November 10, 2015

NOTES (FINAL MEETING RECORD)
TRIBAL ROUNDTABLE #2
BHO WAIVER, BHSO WAIVER, AND FIMC SPA

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

Agenda Setting

9:00 am	Blessing & Welcome/Introductions
9:05 am	Roundtable on ESSHB 2536 Report
9:35 am	Roundtable on BHO Waiver, BHSO Waiver, and FIMC SPA
	Agenda Setting & Opening Statements
9:45 am	Follow-up on Issues from Roundtable #1
	• Discussion
11:00 am	Additional Issues
	• Discussion
11:30 am	Agenda Setting/Planning for Consultation/Closing
12:00 pm	Closing

Attendees

Tribe/Organization	Name(s)
AIHC	Vicki Lowe
Chehalis Tribe	Nancy Dufraine
Nooksack Tribe	Rick George
Port Gamble S'Klallam Tribe	Ed Fox
Seattle Indian Health Board	Aren Sparck
Tulalip Tribe	Helen Fenrich
Upper Skagit Tribe	Marilyn Scott
Yakama Nation	Jay Sampson

Attendees

State Agency/Administration	Name(s)
DSHS/Behavioral Health Services Integration Administration	David Reed, Tara Smith, Tiffany Villines, Loni Greninger
DSHS/Office of Indian Policy	Tim Collins
Health Care Authority	Alice Lind, Isabel Jones, Becky McAninch-Dake, Jessie Dean, Michael Longnecker

Roundtable #1

NOTES

Roundtable #1 Notes

Notes from Roundtable #1 Discussion
Comment: Hospitals are not notifying Tribes that their clients (whether AI/AN or non-AI/AN) are being discharged from inpatient mental health treatment. As a result, these clients are being discharged without any coordination or adjustment to their care. Tribal clinics need to be notified when their clients receive inpatient crisis care. State Response: HCA is working on this issue for the ASO-BH contracts.
Comment: Hospitals are using their Navigators to move clients into MCO plans. State Response: Please let HCA know if you find a client whose coverage is changed through Healthplanfinder without the client's consent.
Comment: Spokane Tribe has some clients enrolled in an MCO plan, while they receive mental health and substance use treatment services at the Tribe.
Comment: Sometimes, RSNs make a determination about a client that the Tribes disagrees with. Tribes need to have the ability to challenge a determination by an RSN that a client does not meet the medical necessity or access-to-care requirements.
Comment: Shared capacity may be a solution, where Tribe and RSN/BHO each handles a piece. RSNs/BHOs need to use their case managers for these patients' safety. Tribes may not be able to. State Response: If the client has Medicaid and a diagnosis, it is the RSN's responsibility.
State Comment: The Program for Assertive Community Treatment (PACT) is an evidence-based service available through the RSNs/BHOs. This is a program for clients who have hard to service diagnoses, with 24/7 responsibility, case load of 10 or less, and minimum contacts of 4 per week. This is the most expensive tool in the tool box. More information is available at: (https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Publications/Mental%20Health%20-%20Program%20for%20Assertive%20Community%20Treatment%20(PACT)%20(2).pdf).

Roundtable #1 Notes

Notes from Roundtable #1 Discussion
Comment: Tribes probably don't know that the Program for Assertive Community Treatment (PACT) service exists. PACT is a powerful tool for dealing with very difficulty clients. State Response: HCA and DSHS will work together to share with Tribes more information about the PACT service.
Comment: On several cases, Spokane Tribe has been able to partner with the county crisis clinic to staff several of the Tribe's more severe patients. This has been helpful. We call each other to update each other on what is happening with those more severe cases.
Question: If MCOs in Clark and Skamania counties contract with inpatient mental health providers throughout the state for beds, will those beds no longer be available for clients who do not live in Clark and Skamania counties? State Response: Residential treatment is a concern, and we know there are capacity issues. The contract language for BHOs is aligned with the contract language for MCOs in Clark and Skamania counties. Hopefully, we will be able to develop some resources for residential treatment.
Comment: Access to specialty care is a major issue, which is true across the board. Due to the federal trust responsibility, we need to make sure that AI/ANs who are in the fee-for-service program have access to care. Some AI/ANs will not give up their participation in the fee-for-service system.
Comment: Are all Tribes aware that they are receiving block grant funding? It is not always obvious; it might be helpful to remind Tribes that are receiving block grant funding.
Question: Are I/T/Us going to have mediators if I/T/U disagrees with BHO assessment of no medical necessity?

Roundtable #1 Notes

Notes from Roundtable #1 Discussion
Comment: Moving clients from fee-for-service to MCO is a workaround and often a hardship. If the client is moved at the beginning of the month, you have to wait until the next month for the change to take effect and you often lose your opportunity to work with the client. State Response: Starting April 1, 2016, MCO changes during a month will be retroactive to the beginning of that month. This should help, even though this will not address the issues around coordination.
Comment: HCA needs to have MCOs accept I/T/U referrals as in-network referrals, even if referring I/T/U does not have a contract with the MCO. State Response: This would be a good topic for discussion at the MCO-Tribal meeting on November 18, 11 a.m. to 1 p.m. If any I/T/U is having challenges getting access to a provider that is contracted with only one MCO, please call that MCO (each MCO has a single point of contact for I/T/Us) or call Alison Robbins or Jessie Dean.
Question: Scenario: Tribal clinic provides outpatient SUD treatment to client in Apple Health. Tribe sends client to inpatient SUD treatment (also covered by Apple Health). When the client is discharged and returns home, the Tribal clinic resumes treatment of the client (covered by Apple Health). Will this change? State Response: No, this will not change.
Comment: MCOs' behavioral health plan subcontractors, like Optum and Centene, should be required to adopt and sign Indian Addendum. However, they shouldn't just treat the Indian Addendum like a pro forma document. This conversation with MCOs needs to cover all of the points we are talking about today.
Question: In many cases, RSNs have built up massive reserves – funds that should have been spent on client care. Will RSNs be required to transfer those reserves to the BHOs? State Response: There is no statutory authority to do that. RSNs will be required to transfer those reserves back to the State.

Roundtable #1 Notes

Notes from Roundtable Discussion
Comment: There are WAC amendments being proposed by DSHS related to the implementation of BHOs.
Comment: One of the challenges is that people use different language between mental health, SUD, and medical. We need to use the same language. For example, we should say "patient" in all systems (no more client or consumer). Similarly, the first visit in the PCCM model is called a "Patient Assessment" (no more intake or new patient visit). Another challenge is having a single patient number in our EHR systems (no more Target or Raintree numbers). The biggest challenge of all is compliance with federal regulations for SUD services, not just HIPAA.
Question: In BHO regions, low end mental health will be available through MCOs and the rest through BHOs. In the Early Adopter region (Clark and Skamania counties), will all mental health services be available through MCOs? State Response: Yes.
Comment: For BHO contracts, drug courts should be prohibited from requiring a contract with an I/T/U in order to refer clients to the I/T/U. It took a year for Cowlitz Tribe to get AI/ANs referred to the Cowlitz behavioral health program by King County, and King County tried to require that all AI/ANs be referred to one I/T/U exclusively. In addition, courts are wanting to refer patients solely to co-occurring disorder programs using medication-assisted treatment (MAT). This should not be permitted.
Comment: MAT is being shoved down everyone's throat. MAT should be an option, not a requirement. To support MAT, everyone keeps quoting a study in Sweden. No research exists supporting MAT for AI/ANs; it is offensive to try force this as best practice on minority populations.

Roundtable #1 Notes

Notes from Roundtable #1 Discussion
Question: Will behavioral health funding/reimbursement be tied to providing MAT? State Response: MAT is currently not tied to behavioral health funding/reimbursement. There are no plans at the State agencies to do so. State agencies cannot speak for the legislature, however.
Comment: Two State legislators are trying to pass legislation to increase MAT, perhaps tying funding to MAT. SIHB was the only provider at a meeting arranged by these legislators. Very political.
Comment: On November 12, Muckleshoot will be hosting the 5th Annual Northwest Tribal Opiate Symposium.
Question: What will the State do if an RSN chooses not to become a BHO? State Response: All RSNs have indicated their intention to become BHOs.
Question: How will Inter-Governmental Transfers (IGT) work with BHOs? State Response: The IGT requirement is incorporated into the Per Member Per Month (PMPM) rate. Tribes will continue to be responsible for the IGT match.

Roundtable #2

NOTES

Roundtable #2 Notes

Notes from Roundtable #2 Discussion
Comment: UIHOs do not want to contract with BHOs in order to provide BHO-administered services. State Response: DSHS is meeting with SIHB next week Friday. DSHS has no legal authority to contract separately with UIHOs.
Comment: Patient care needs to be better coordinated with I/T/Us • Hospitals need to notify I/T/Us when their clients are being discharged from inpatient mental health treatment. • BHOs and PACT and WISe teams need to work with I/T/Us • Payments should be tied to I/T/U notification State Response: State will look into facilitating: • Government-to-government training for providers, including WISe teams • ICW and cultural competency training • Development of written primer for providers • Use of DBHR Tribal Liaison State will also reach out to Washington State Hospital Association and discuss with BHOs and MCOs the need to notify I/T/Us of discharges.

Roundtable #2 Notes

Notes from Roundtable #2 Discussion
Comment: I/T/Us need administrative process to resolve differences with BHOs, from major policy and process issues to individual determinations of lack of medical necessity • Need mediation requirement • Need meetings of BHOs and Tribes before April 1, 2015 to start building trust and establishing common understanding of roles and functions State Response: DBHR Tribal Liaison is working on bringing the BHOs into better communication with Tribes.
Comment: If MCOs in Clark and Skamania counties contract with inpatient mental health providers throughout the state for beds, will those beds no longer be available for clients who do not live in Clark and Skamania counties? State Response: These contracts are private contracts between MCOs and providers, which have not yet been entered into. The State will need to wait and see what happens. In addition, MCOs and BHOs have requirements to provide necessary care. If they fail, they are subject to patient appeals. In addition, they are monitored for outcomes measures and quality.

Roundtable #2 Notes

Notes from Roundtable #2 Discussion
Question: What will be the protocol for I/T/Us to get authorization for inpatient substance use disorder treatment? State Response: [START HERE]
Need to improve access-to-care for AI/AN clients • I/T/U referrals deemed to be in-network for MCOs?
DSHS should remind Tribes whether they are receiving or not receiving block grants
HCA needs to require MCOs' behavioral health plan subcontractors (Optum, Centene) to adopt the Indian Addendum (additional concern that organizations are not fulfilling the obligations in the Addendum)
Everyone needs common language across care types • Patient vs. client vs. consumer • Assessment vs. intake vs. new patient visit

Roundtable #2 Notes

Description
Drug courts should be prohibited from: • Requiring a contract with an I/T/U in order to refer clients to the I/T/U. • Pushing for exclusive contracts with one I/T/U in their regions.
Medication-assisted treatment (MAT) • Is not an evidence-based practice for AI/ANs • Should not be required for referrals (e.g., from drug court) or reimbursement/funding

Tribal Consultation

PROPOSED AGENDA

Tribal Consultation Proposed Agenda