



Slides & Notes from Meeting with Tribes on State Health Reform

January 5, 2015

Attendees

Tribal Attendees

- Chehalis Confederated Tribes - Charlene Abrahamson
- Colville Confederated Tribes - Nancy Johnson, Colleen Cawston
- Kalispel Tribe - Ron Poplawski
- Lummi Nation - Maureen Kinley, Cheryl Sanders
- Port Gamble S'Klallam Tribe - Ed Fox, Kerstin Powell
- Puyallup Tribe - Jennifer LaPointe
- Quileute Tribe - Andrew Shogren
- Seattle Indian Health Board - Aren Sparck
- Shoalwater Bay Tribe - Kim Zillyet-Harris
- Skokomish Tribe - Tiffany Eklund
- Snoqualmie Tribe - Rebecca Crocker
- Spokane Tribe - Ann Dahl
- Suquamish Tribe - Robin Sigo, Leslie Wosnig
- Swinomish Tribe - John Stephens
- Tulalip Tribes - Rose Lukes
- Upper Skagit Tribe - Marilyn Scott
- Yakama Nation - Jay Sampson
- American Indian Health Commission - Jan Olmstead
- South Puget Intertribal Planning Agency - Tamara Fulwyler

State Attendees

- HCA
 - Dorothy Teeter - Director
 - MaryAnn Lindeblad – Medicaid Director
 - Nathan Johnson – Assistant Director
 - Jessie Dean – Tribal Affairs Administrator
 - Chase Napier – ACH Program Manager
 - Mike Longnecker – Tribal Program Specialist
 - Rachel Burke – Communications Consultant
- DSHS
 - David Reed – Acting Office Chief, Mental Health
 - Tiffany Villines – Behavioral Health Administrator



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This deck of slides is the final record of the meeting between HCA and the Tribes on January 5, 2015. These slides are organized as follows:

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 - Slides presented on January 5, 2015*
 - Notes from discussion that followed
2. Accountable Communities of Health (Healthier Washington)
 - Slides presented on January 5, 2015*
 - Notes from discussion that followed
3. Non-Tribal Provider Payment Redesign (Healthier Washington)
 - Slides presented on January 5, 2015*
 - Notes from discussion that followed
4. Practice Transformation Support (Healthier Washington)
 - Slides presented on January 5, 2015*
 - Notes from discussion that followed

**Slides presented on January 5, 2015 are indicated in the upper left corner of the slide.*

Slides presented on January 5, 2015 on

Integrated Medicaid Purchasing

Slide Presented on January 5, 2015

Apple Health (Medicaid) Managed Care

- **Since early 1990s, Medicaid transitioning beneficiaries to health plans** with CMS approval
- **Today, over 90% of full-benefit Medicaid eligibles** covered through Apple Health Managed Care Plans
- **State pays PMPM (per-member, per-month) to Plans** with defined set of benefits for defined groups — each Plan is fully at risk for care of assigned population
- **Currently, Apple Health Managed Care Plans cover** physical health care services and mental health care services below the access to care standard

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Slide Presented on January 5, 2015

Medicaid Managed Care Purchasing Today: Not Integrated

State contracts with entities to provide Medicaid services by county

	Entity
Physical health care	MCOs
Mental health care	
• Below "access to care" standard	MCOs
• Above "access to care" standard	RSNs

MCO = Medicaid Managed Care Organization RSN = Regional Support Network

Other Medicaid services (such as chemical dependency treatment and dental services) are provided outside of managed care (on a fee-for-service basis)

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Slide Presented on January 5, 2015

Legislative Directives (Senate Bill 6312)

Purchasing Reforms

- **Regional purchasing** - DSHS & HCA jointly establish common regional service areas for behavioral health and medical care purchasing
- County authorities elect fully integrated purchasing ("**Early Adopters**") by April 2016, with opportunity for shared savings incentive payment (up to 10% of state savings in region)
- **Other regions – separate managed care contracts** for physical health (MCOs) and integrated behavioral health care (newly created **Behavioral Health Organizations**)

Clinical Integration

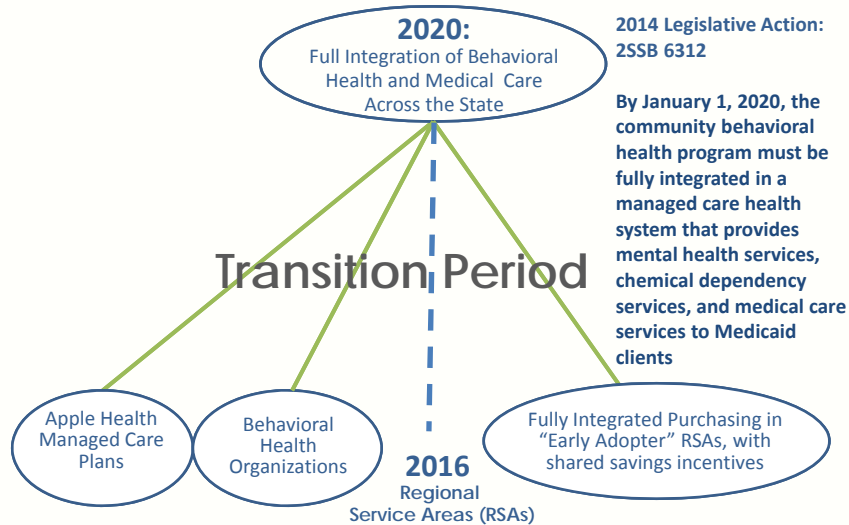
- Primary care services available in mental health and chemical dependency treatment settings and vice versa
- Access to recovery support services
- Opportunity for dually-licensed CD professionals to provide services outside CD-licensed facility

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Washington State Health Care Authority

Slide Presented on January 5, 2015

Parallel Paths to Integrated Managed Care



Washington State Health Care Authority

Slide Presented on January 5, 2015

Goals of Integrated Managed Care

- **Provide more holistic, better managed care** for people with co-occurring disorders.
- **Support seamless access to services** with standards and medical necessity guidelines in one system, without “access to care” standard.
- **Improve ability to monitor quality** across all providers
 - Quality metrics in managed care contracts
 - Sanctions for specific performance measures.
- **Align financial incentives** for expanded prevention and treatment and improved outcomes across physical and behavioral health systems.
- **Create system for interdisciplinary care teams** that are accountable for full range of physical and behavioral health services.
- **Improve information and administrative data sharing**, making relevant information more available to multidisciplinary care team.

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Medicaid Managed Care Purchasing in 2016

State will contract with entities to provide Medicaid services by RSA

	Today	Beginning April 1, 2016	
	By County	All Other RSAs	Early Adopter RSAs
Physical health care	MCOs	MCOs	MCOs
Mental health care			
• Below “access to care” standard	MCOs	MCOs	MCOs*
• Above “access to care” standard	RSNs	BHOs	
Chemical dependency treatment	FFS	BHOs	MCOs

*There will be no “access to care” standard in Early Adopter RSAs
 BHO = Behavioral Health Organization
 FFS = Fee-For-Service (not managed care)
 MCO = Medicaid Managed Care Organization
 RSA = Regional Service Area
 RSN = Regional Support Network

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Criteria for Regional Service Areas

- Include full **counties that are contiguous** with one another
- Reflect natural medical and behavioral health **service patterns**
- Include a **sufficient number of Medicaid lives** to support full financial risk managed care contracting
- Ensure **access** to adequate provider networks
- **Minimize disruption** of business relationships (i.e., provider, payer and community) that evolved over time

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Goals for Regional Service Areas

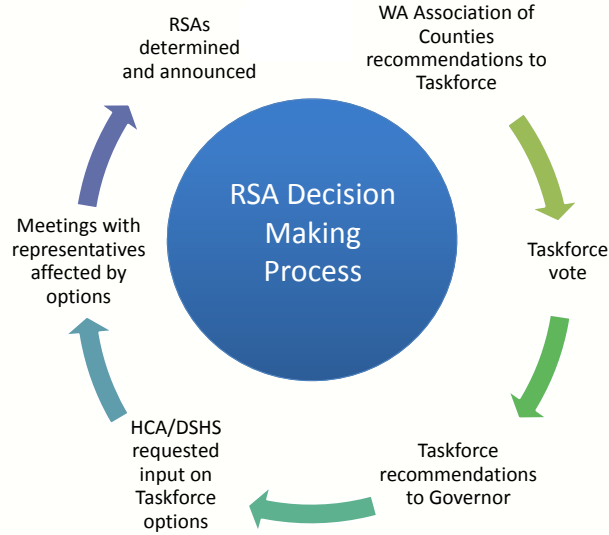
- **Align interests around common population**, especially individuals who have complex, high cost, multi-system service use and needs
- **Bring partners together for shared accountability** and to meet the legislated outcome measures of SB 5732 and HB 1519
- Serve as **platform for fully integrated managed care** delivery systems **by 2020**, as directed by statute
- Provide **framework for evolution of community role** in Medicaid purchasing through Accountable Communities of Health (ACHs)

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RSA Designation Process Directed by Statute



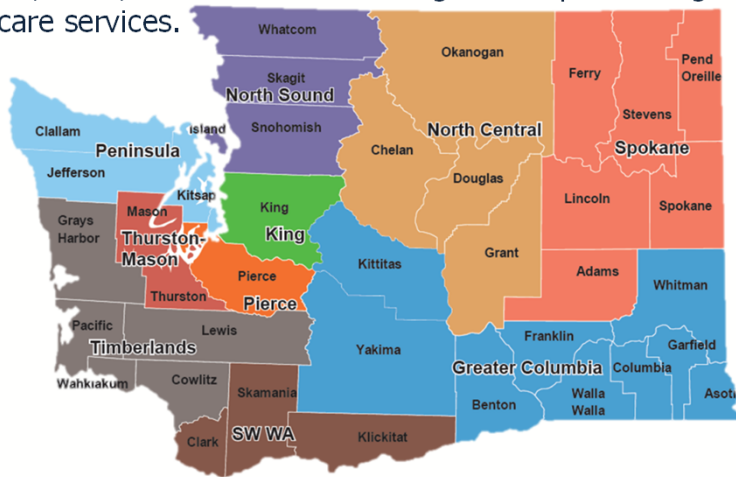
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Regional Service Area Designations

By April 1, 2016, HCA and DSHS will regionalize purchasing of health care services.



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North Central Alternative

Transitional two-RSA approach for counties presently served by the Chelan-Douglas and Spokane Regional Support Networks:

- **Apple Health Managed Care:** New North Central RSA separate from Spokane RSA
- **BHO:** Single BHO will serve new North Central and Spokane RSAs during the transition
- **2020 Full Integration:** Fully integrated managed care is required in 2020 by Senate Bill 6312. North Central and Spokane RSAs will be separate regions for purposes of integrated physical and behavioral health managed care systems in 2020.

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Special Cases – Potential Early Adopter RSAs

Counties in 3 RSAs have expressed interest in early adoption of fully integrated physical and behavioral health care purchasing in 2016. Non-binding letters of intent are due in January 2015.



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Medicaid Purchasing in “Early Adopter” RSAs

- Standards being developed jointly by HCA and DSHS
- County authorities in Regional Service Area must agree to become Early Adopter RSAs
- Procurement process will be necessary to select MCOs
- Compliance with Medicaid and State managed care contracting requirements
- Shared savings incentives
 - Payments to Early Adopter counties targeted at 10% of savings realized by the State, based on outcome and performance measures
 - Available for up to 6 years or until fully integrated purchasing occurs statewide
- Models continue to be discussed broadly

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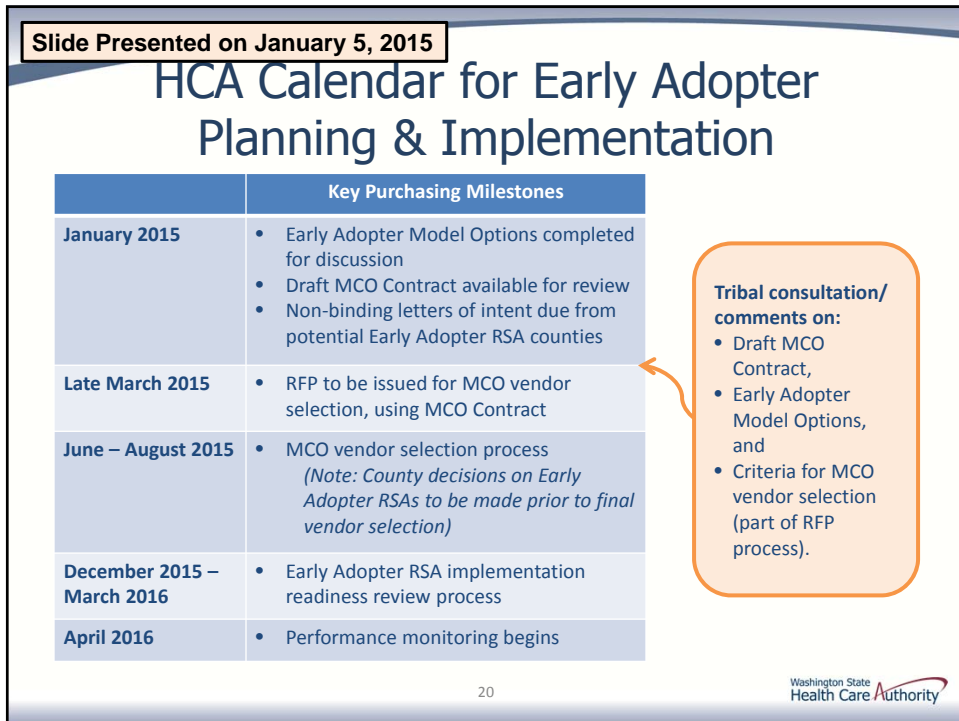
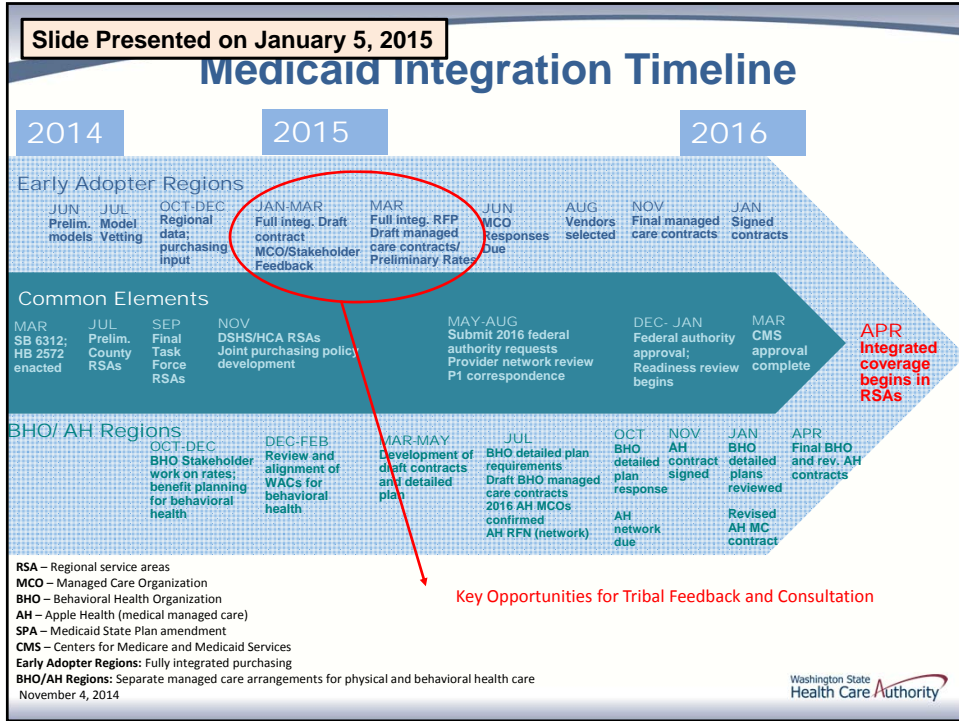
Some Criteria for MCO Early Adopter Participation

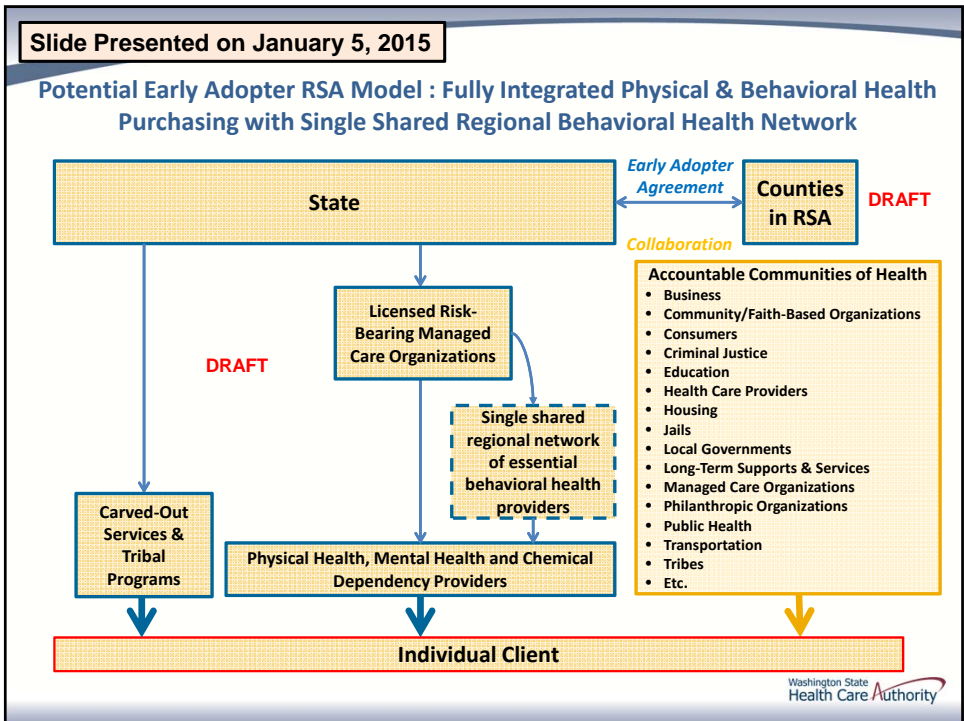
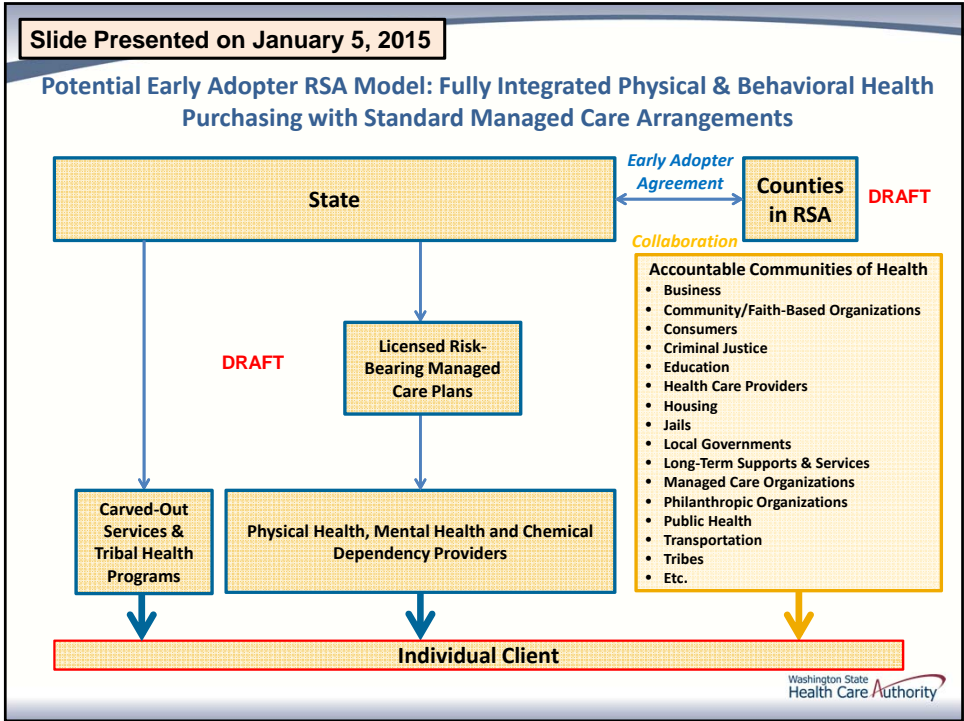
Managed care organizations must:

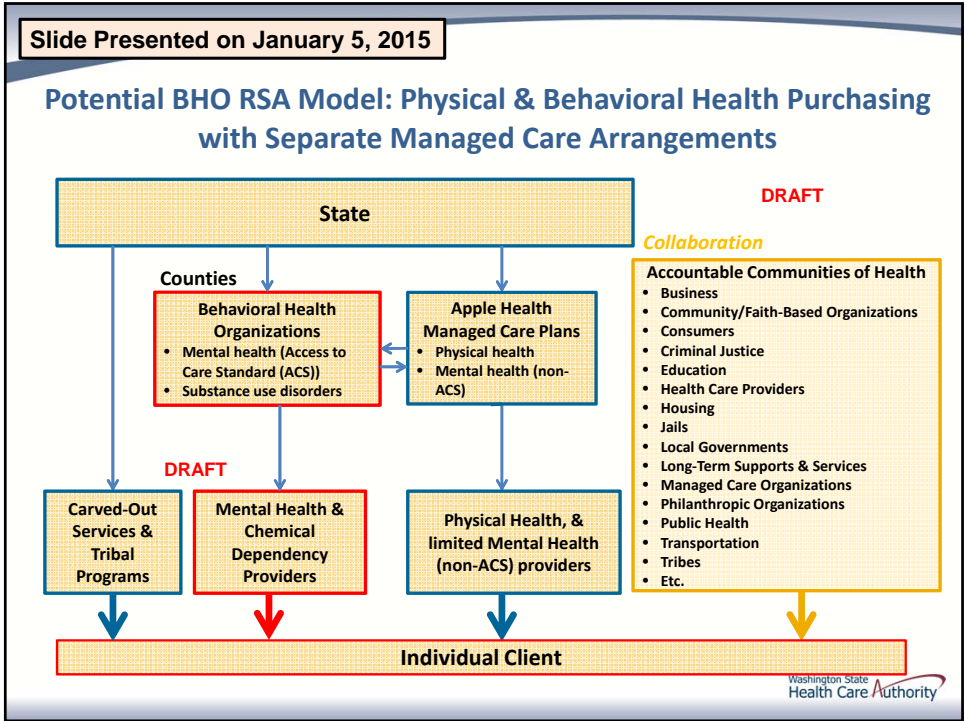
- Meet network adequacy standards established by HCA and pass readiness review
 - Provide full continuum of comprehensive services, including critical provider categories (e.g., primary care, pharmacy, and behavioral health)
 - Ensure no disruption to ongoing treatment regimens
- Be licensed as an insurance carrier by the Office of the Insurance Commissioner
- Meet quality, grievance and utilization management and care coordination standards and achieve NCQA accreditation by December 2015

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Current Medicaid + Non-Medicaid Service Administration

AI/AN Population	MC Plan?	Medicaid Funded Services	Entity	State/Local Funded Services	Entity	
Medicaid Enrollees	Yes	Physical + some mental health	MCO	Examples: • Involuntary Treatment Act • Therapeutic Courts • Transitional Care Coordination from Prison or IMDs • Inpatient chemical dependency treatment • IMD/State Mental Health Hospital inpatient care	• RSN	
		Mental health	RSN			• County
		Chemical dependency	County FFS			
	No	Physical + some mental health	FFS		• RSN/ County	
		Mental health	RSN + FFS		• State	
Chemical dependency	County FFS	• State				
Not Eligible for Medicaid					• State	

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Medicaid Integration Planning – Early Adopter RSAs

AI/AN Population	MC Plan?	Medicaid Funded Services	Entity
Medicaid Enrollees	Yes	Physical health, mental health, and chemical dependency services	MCO
	No	Physical health, mental health, and chemical dependency services	FFS*
Not Eligible for Medicaid			

Questions - Early Adopter RSAs:

- How can HCA facilitate better care for Medicaid enrollees who opt out of Managed Care? What can HCA do to convince AI/ANs to remain in Managed Care??
- How can HCA best support Tribal clinics? Would Tribal clinics consider becoming in-network providers?
- How can HCA facilitate more effective care coordination between BHOs and MCOs across RSAs?

*In Early Adopter RSAs, there may not be a county-based entity responsible for mental health or chemical dependency treatment.

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Medicaid Integration Planning – Early Adopter RSAs

State/Local Funded Services	Potential Entities in Early Adopter RSAs to Perform Service
<p>Examples:</p> <ul style="list-style-type: none"> • Involuntary Treatment Act • Therapeutic Courts • Transitional Care Coordination from Prison or IMDs • Inpatient chemical dependency treatment • IMD/State Mental Health Hospital inpatient care 	MCO <ul style="list-style-type: none"> • With services carved-in or carved-out of MCO contract
	ASO (administrative service organization) <ul style="list-style-type: none"> • For services carved-out of MCO contract
	County <ul style="list-style-type: none"> • Alternative to ASO

Questions – Early Adopter RSAs:

- Are Tribes performing any of these non-Medicaid services for their clients?
- What are Tribes’ and Urban Indian Organizations’ thoughts or concerns regarding the potential entities to perform non-Medicaid services in Early Adopter RSAs?

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Notes from Discussion on

Integrated Medicaid Purchasing


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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Mobile clients: What protections will MCO clients have when they travel outside an RSA?	MCO clients will have access to urgent care when traveling outside an RSA (like today).
Access to specialty care: What happens if MCO client needs access to a provider type not in an RSA?	MCO clients who need specialty care not available in RSA will be referred to provider outside the RSA (like today).
Medicaid incentives for providers: Are there plans to improve incentives for providers to accept Medicaid?	MCOs ensure access to sufficient providers in their networks, but this is a challenge for fee-for-service.
IHS encounter rate: Will Tribes receive the encounter rate in Medicaid managed care?	The encounter rate is paid as a wraparound payment for care to AI/ANs enrolled as MCO clients.
Federal grant opportunity: There is currently a federal grant opportunity for tribal care integration.	HCA would be happy to work with Tribes on this. Please share more on this.

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
County oversight of MCOs/BHOs: Tribes are not subordinate to the counties, but counties appear to be the primary governance authorities.	AI/ANs continue to be exempt from Medicaid managed care, but this raises the following questions. Tribes and counties have roles to play in MCO oversight.
<i>HCA Question: How do we make sure Tribes still have access to behavioral health services in Early Adopter RSAs?</i>	
<i>HCA Question: How do we best serve AI/ANs and Tribes in this changing Medicaid purchasing environment?</i>	
MCO contracts with Tribes: It has been difficult even for Tribes that want to contract with MCOs to finalize these contracts. What will be done?	HCA would appreciate Tribal input on how to make contracting with MCOs more streamlined and effective.
Culturally competent care: Tribes do not want interference from MCOs.	HCA agrees.

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
MCOs and Tribes: Why isn't there a requirement for MCOs to collaborate with Tribes?	Until recently, Tribes have been mostly outside the MCO system. HCA is now seeking input from Tribes to bring better collaboration/coordination with MCOs.
PCCM and Health Homes: What's happening with the PCCM and Tribal Health Home programs?	HCA is currently in discussions with CMS on the PCCM program. The Tribal Health Home program is for higher need clients.
Health equity goals in MCO contract: For the Early Adopter regions, would HCA include RFP criteria for MCOs to target health equity goals, such as reducing uninsurance among urban AI/ANs? North Sound RSN is working with Tribes on how they will meet AI/AN needs.	Great suggestion.

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Tribal comments to MCO contract: It is important for Tribes to comment on the HCA-MCO contract.	The comment window will be short, but we want Tribal comments. We will also share the set of clinical criteria HCA is working on; this is still a few weeks out.
Tribes in Early Adopter RSAs: Which RSAs will be Early Adopters?	The counties have until January 16, 2015 to give non-binding letters of intent to be Early Adopters. We have received indications of interest from King County, Pierce County, and Clark County.
Tribes and MCO RFP review: Can Tribes be part of the RFP review?	We would appreciate input from the Tribes. Tribes can also participate in developing the MCO selection criteria that will drive the RFP review.
List of Non-Medicaid Services: Can Tribes get the full list of non-Medicaid services?	HCA will provide the full list when it is completed.

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Burden to Tribes: Creating new relationships in a new system is an added burden for Tribes. This is a huge job.	HCA will do what it can to reduce this burden.
Lack of trust with MCOs: Tribes still do not trust MCOs and RSNs (to be BHOs).	HCA would like to hear what has been problematic in the past and how HCA could facilitate better relations.
IHS encounter rate: Washington needs to protect the IHS encounter rate.	HCA has no intention to eliminate the IHS encounter rate.
MCO standards for Tribes: What MCO standards will Tribes have to adhere to if they contract with MCOs?	HCA is hosting a meeting with the MCOs and Tribes in Olympia on February 13, 2015 to discuss these issues.
Specialty networks and Tribes: Tribes need guarantee that MCOs will work with Tribes in effective way for AI/ANs to access MCO specialty networks.	

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
MCO pass-through of encounter rate: Why doesn't the State allow MCOs to pay Tribes the encounter rate? The Tribes would prefer this.	HCA and MCOs are in the middle of implementing this for FQHCs. HCA will look into extending this to Tribes after the kinks are worked out.
MCO interest in/support to Tribes: Tribes have excellent programs. MCOs should be knocking on our doors to learn and support our programs, instead of telling us to follow their rules. How do MCOs see themselves helping Tribes to become better primary care providers?	HCA is hosting a meeting with the MCOs and Tribes in Olympia on February 13, 2015 to discuss these issues.
MCOs and encounter rate: If Tribes contract with MCOs, how will that affect the encounter rate?	Tribes will still be able to receive the encounter rate for services to MCO-enrolled AI/ANs. MCOs pay providers in many ways, in attempts to reward keeping clients healthy rather than encounters.

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Integrated Medicaid Purchasing


Tribal Thoughts/Concerns	HCA's Response
MCOs and Tribal network adequacy: What incentives will MCOs have to contract with Tribes? It has been difficult.	MCOs have network adequacy requirements. Tribes may be very attractive in some parts of the State.
Tribal members and MCOs: Tribal members do not trust outside entities. This is not going to be easy.	HCA would like to work with Tribes to identify the benefits and the concerns from contracting with MCOs.
MCO contract and non-Natives: If a Tribe contracts with an MCO, will the Tribe be forced to see non-Native patients? If a Tribe sees non-Native patients for medical care but not for behavioral health care due to lack of capacity, will contracting with an MCO interfere with the Tribe's decision on whom to treat?	HCA and the MCOs have certain legal requirements regarding access, waiting periods, urgent care, etc. However, Tribes have the right to determine whom their clinics treat. HCA would like to hear more about these concerns and work through these issues with Tribes.

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Tribes are different: Different Tribes have different issues. These issues are more complex than Medicaid expansion.	HCA will email a list of issues and ask Tribal Health Directors to identify which issues apply to their Tribe.
Tribal MCO: For Tribes that serve only AI/AN clients, can they be an MCO for natives?	HCA can explore this with the Tribes.
Facility-based payment: Tribal clinic may have multiple primary care providers who serve clients as a team. MCOs seem to expect one PCP to see the client. If this does not happen, the MCO holds up payment.	More and more patients are being assigned to a clinic rather than a provider. This is pretty easily negotiated in a contract.
MCO support for case management: We don't get paid for case management, but it is very effective so we do it.	More and more MCOs are paying for community health workers, nurses, social workers. Many more options than before.


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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Tribes that opt out: MCOs and Tribes are of two different cultures. MCOs focus on money; Tribes focus on sustainable care. How can Tribes not be pressured to contract with MCOs (opt out of the managed care system)?	AI/ANs will continue to have the federal exemption from managed care, and Tribes will continue to receive the encounter rate for services provided at the Tribal clinic.


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Slides Presented on January 5, 2015 on

Accountable Communities of Health


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Slide Presented on January 5, 2015

Healthier Washington

- Improving how we pay for services
...so people and their providers can choose the best treatment options
- Ensuring health care focuses on the whole person
...people's physical and mental health care are integrated to better meet their needs
- Building healthier communities through a regional approach
...local organizations work together to build strategies that work for their community



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Healthier Washington

Strategies include:

- Accountable Communities of Health *to support locally-driven goals, approaches, and processes*
- Redesign of provider payments* *to improve the quality and value of care*
- Creation of a regional extension service *to share information about best practices*

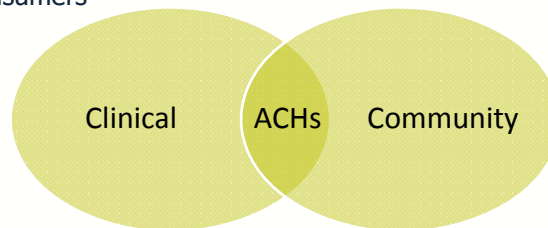
*Tribal clinics will not be affected

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Accountable Communities of Health

What is an Accountable Community of Health (ACH)?

- A group of public and private organizations and individuals working together to integrate health care and improve health in their region
- Participants include: public health, housing, and social service providers; MCOs; insurers; county and local government; Tribes; and consumers



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Accountable Communities of Health

ACHs are intended to regionally align with Regional Service Areas (RSAs) in order to enable ACH input on Medicaid purchasing priorities to ensure they are responsive to regional health needs. ACH input will be informed by data on population health produced by HCA and DSHS and its partners and provided to the ACH for development of a health action plan.

The State proposes phased engagement of ACHs based on the evolution of the ACH Initiative and the maturation of ACHs as follows:

1. **Statewide procurement objectives** that address regional needs and perspectives;
2. **Assessment of MCO RFP responses** for the ACH's specific region;
3. **On-going oversight of MCO and BHO effectiveness**;
4. **Sharing of public health and managed care data** to inform priorities for improving health within the ACH in partnership with public and private entities within the ACH boundary.

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Accountable Communities of Health

An Accountable Community of Health is **not** intended to:

- Add approval layers
- Replace government entities
- Divert state funds
- Bear financial risk

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Accountable Communities of Health

The ACH Timeline

Q3 2014	Q4 2014	2015	2016	2017	2018
COH Planning Grants					
		Two Pilot ACHs			
		Design Regions			
		Progression through the "ACH Continuum"			
					Fully functioning ACHs by the end of 2018!

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Accountable Communities of Health

Total Four-Year ACH Budget: \$10.8 million

- ACH Design and Implementation (including personnel, travel, consultants, grants)
 - Year 1
 - ~ 2 Pilot ACHs
 - ~ 8 Design Regions
 - Years 2 – 4
 - ~ 10 ACHs
- ACH-Tribal Coordination

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Accountable Communities of Health

Total Four-Year ACH-Tribal Coordination Budget: \$300,000

Proposed Funding Structure for RFP:

- Year 1 (pre-implementation year): \$75,000
- Year 2: \$150,000
- Year 3: \$50,000
- Year 4: \$25,000

Proposed Contract Deliverables to HCA:

- Protocols, templates, coordination plans for ACHs to engage with Tribes in their regions
- Data analytic recommendations for ACHs
- Recommendations for maintaining ACH-Tribal coordination process



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Accountable Communities of Health

ACH-Tribal Coordination

- Principles
 - Health disparity reduction is a key goal of ACHs
 - ACH participants are expected to understand and respect the Tribal-State government-to-government relationship
- Framework
 - Tribal representation on local ACH governance/oversight board
 - Tribe may invoke right to have State participate in any ACH meetings
 - State must be cc'd on all written communication from ACH to Tribes



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Accountable Communities of Health

ACH-Tribal Coordination

- Financial Support
- Deliverables
- Principles
- Framework

How can HCA facilitate productive relationships between ACHs and Tribes/Urban Indian Organizations in order to improve the health of American Indians/Alaska Natives?


Notes from Discussion on

Accountable Communities of Health

Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
<p>ACH Function: What is an ACH supposed to do?</p>	<p>ACHs are regional partnerships of care providers, social service providers, and community organizations - intended to serve as regional connectors, bringing together programs and services to work better to address the needs of the whole person and improve the well-being of the community. ACHs would, for instance, link health with housing, criminal justice, etc.</p>
<p>ACH Structure: What will an ACH be? What will it look like?</p>	<p>Regional "lead organizations" have been doing planning, learning from mistakes over the past year. While the organizational structure may differ from RSA to RSA, HCA envisions boards of directors with Tribal representation.</p>


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Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
<p>Accountability of ACHs: What is the mechanism to hold an ACH accountable? RSNs have not worked for Tribes at all.</p>	<p>There are two components to ACH accountability: (1) voluntary compact by which the ACH is held accountable to its participants/the community; and (2) funding from the community to sustain the ACH. With these two elements, ACHs are held accountable to their communities.</p>
<p>Government-to-Government: If you go directly to the county without going to the Tribes at the same time, it looks like Tribes are subordinate to the county, and that is not acceptable. Also, if these are non-profits, what is the take on having a government-to-government relationship with ACHs?</p>	<p>The Tribes have a government-to-government relationship with the State, which is HCA in this context. With HCA delegating some duties to ACHs in order to regionalize decision-making, HCA still has the responsibility to maintain the government-to-government relationship with the Tribes.</p>

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Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
<p>Tribal-ACH Relations: Will my staff feel comfortable attending ACH meetings, even ACH governance meetings? Tribes often feel like little fish in big ponds with much bigger fish (hospitals, managed care organizations, etc.). How do Tribes become prepared to be effective in these big ponds?</p>	<p>HCA has budgeted \$300,000 for the Tribes to plan for the best way to interact with ACHs effectively. The Tribes could work through a Tribal coordinating entity, for instance, to identify key issues for each ACH or to develop a template of ACH requirements for addressing AI/AN health disparities.</p>
<p>Tribal Representation on ACH: In some RSNs, Tribes get 1 vote even though there might be up to 8 Tribes in that RSN's region. Tribes are not always recognized on a government-to-government basis.</p>	<p>The ACHs are in the planning phase now and will be over the course of 2015. If Tribes have additional requirements for ACHs that they would like to see, HCA wants to work with Tribes on this. HCA is looking to make the government-to-government relationship work in the context of ACHs.</p>

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Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
<p>ACH Coordination of Services: Will the services that ACHs coordinate compete with Tribal services for funding?</p>	<p>ACHs will not displace what Tribes are doing. ACHs can supplement what Tribes are doing by bringing in non-Tribal services, if the Tribes want that. ACHs are intended to help communities work together.</p>
<p><i>A SPIPA representative noted that SPIPA decided that it would not move forward as a lead organization for ACH planning and development.</i></p>	
<p>State Commitment to ACHs: If this is so good, where is the state dollars to support this?</p>	<p>Last year, the legislature appropriated \$1 million for this effort. HCA, DSHS, DOH have also contributed in-kind support to complement the federal CMMI funding.</p>
<p>Cultural Competency: With so many other issues, it would help to have others address cultural competency issues.</p>	<p>During this ACH planning period, HCA can include requirements, such as cultural competency training.</p>

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Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
Tribal Next Step: Each Tribe designates someone to link to these efforts. Is this a "To Do" we could take care of?	Yes, and please let HCA know how you (the Tribes) are experiencing those efforts.
More Information: Where can we find out more information about these ACH lead organizations?	The list of ACH lead organizations can be found at: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

Slides Presented on January 5, 2015 on

Non-Tribal Provider Payment Redesign

Slide Presented on January 5, 2015

Redesign of provider payments

The state – as “first mover” – will move away from a fee-for-service reimbursement system to an outcomes-based system that:

- Integrates physical and behavioral health
- Measures and reports on the quality, effectiveness, and cost of services provided
- Focuses on quality improvements in care
- Makes use of decision aids for providers and consumers
- Promotes workforce wellness programs

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Models for payment redesign

- **Model Test 1: *Early adopters of Medicaid integration***
Test how integrated Medicaid financing for physical and behavioral health accelerates integrated delivery of whole-person care
- **Model Test 2: *Encounter-based to value-based***
Test a value-based alternative payment methodology in Medicaid for federally-qualified health centers and rural health clinics and pursue new flexibility in delivery and financial incentives for participating Critical Access Hospitals
- **Model Test 3: *Puget Sound PEB and multi-purchaser***
Through existing PEB partners and volunteering purchasers, test new accountable network, benefit design and payment approaches
- **Model Test 4: *Greater Washington multi-payer***
Test integrated finance and delivery through a multi-payer network with a capacity to coordinate, share risk and engage a sizeable population

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Redesign of provider payments

Note: Tribal clinics will not be affected by any of the planned Model Tests for provider payment redesign.

If Tribal clinics were guaranteed at least the IHS encounter rate, what value-based payment methods might Tribal clinics consider to better support:

- Quality care and
- Integrated physical and behavioral health?

Notes from Discussion on

Non-Tribal Provider Payment Redesign

Non-Tribal Provider Payment Redesign

Tribal Thoughts/Concerns	HCA's Response
<p>IHS Encounter Rate: It is very important for a number of Tribes that the separate categories for physical health and behavioral health be kept separate.</p>	<p>HCA's efforts to redesign provider payments are <u>not</u> targeted at Tribal providers. Neither DSHS nor HCA has any plan to change the encounter types for the IHS encounter rate.</p>
<p>Funding of Behavioral Health: The one area of concern for me is state block grant funding. How can we maximize the benefit for AI/ANs?</p>	<p>DSHS and HCA want to work with Tribes to maximize the benefit for AI/ANs.</p>
<p>Multiple Performance Measures: Tribes are already reporting on multiple performance measures. Any effort aimed at Tribes has to work with measures Tribes are already tracking.</p>	<p>HCA's efforts to redesign provider payments are <u>not</u> targeted at Tribal providers. HCA wants to work with providers to use performance measures efficiently – not impose redundant measures.</p>

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Non-Tribal Provider Payment Redesign

Tribal Thoughts/Concerns	HCA's Response
<p>Issues with Payment Redesign: Payment redesign tied to performance measures often requires more information technology and a longer term to see result, but there is no money for IT needs and the timeframe before money is taken away is shorter term.</p>	<p>As HCA works on non-Tribal payment redesign, HCA will keep these concerns in mind.</p>

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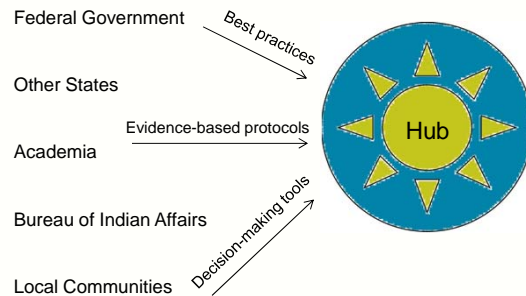
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Support for Best Practices

A "hub" for information about best practices will be developed and housed at the Department of Health will include evidence-based protocols and decision-making tools to transform health care practices.

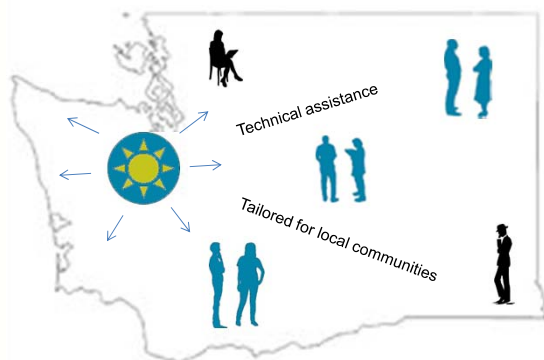


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Support for Best Practices

This clearinghouse will work like an extension service, with regional extension agents supporting providers, communities, and consumers in the use of these programs and tools.



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Concerns from TCBH Report

- Few evidence-based, best practices have been tested in Tribal or American Indian/Alaska Native communities, let alone in urban, rural, or frontier AI/AN communities.
- Tribes know what works best in a Tribal community and that a pilot project or study that works in one Tribal community may not necessarily be easily replicated in another. Each tribe in Washington has its own rich and unique history, culture and traditions.
- Tribes have a strong interest in looking at current Tribal practices and pursuing them as promising practices. Through this process, Tribes seek modalities that will fit within the current Tribal Health system and make adjustments as necessary to keep the core practice.
- Challenges with continuity and consistency can exist in the development of evidence-based, best practices.
- Tribes experience the same, if not more, challenges in the workforce development necessary to meet the needs of Tribal communities.

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Support for Best Practices

How can HCA support integrated care protocols with assurance that cultural competence is incorporated into evidence-based protocols?

Notes from Discussion on

Practice Transformation Support

Practice Transformation Support

Tribal Thoughts/Concerns	HCA's Response
<p><i>HCA and DOH are working to create a practice transformation center to provide training and exchange information about what works and what doesn't. Would the Tribes work with HCA/DOH to ensure that some of that training and information exchange is Tribal-centric?</i></p>	
<p><i>Focused work is needed to ensure that evidence-based protocols are culturally competent. How can HCA support integrated care protocols with assurance that cultural competence is incorporated into evidence-based protocols?</i></p>	
<p>Promising Practices: Tribes need to have the ability to use promising practices that are not yet evidence-based practices (for example, Eye Movement Desensitization and Reprocessing (EMDR) therapy, which is on the SAMHSA list of promising practices but not of evidence-based practices).</p>	<p>Practice transformation support is not intended to preclude the use of promising practices; it is intended to promote evidence-based practices/promising practices, while taking into account the limitations on evidence-based practice research, including the need for more culturally competent treatment.</p>

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Practice Transformation Support

Tribal Thoughts/Concerns	HCA's Response
<p>Offer Training for Tribes: Many Tribes have small health programs with limited ability to keep up on best practices and training. Tribes would appreciate training.</p>	<p>Practice transformation support contemplates technical assistance and training for providers on specific practices.</p>
<p>Tribal Evidence-Based Practices Needed:</p> <ol style="list-style-type: none"> 1. Tribes can share many promising practices, but Tribes have no resources to share information. 2. Rather than always starting with mainstream evidence-based practices and adjusting them for Tribal providers, Tribal Health Programs should also be the starting point for research on evidence-based practices. 3. Herbal and traditional practices should be included. 	<p>These are valuable insights that we will work to incorporate into the practice transformation support planning process.</p>

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