above the Statewide Average
RED - % below the Statewide Average

The percentage of children who received recommended vaccines before their 2nd birthday.

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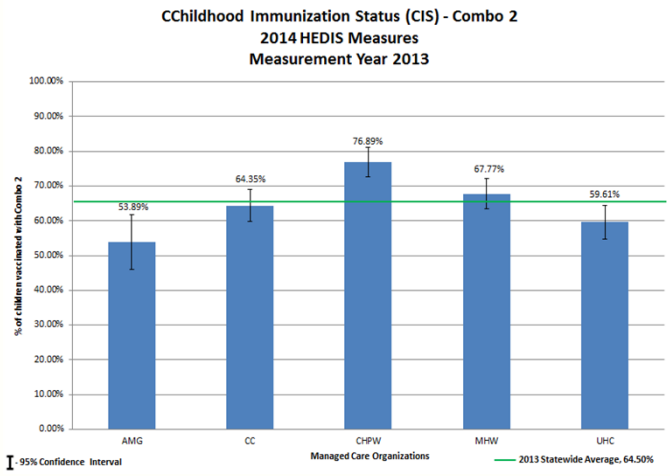
Childhood Immunization Status (CIS) Combo 2



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Comprehensive Diabetes Care (CDC)

Comprehensive Diabetes Care (CDC)
Adults Ages 18 - 75
2014 HEDIS Measures
Measurement Year 2013

	HbA1c Testing	Eye Exam
AMG	81.64%	38.72%
CC	86.09%	47.24%
CHPW	91.79%	51.82%
MHW	87.61%	52.70%
UHC	82.73%	37.96%
2013 Statewide Averages	85.97%	45.69%

GREEN - % above the Statewide Average
RED - % below the Statewide Average

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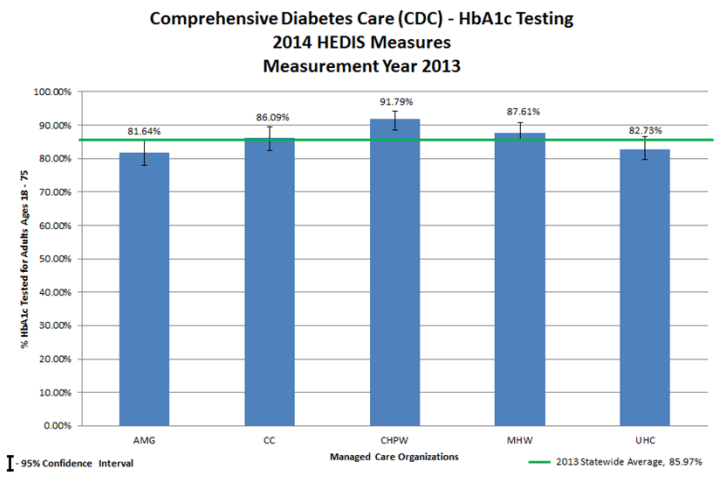
Comprehensive Diabetes Care (CDC) HbA1c Testing



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Mental Health Utilization: Total (MPTA) Outpatient/ED Services

Mental Health Utilization: Total (MPTA) Outpatient/ED Services
2014 HEDIS Measures
Measurement Year 2013

Age	Sex	AMG	CC	CHPW	MHW	UHC	Group Averages
0 - 12	M	1.14%	0.95%	1.64%	3.54%	0.94%	**1.64%**
	F	0.88%	0.59%	1.00%	2.25%	0.54%	**1.05%**
13 - 17	M	0.87%	1.11%	2.32%	4.63%	1.40%	**2.07%**
	F	2.25%	2.05%	2.97%	7.76%	2.27%	**3.46%**
18 - 64	M	2.19%	2.51%	3.53%	3.86%	2.69%	**2.96%**
	F	2.48%	3.30%	4.15%	6.14%	2.54%	**3.72%**
0 - 17	n/a	1.29%	1.18%	1.98%	4.55%	1.29%	**2.06%**
18 - 64	n/a	2.34%	2.91%	3.84%	5.00%	2.62%	**3.34%**
All Ages	M	1.40%	1.52%	2.50%	4.01%	1.68%	**2.22%**
	F	1.87%	1.98%	2.71%	5.38%	1.78%	**2.74%**

2013 Statewide Average **2.48%**

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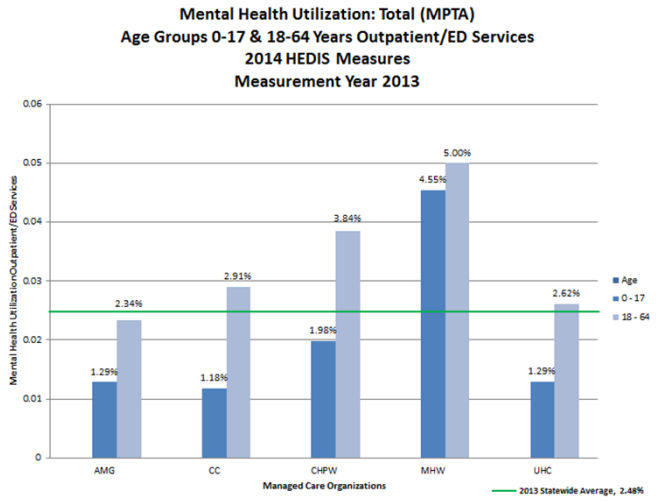
Mental Health Utilization: Total (MPTA)
Male/Female All Ages
Outpatient/ED Services



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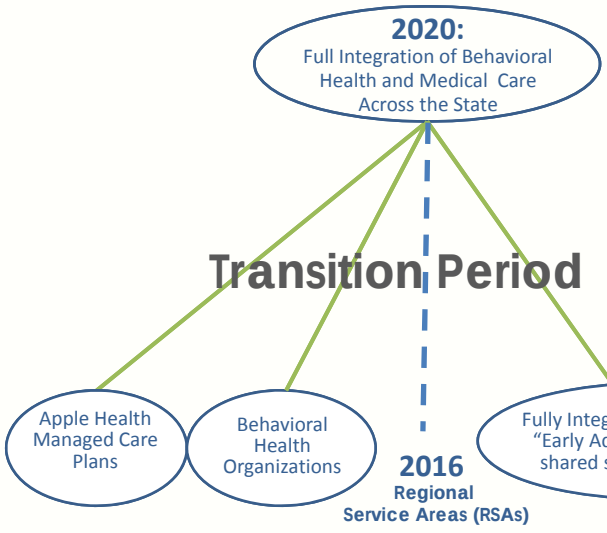
Parallel Paths to Integrated Managed Care



2014 Legislative Action: 2SSB 6312

By January 1, 2020, the community behavioral health program must be fully integrated in a managed care health system that provides mental health services, chemical dependency services, and medical care services to Medicaid clients

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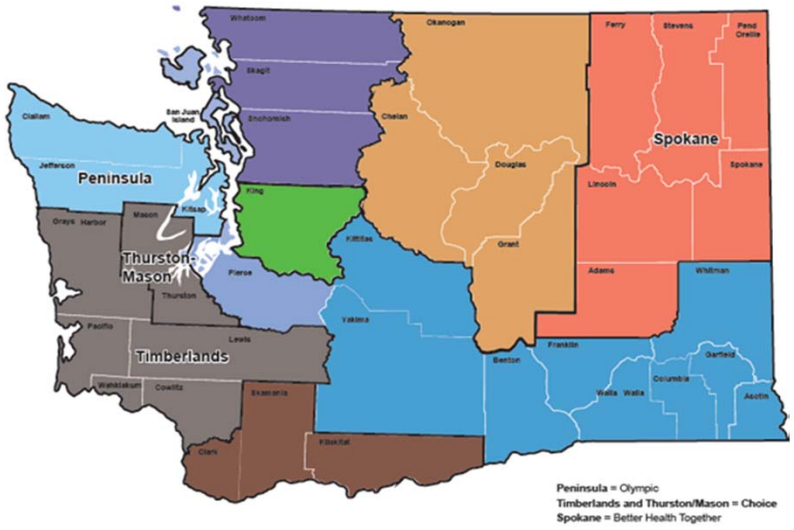
Regional Service Areas - 2016



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Behavioral Health Administrative Service Organization

- BH-ASO will operate on a regional basis to provide insurance blind crisis services to all SWWA residents, and limited behavioral health services (including SAPT-funded SUD residential) to individuals who are not eligible for Medicaid.
- Opportunities to manage additional services and/or functions on a regional basis may arise
  - e.g. operate Behavioral Health Ombuds, manage the distribution of Mental Health Block Grant funds regionally.
- HCA to release a Request for Information related to the BH-ASO; all types of organizations welcome to respond to RFI and RFP including public, private, non-profit and for-profit.
- HCA envisions opportunities for BH-ASO to expand geographic scope as additional regions move to full-integration.

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Crisis Services

Key Principles:

- One crisis system should serve the Medicaid/non-Medicaid populations on a regional basis.
- The crisis system should coordinate and intersect with the community, court system, first responders, inpatient/residential service providers, outpatient behavioral health system, and Medicaid Managed Care plans.
- Crisis system must consist of Designated Mental Health Professionals (DMHPs) and on-call Chemical Dependency Professionals (CDPs) available to serve everyone in the community 24 hours a day, seven days a week regardless of insurance type or uninsured.
- Managed care plans must be accountable (via performance or financial risk) for their beneficiaries use of the crisis system.
- The crisis system requires a blending of Medicaid and state-only funds in order to operate.

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Early Adopter Regional Crisis Model Draft

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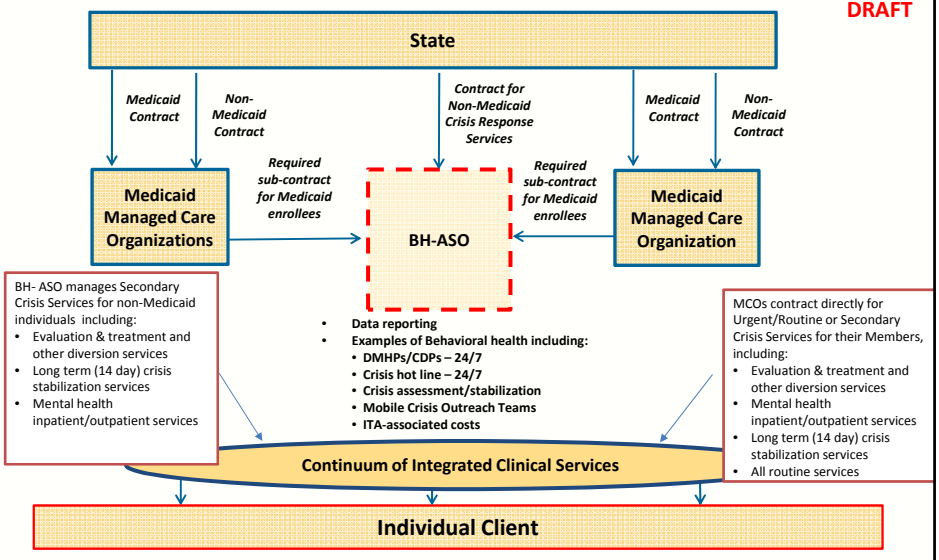

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Medicaid Enrollees

Crisis Response Organization Responsible For:

- **Regional Crisis Hotline**
  - Staffed by live person 24/7/365
  - Provides initial triage/documents calls and outcomes
- **Mobile Crisis Outreach Team**
  - Team staffed by MHPs (CDPs on call) who respond to crises, assess for mental health/drug related issues, provide initial stabilization, and refer to appropriate services (DMHP or other)
- **DMHPS (funded by GF-S only)**
  - Must be available 24/7 to conduct evaluation of need for emergency detention or to determine if person will receive appropriate care from triage facility or stabilization unit
  - File petitions for detentions
- **ITA Costs (funded by GF-S only)**
  - Testimony for ITA services
  - Reimburse county for Court costs associated with ITA

Managed Care Plan Responsible For:

- **Crisis Stabilization Services**
  - Available 24/7; often referred to as hospital diversion
  - Typically managed by specific programs
  - Services provided for up to 14 days by an MHP, CDP or DMHP to individuals experience a mental health crisis
- **Evaluation and Treatment Services**
  - Services provided in freestanding inpatient residential facilities or community hospitals to provide medically necessary evaluation and treatment services, including:
    - Evaluation, stabilization and treatment under direction of psychiatrist, nurse or other MHPs; discharge planning; nursing care; and clinical treatment including: individual an family therapy, milieu therapy, psycho-educational groups, pharmacology .
- **E&T Room and Board Costs (GF-S only)**
- **All other urgent and routine physical/behavioral health services**

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Non-Medicaid Individuals

Crisis Response Organization State-only Funds provide the following services to non-Medicaid individuals:

- **Regional Crisis Hotline**
  - Staffed by live person 24/7/365
  - Provides initial triage/documents calls and outcomes
- **Mobile Crisis Outreach Team**
  - Team staffed by MHPs (CDPs on call) who respond to crises, assess for mental health/drug related issues, provide initial stabilization, and refer to appropriate services (DMHP or other)
- **DMHPS**
  - Must be available 24/7 to conduct evaluation of need for emergency detention or to determine if person will receive appropriate care from triage facility or stabilization unit
  - File petitions for detentions
- **ITA Costs (funded by GF-S only)**
  - Testimony for ITA services
  - Reimburse county for Court costs associated with ITA
- **Crisis Stabilization Services**
  - Available 24/7; often referred to as hospital diversion
  - Typically managed by specific programs, apart from initial/emergent crisis services
  - Services provided for up to 14 days by an MHP, CDP or DMHP to individuals experience a mental health crisis, in the persons home or a home-like setting
- **Evaluation and Treatment Services**
  - Services provided in freestanding inpatient residential facilities or community hospitals to provide medically necessary evaluation and treatment services
- **E&T Room and Board Costs**

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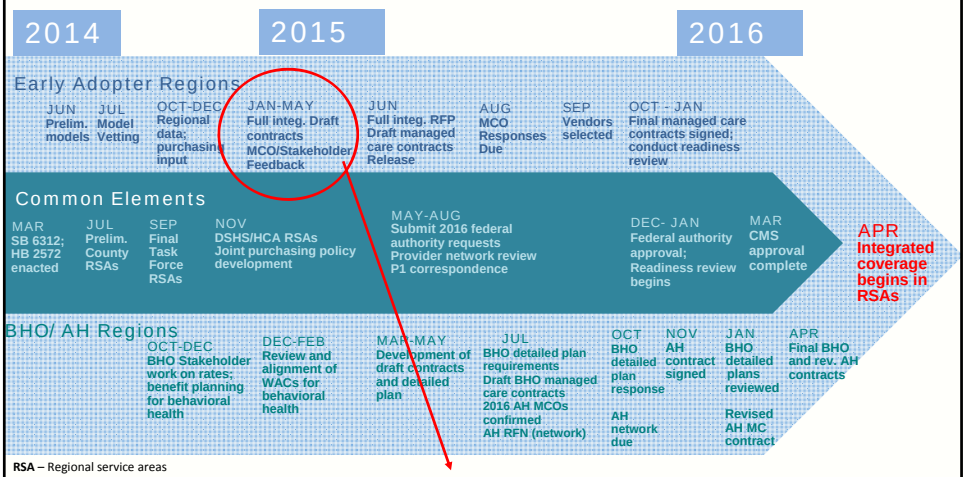
Medicaid Integration Timeline



RSA – Regional service areas
MCO – Managed Care Organization
BHO – Behavioral Health Organization
AH – Apple Health (medical managed care)
SPA – Medicaid State Plan amendment
CMS – Centers for Medicare and Medicaid Services
Early Adopter Regions: Fully integrated purchasing
BHO/AH Regions: Separate managed care arrangements for physical and behavioral health care

Key Opportunities for Feedback and Engagement
** County Letters of Intent Due: January 16, 2015

April 16, 2015
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Draft FIMC Contract: Overview

1. Definitions
2. General Terms & Conditions
3. Marketing & Information Requirements
4. Enrollment
5. Payment & Sanctions
6. Access to Care & Provider Network
7. Quality Assessment & Performance Improvement
8. Policies & Procedures
9. Subcontracts
10. Enrollee Rights & Protections
11. Utilization Management Program & Authorization of Services
12. Program Integrity
13. Grievance System
14. Care Coordination
15. General Requirements
16. Benefits
17. Business Continuity & Disaster Recovery

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Draft Section 1: Definition

1.108 "Indian/Tribal/Urban (I/T/U) Provider" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Organization which provides Medicaid-reimbursable services.

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Draft Section 10: Enrollee Rights & Protections

10.6.5 In the case of American Indian/Alaska Native (AI/AN) enrollees, the enrollee may choose a tribal clinic as his or her PCP, whether or not the tribal clinic is a network provider.

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Draft Section 14: Care Coordination

14.6 …The following measures shall be calculated and reported based on the populations served by clinic/agencies within a SOC as follows:

- 14.6.3 Clinics serving obstetrical population:
  - …
  - 14.6.3.2 LBW in American Indian/Alaska Native and African American population; and .

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Draft Section 15: General Requirements

15.4 Special Provisions for American Indians and Alaska Natives

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating Indian health care providers for contracted services provided to AI/AN enrollees at a rate equal to the rate negotiated between the Contractor and the Indian health care provider. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an Indian health care provider.

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Draft Section 16: Benefits

16.6.5 The Contractor shall make a reasonable and fair effort to subcontract with all local health departments, school-based health centers, family planning agencies contracted with HCA, and I/T/U Providers.

16.6.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or I/T/U Providers as participating providers or refers enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.

16.6.7 The services to which an enrollee may self-refer are:

- 16.6.7.4 All services received by American Indian or Alaska Native enrollees under the Special Provisions for American Indians and Alaska Natives Subsection of this Contract.

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Draft Section 4: Enrollment

- Placeholder in the contract for Benefits by Enrollment Groups table
- ALL Medicaid clients will be enrolled in a plan for behavioral health services only (BHSO)
- American Indian/Alaskan Native enrollees may opt in to Fully Integrated Managed Care
- Retroactive enrollment policy is planned for implementation in April 2016

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Draft Section 9: Tribal Relationships

9.8 Subcontracts with Indian Health Service (IHS), Indian Tribe Tribal Organization, and Urban Indian Organization (I/T/U) Providers

9.8.1 If an I/T/U Provider requests to enter into a subcontract with the Contractor, the contractor must negotiate in good faith with the I/T/U Provider and the subcontract with the I/T/U Provider must include:

9.8.1.1 General Special Terms and Conditions that approved by the I/T/U Provider and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of the same Special Terms and Conditions, in the format specified by the Agency, and a written statement that both parties have agreed to the Special Terms and Conditions.

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Draft Section 9: Tribal Relationships

9.8.2 Any subcontracts with I/T/U Providers must be consistent with the laws and regulations that are applicable to the I/T/U Provider. The Contractor must work with each I/T/U Provider to identify those areas that place legal requirements on the I/T/U Provider that are not applicable and refrain from passing these requirements on to I/T/U Provider.

9.8.3 The HCA Tribal Liaison may be available for technical assistance in identifying the legal requirements the of a subcontract between the Contactor and the I/T/U Provider.

9.8.4 In the event that the Contractor and I/T/U Provider fail to reach an agreement on a subcontract, including Special Terms and Conditions as described in Section 9.8.1, within 90 days of the Contract Start Date, the Contractor shall meet with the Agency and the I/T/U Provider within 105 days of the Contract Start Date in an effort to resolve differences and come to an agreement. Executive leadership of the Contractor shall attend this meeting in person and be permitted to have legal counsel present.

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Draft Section 9: BH Administration

1.69 Essential Behavioral Health Functions defined as: utilization management, grievance and appeals, ombuds services, network development and management, provider relations, quality management, data management and reporting, claims and financial management.

9.7.1 The Contractor shall achieve full integration of Essential Behavioral Health functions within 18 months of the effective date of this contract according to the following milestones.

9.7.2 Nothing in this Subsection 9.7 prohibits the Contractor from delegating care coordination and Health Home management to fully integrated providers. A subcontractor that is a provider of behavioral health services and providing behavioral health administrative functions has established a conflict of interest policy.

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Draft Section 9: Crisis Services

9.16.1 The Contractor shall contract with the HCA's selected Behavioral Health Administrative Services Organization (BH-ASO) for the administration of crisis services.

9.16.2 The Contractor shall reimburse the BH-ASO for behavioral health crisis services delivered to individuals enrolled in the Contractor's Early Adopter plan. The reimbursement shall be upon receipt of a valid claim per the requirements for timely accurate claims payment under this Contract or a monthly sub-capitation.

9.16.3 In order to ensure the current level of crisis funding for the Early Adopter Region is sustained for the initial two (2) years of the contract…: (HCA approves sub-cap; fiscal reconciliation)

9.16.4 The Contractor shall submit complete and accurate encounter data related to the provision of crisis services under this Contract in formats prescribed by the HCA.

9.16.5 The Contractor shall enter into a subcontract with the BH-ASO to evaluate and monitor the performance of the crisis system and develop corrective action where needed.

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Draft Section 14: Care Coordination

14.19.1 In the event the Contractor is aware that an enrollee is a Tribal Member or receiving behavioral health services from a Tribal or Urban Indian Health Program and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or Recognized American Indian Organization (RAIO) to assist in transitions for the enrollee. If the enrollee chooses to be served only by the Tribal Behavioral Health Service, a referral to a contracted network CMHA is not required.

14.19.2 If an enrollee is a Tribal Member of a Washington Tribe and is referred to or presents for non-crisis services and the enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the enrollee. If the enrollee chooses to be served only by the Tribal Behavioral Health Service referral to a contracted network CMHA is not required.

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14.19.3 Tribal Coordination for Crisis, Voluntary Inpatient and Involuntary Commitment Evaluation Services

14.19.3.1 The Contractor shall submit to the HCA Tribal Liaison a plan for providing crisis, ITA evaluation, voluntary inpatient authorization and discharge planning services on Tribal Lands within the Regional Service Area, on or before date to be determined, and developed in conjunction with the regional BH-ASO.

14.19.3.2 The plan shall be developed in conjunction with the affected Tribal entities within the region and must be co-signed by the appropriate Tribal representative for each affected Tribe.

14.19.3.3 The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.

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14.19.3.3 The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.

14.19.3.3.1 If the Contractor and Tribal entity are not able develop a plan or the tribe does not respond to the request, HCA will work with both the Tribes and Contractor to reach an understanding.

14.19.3.3.2 These meetings will be conducted in a manner which comports with the HCA government-to-government relationship with Washington Tribes.

14.19.3.3.3 Those Tribes whose Tribal lands lie within multiple regions, may develop joint plans with those Contractors. If a Contractor has multiple Tribal lands within their service region one plan may be developed for all Tribes if all parties agree.

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14.19.4 The plan must include a procedure for crisis responders and DHMPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.

14.19.4.1 Any notifications and authority needed to provide services including a plan for evening, holiday and weekend access to Tribal lands if different than business hours.

14.19.4.2 A process for notification of Tribal authorities when crisis services are provided on Tribal land, especially on weekends, holidays and after business hours. This must identify the essential elements included in this notification, who is notified and timeframe for the notification.

14.19.4.3 A description of how crisis responders will coordinate with Tribal Behavioral Health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal behavioral health providers will occur after a crisis service has occurred.

14.19.4.4 This must include the process for determining when a DMHP is requested and a timeframe for consulting with Tribal behavioral health providers regarding the determination to detain or not for involuntary commitment.

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14.19.5 ITA Evaluation Services

14.19.5.1 The plan shall include procedures for coordination and implementation of ITA evaluations on Tribal lands, including whether or not DMHPs may conduct ITA evaluations on Tribal lands.

14.19.5.2 If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom individuals will be transported to non-Tribal lands for ITA evaluations and detentions.

14.19.5.3 If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment facility.

14.19.5.4 The plan shall specify where individuals will be held and under what authority, if no E&T beds are available.

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14.19.6 Voluntary Hospital Authorization

14.19.6.1 The plan will include specifics as to how the Contractor would like Tribal Behavioral Health providers to request voluntary psychiatric hospitalization authorizations for Medicaid-eligible enrollees.

14.19.6.2 The Contractor shall provide to the Tribes information on how to request for voluntary authorization, appeals and expedited appeals. The plans shall reiterate that only a psychiatrist or a doctoral level psychologist may issue a denial and that denials may only be issued by the Contractor and not the crisis provider.

14.19.7 Inpatient Discharge Planning

14.19.7.1 The plan shall address a process for identifying the Tribal behavioral health provider as the liaison for inpatient coordination of care when the enrollee is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care. This includes all liaison activities required.

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- New terms introduced in the FIMC contract:
- "System of Care (SOC)" means a system of care is a framework for organizing and coordinating health care services and community resources into a comprehensive and interconnected network. SOC goals involve partnerships with the enrollee and the enrollee's support network and include the provision of services and resources from clinical and social service agencies. SOC services are delivered in a coordinated way and intended to achieve optimal enrollee health outcomes. (Systems of care may encompass: mental health, primary care, SUD treatment)

1.95 Health Care Settings (HCS): health care clinics where primary care services are delivered, community mental health agencies or substance use disorder agencies.

1.96 Health Care Setting - Care Coordinator (HCS-CC): a Registered Nurse, Mental Health Professional or Certified Chemical Dependency Professional who provides care coordination services in a health care setting, as opposed to in a centralized office of a managed care plan or care coordination organization.

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14.1 System of Care Strategic Plan

- The Contractor shall develop strategies that promote high quality and efficient care for the whole person. Contractor actions shall include the development of a system of care strategic plan for enrollees that allows for seamless delivery of physical, mental health (MH) and substance use disorder (SUD) services, including the delivery of social services, as needed to meet the health needs of the enrollee.
- The strategic plan shall address care coordination that includes two levels of services: Level 1 - Care Coordination (CC) and Level 2 - Health Home Care Management (HHCM).
- Level 1 – Care Coordination (CC) services shall be provided by both the Contractor (MCO-CC) and Health Care Settings (HCS-CC) as described in this section.
- Level 2 – Health Home Care Management (HH-CM) shall be provided in Health Care Settings or may be contracted to Care Coordination Organizations as described in Exhibit C, Health Homes.

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- Other requirements of note:
  - New screening tool requirements, such as GAIN-SS and SAMHSA Protocol
  - New performance measures, such as mental health and alcohol or drug treatment penetration rate
  - Allied System Coordination Plan
  - Special requirements for children and youth, such as WISe and Transitional Age Youth program
  - Continuity of care for enrollees in active behavioral health treatment
  - Coordination with Children's Long Term Care and State Mental Health Hospital

Other Draft Sections to Review

- Utilization Management
- Benefits
- Exhibit F, Essential Behavioral Health Providers

Next Steps

- Multiple Health Plan Procurement:
  - Request for Proposals for Medicaid/non-Medicaid managed care plans, June 18, 2015.
  - Due date for Responses, August 27, 2015.
  - Announcement of apparently successful bidders, September 30, 2015.
- Single Regional Administrator of Crisis and other Regional Services:
  - Request for Proposals, crisis services under administrative services organization, July 2015.
  - Due date for Responses, August, 2015.
  - Announcement of apparently successful bidders, September 30, 2015.

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Questions

- Input on the Contract?
- Also see: "Integrating Behavioral and Physical Health Care Purchasing" website, http://www.hca.wa.gov/hw/Pages/integrated_purchasing.aspx

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Closing Statements

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Thank you!

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