DRAFT

Governor's Behavioral Health Integration Work Group

Proposals and Options for Tribal Consideration

May 23, 2016

Last month, the Governor's office convened a Behavioral Health Integration Work Group, with the goal of identifying any changes needed at the state level to accomplish fully integrated state financing of physical and behavioral health care to better support clinical integration of physical and behavioral health care. As part of this work, a Tribal Sub-Group was convened to advise the Governor on changes that are needed to reduce barriers to access to care for American Indians/Alaska Natives (AI/ANs) and to encourage more integrated interface between the state and regional health care systems and Indian health care providers. Over the course of six weeks, the Tribal Sub-Group has prepared the following five proposals (some with different options) to present to the Governor. The Tribal Sub-Group now seeks feedback from Tribal leadership on the five proposals and, for the first two proposals, which option to propose.

1. **Medicaid System Proposals**

Option A. Tribal Sub-Group proposes changes to the existing Behavioral Health Organization (BHO) and Medicaid Managed Care (MCO) programs – with the goal to keep AI/ANs in the BHO/MCO (Table 1, Column A).

Option B. Tribal Sub-Group proposes changes the changes in Option A plus a separate, statewide Tribal-centric Medicaid system which would be either or both of the following (with Tribal involvement in design and oversight):

> *B1*: A statewide Fully Integrated Managed Care program for AI/ANs (Table 1, Column B1). AI/ANs would continue to have the option to opt out for fee-for-service.
>
> *B2*: A statewide Third Party Administrator for the fee-for-service program for AI/ANs (Table 1, Column B2).

The Tribal Sub-Group prepared Option B, with the choice of B1 or B2 or both B1 and B2, with the recognition that whichever Option B configuration is proposed could serve as an interim step toward a Tribal Managed Care program (i.e., Tribal BHO or Tribal MCO).

2. **Crisis and Non-Medicaid System Proposals**

Option A. Tribal Sub-Group proposes changes to the existing BHO program – with the goal to keep AI/ANs in the BHO (Table 2, Column A).

Option B. Tribal Sub-Group proposes changes in Option A plus a separate, statewide Tribal-centric Crisis and Non-Medicaid system.

3. **Medicaid State Plan Proposals for Tribal-Centric Care Coordination and Tribal Encounter Rate(s)**

Tribal Sub-Group proposes (a) three-tiered Primary Care Case Management (PCCM) rates to support Tribal care coordination and state savings by making certain non-Tribal health care services eligible for the AI/AN 100% federal match, (b) changes to the IHS encounter rate to include more provider types, and (c) new cost-based Tribal encounter rates to support higher cost services provided by Tribal facilities.

4. Tribal Facility Construction Funding Proposals

Tribal Sub-Group proposes legislative appropriations to fund construction of certain types of Tribal facilities, including a Tribal Evaluation & Treatment (E&T) facility, a Tribal specialty care facility, and a Tribal residential substance use disorder (SUD) treatment facility in exchange for state savings from those services being provided by Tribal facilities and eligible for the AI/AN 100% federal match.

5. Other Funding Proposals

Tribal Sub-Group proposes legislative appropriations to fund (a) a study and report on data and data interface needs for the Tribes and Urban Indian Health Organizations and for their interface with state and regional data systems, and (b) the development of evidence in support of practices which target health improvement for AI/ANs (AI/AN evidence-based practices).

<table>
<tr><th>1. Medicaid Health Benefit</th><th>A. Current Managed Care (Managed Care Org. (MCO) & Behavioral Health Org. (BHO))
State implements changes to address issues raised with MCOs and BHOs</th><th>B1. Statewide Fully Integrated Managed Care (FIMC)
State implements statewide FIMC for all AI/ANs (with opt out for fee-for-service)</th><th>B2. Fee-for-Service with Third Party Administrator (TPA)
State implements statewide TPA for AI/ANs in fee-for-service (with opt in for fully integrated managed care)</th></tr>
<tr><td>Risks</td><td>Current issues unresolved
• Current system could fail to overcome current issues</td><td>1. New program based on regional pilot
• FIMC has only been implemented in Clark and Skamania counties
2. FIMC MCO could fail to meet performance requirements
3. Insufficient FIMC enrollment</td><td>1. New program without pilot
2. TPA could fail to recruit significantly more providers for fee-for-service
3. TPA could fail to gain access to behavioral health beds, with rest of system under contract in managed care</td></tr>
<tr><td>Benefits</td><td>1. Minimizes complexity
• Keeps AI/ANs in same systems as other Medicaid clients
2. Keeps choice of MCO</td><td>1. Anticipates statewide changes by 2020 with single AI/AN FIMC
2. Tribes/UIHOs work with one MCO for all health care (except dental) for all AI/ANs
3. Targeted performance req'ts and services possible under this contract</td><td>1. Enhances fee-for-service program with targeted services
2. Targeted performance requirements possible under this contract
3. Supports 100% federal payment</td></tr>
<tr><td rowspan="3">Options</td><td></td><td></td><td>1. TPA for behavioral health or physical and behavioral health
2. Clinical family member eligibility</td></tr>
<tr><td></td><td colspan="2">1. Same entity for both FIMC MCO and TPA
2. Clinical family member eligibility
3. Potential RFP bonus if FIMC MCO or TPA is also a Qualified Health Plan</td></tr>
<tr><td colspan="3">State contracts with FIMC MCO, MCO, BHO, or other insurance organization (e.g., Blue Cross) to rent network of providers</td></tr>
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1. Medicaid Health Benefit	**A. Current Managed Care (Managed Care Org. (MCO) & Behavioral Health Org. (BHO))** State implements changes to address issues raised with MCOs and BHOs	**B1. Statewide Fully Integrated Managed Care (FIMC)** State implements statewide FIMC for all AI/ANs (with opt out for fee-for-service)	**B2. Fee-for-Service with Third Party Administrator (TPA)** State implements statewide TPA for AI/ANs in fee-for-service (with opt in for fully integrated managed care)
Oversight with Tribal/UIHO Input	Tribal representation on BHO boards	1. State creates oversight committee, with Tribal representation, to monitor services to American Indians/Alaska Natives (AI/AN) 2. State issues regular, periodic reports on AI/ANs in program(s) with oversight data for Tribal/UIHO review 3. State works with Tribes/UIHOs to develop process and outcome measures data and cost data to be provided by contracted parties	
Access to Providers	Network adequacy rules require managed care entities to find providers for clients with medical needs • Managed care entities permitted to pay higher rates to providers		Contracted service: TPA recruits providers to enroll with Medicaid and provide care to TPA clients
Tribal Preferred Provider Network	Contracted expectation: MCO/BHO/TPA targets Tribal preferred provider network for inclusion in their networks		
Support for Care Coordination Agreements	1. Contracted service: Facilitate care coordination agreements between IHS/Tribal providers and other providers 2. Contracted service: Support compliance with CMS requirements for 100% federal payment		
Care Coordination Services	MCO offers care coordination services (including transitional care coordination and coordination with long-term support services), with Tribal input, and supports primary care provider and Tribal Contract Health Service (CHS) care coordination with data and technical assistance		TPA supports PCP and Tribal CHS care coordination (including transitional care coordination and coordination with long-term support services), with data and technical assistance
Support for Cultural Curriculum	Contracted service: Support for provider and staff completion of AI/AN CLAS Curriculum	Contracted service: Greater support for provider and staff completion of AI/AN CLAS Curriculum	Contracted service: Greater support for provider and staff completion of AI/AN CLAS Curriculum (subject to provider enrolling in fee-for-service)

1. Medicaid Health Benefit	**A. Current Managed Care (Managed Care Org. (MCO) & Behavioral Health Org. (BHO))** State implements changes to address issues raised with MCOs and BHOs	**B1. Statewide Fully Integrated Managed Care (FIMC)** State implements statewide FIMC for all AI/ANs (with opt out for fee-for-service)	**B2. Fee-for-Service with Third Party Administrator (TPA)** State implements statewide TPA for AI/ANs in fee-for-service (with opt in for fully integrated managed care)
Integration with Tribal Contract Health Services	Contracted service: Support for better integration and coordination with Tribal CHS services	Contracted service: Better support for integration and coordination with Tribal CHS services	
Determination of Care Coordination Tier (if #3 is implemented)	N/A	Contracted service: Determine Care Coordination Tier for Medicaid clients (see #3) to support Tribal care coordination and meet CMS compliance requirements for 100% federal payment	
Culturally Trained Ombuds	Contracted service		
Provider Reporting	Contracted service: Support for IHS, Tribal, and UIHO performance measures as appropriate	Contracted service: Greater support for IHS, Tribal, and UIHO performance measures and for crosswalk with Washington State statewide performance measures	
Steps to Implement			
Legislation	1. Tribal representation on BHO boards 2. Authorization for above features in BHO contracts	1. Statewide FIMC program for AI/ANs with above features 2. Authorization for certain features in BHO contracts to the extent Tribes need to work with BHOs for non-AI/AN clients	1. Statewide Third Party Administrator with above features + funding 2. Authorization for certain features in BHO contracts to the extent Tribes need to work with BHOs for non-AI/AN clients
Budgeting	None required	Standard process	Non-standard (requires cost estimation)

1. Medicaid Health Benefit	**A. Current Managed Care (Managed Care Org. (MCO) & Behavioral Health Org. (BHO))** State implements changes to address issues raised with MCOs and BHOs	**B1. Statewide Fully Integrated Managed Care (FIMC)** State implements statewide FIMC for all AI/ANs (with opt out for fee-for-service)	**B2. Fee-for-Service with Third Party Administrator (TPA)** State implements statewide TPA for AI/ANs in fee-for-service (with opt in for fully integrated managed care)
Financing	None required	Medicaid entitlement with state funds: • 100% federal payment for non-Tribal services if coordinated by IHS/Tribal clinic - CMS requires actuarial adjustment Standard federal payment for non-Tribal services if not coordinated by IHS/Tribal clinic (i.e., urban AI/ANs and clinical family members (if applicable))	1. Savings from 100% federal payment (potentially $2.3 million per year) 2. Legislative 3. Other sources
Interim Steps	1. June 30, 2016 – 1915(b) Waiver Renewal a) Carve AI/AN back into BHO for all behavioral health services OR b) Keep AI/AN carved out of BHO for SUD services (leaving AI/AN in BHO for mental health service above the access to care standard) 2. June 30, 2017 – Legislation enacted	1. June 30, 2016 – 1915(b) Waiver Renewal a) Carve AI/AN back into BHO for all behavioral health services OR b) Keep AI/AN carved out of BHO for SUD services (leaving AI/AN in BHO for mental health service above the access to care standard) 2. June 30, 2017 – Legislation enacted 3. June 30, 2018 – RFP completed 4. January 1, 2019 – Implementation completed with CMS authority effective	1. June 30, 2016 – 1915(b) Waiver Renewal a) Carve AI/AN back into BHO for all behavioral health services OR b) Keep AI/AN carved out of BHO for SUD services (leaving AI/AN in BHO for mental health service above the access to care standard) 2. June 30, 2017 – Legislation enacted 3. June 30, 2018 – RFP completed 4. January 1, 2019 – Implementation completed with CMS authority effective

2. Crisis System and Non-Medicaid Services	**A. Current Crisis System (BHOs)** State implements changes to address issues raised with BHO crisis system	**B. Statewide AI/AN Crisis System Administrator** State implements administration of statewide crisis system for AI/ANs
Risks	Current issues unresolved • Current system could fail to overcome current issues	1. New program 2. Statewide AI/AN Crisis System Administrator could fail to meet performance requirements
Benefits	Minimizes complexity • Keeps AI/ANs in same systems as other state residents	1. Anticipates potential statewide changes to be made by 2020 in connection with FIMC, using Early Adopter set up as a model 2. Tribes/UIHOs work with one crisis system administrator for all AI/ANs 3. Targeted performance requirements and services possible under this contract
Options		1. Administrator develops or contracts for actual statewide AI/AN crisis system 2. Administrator creates virtual statewide AI/AN crisis system • Creates statewide crisis and administration line • Contracts with BHOs or crisis providers throughout the state
Oversight with Tribal/UIHO Input	Tribal representation on BHO boards	1. State creates oversight committee, with Tribal representation, to monitor services to American Indians/Alaska Natives (AI/AN) 2. State issues regular, periodic reports on AI/ANs in program(s) with oversight data for Tribal/UIHO review 3. State works with Tribes/UIHOs to develop process and outcome measures data and cost data to be provided by contracted parties

2. Crisis System and Non-Medicaid Services	A. Current Crisis System (BHOs) State implements changes to address issues raised with BHO crisis system	B. Statewide AI/AN Crisis System Administrator State implements administration of statewide crisis system for AI/ANs
Crisis Line	BHO (or Beacon in Clark and Skamania counties) currently contracts for 24/7 crisis line with MHPs and CDPs on location	Administrator contracts for single statewide 24/7 crisis line with MHPs and CDPs at single location
Tribal DMHPs	1. Designation of Tribal DMHPs by BHO, county, state, or Tribe (for recognition by non-Tribal providers and courts) • Current Pilot: Tribe provides Mental Health Professional (who has met all other DMHP requirements) to be certified as a DMHP by BHO or County 2. Financing for Tribal DMHP: BHO • DMHPs are a fixed cost (as they are full-time on-call) for a specific geographic region (as they must be able to travel to clients) • Requires sufficient client base within the DMHP's region 3. Civil jurisdiction questions related to client's Tribal membership or non-membership • Additional issues with foster children and Indian Child Welfare Act	1. Designation of Tribal DMHPs by BHO, county, state, or Tribe (for recognition by non-Tribal providers and courts) 2. Financing for Tribal DMHP through statewide crisis system • DMHPs are a fixed cost (as they are full-time on-call) for a specific geographic region (as they must be able to travel to clients) • Requires sufficient client base within the DMHP's region 3. Civil jurisdiction questions related to client's Tribal membership or non-membership • Additional issues with foster children and Indian Child Welfare Act
Involuntary Commitment	Full faith and credit for Tribal Involuntary Treatment Act (ITA) court orders for mental health and substance use disorders • Amend RCW 71.05.150(2)(a) as amended by HB 1713 to authorize state courts and non-Tribal providers to recognize tribal court orders to detain to an Evaluation & Treatment facility upon recommendation of a DMHP for mental health and/or substance use disorders • Note: Involuntary commitment hearings must be held where the facility is located (i.e., where the client is treated), not where the client was detained • Note: HB 1713 may eliminate current recognition of tribal court orders to detain for substance use disorder	
7.01 and Crisis Plans	Contractual requirement with accountability mechanism for BHOs	Contractual requirement with accountability mechanism for Administrator and BHOs

2. Crisis System and Non-Medicaid Services	**A. Current Crisis System (BHOs)** State implements changes to address issues raised with BHO crisis system	**B. Statewide AI/AN Crisis System Administrator** State implements administration of statewide crisis system for AI/ANs
Non-Medicaid Services	Contractual requirement for culturally appropriate WISe and PACT services	
Steps to Implement		
Legislation	1. Tribal representation on BHO boards 2. Authorization for Tribal DMHP designation by BHO, county, state, or Tribe 3. Authorization for financing of Tribal DMHPs by BHOs 4. Funding for study and report to legislature on civil jurisdiction issues, including full faith and credit for ITA court orders and Tribal DMHP jurisdiction 5. Amendment to RCW 71.05.150 to authorize state courts and non-Tribal providers to recognize tribal court ITA orders	1. Statewide Third Party Administrator with above features + funding 2. Authorization for certain features in BHO contracts to the extent Tribes need to work with BHOs for non-AI/AN clients 3. Tribal representation on BHO boards 4. Authorization for Tribal DMHP designation by BHO, county, state, or Tribe 5. Authorization for financing of Tribal DMHPs by BHOs 6. Funding for study and report to legislature on civil jurisdiction issues, including full faith and credit for ITA court orders and Tribal DMHP jurisdiction 7. Amendment to RCW 71.05.150 to authorize state courts and non-Tribal providers to recognize tribal court ITA orders
Budgeting	Standard process	Non-standard (Requires cost estimation)
Financing	Required for payments by BHOs for Tribal DMHPs and for study and report on civil jurisdiction issues for Tribal DMHPs	1. State and federal block grant funding to Administrator for statewide AI/AN crisis system and other services 2. Additional legislative funding, if needed 3. Other sources
Interim Steps	June 30, 2017 – Legislation enacted	June 30, 2017 – Legislation enacted

3. Amendments to Medicaid State Plan Payments	**A. Three-Tiered Care Coordination** State implements new care coordination rates for AI/AN clients who are not in managed care	**B. Updates to IHS Encounter Rate** State amends encounter rate to include more provider types and encounter categories and exclude Tribal labs	**C. New Tribal Daily Rates** State implements new cost-based daily rates for certain Tribal health care facilities
Risks	Higher care coordination rates do not result in better health outcomes	Any amendment to an existing section of the Medicaid State Plan is a negotiation between the state and the federal government. During this negotiation, the federal government may seek to reduce the number of IHS encounter categories, the number of providers eligible for the IHS encounter rate, or another payment in this section of the State Plan.	The process to establish the cost-based daily rates imposes significant burdens on facilities
Benefits	Financial incentive for providers to coordinate the care of their AI/AN clients who are not in managed care (who are in fee-for-service)	The IHS encounter rate becomes available for more types of Tribal services and increases the scope of services which Tribes can provide.	Residential Tribal health care facilities receive Medicaid funding that is better able to sustain their services.
Proposal Summary	Three-tiered Primary Care Case Management (PCCM) rates to support care coordination: **Tier 1** -Default • PCCM rate **Tier 2** - Multiple chronic health conditions but PRISM score less than 1.5 • Enhanced PCCM rate **Tier 3** – PRISM score 1.5 or more • Chronic Care PCCM rate	State amends Medicaid State Plan: 1. Following provider types eligible for outpatient IHS encounter rate (new provider types in *italics*): Physician Physician Assistant Nurse Midwife Nurse Practitioner Speech-Language Pathologist Audiologist Physical Therapist Occupational Therapist Podiatrist Optometrist Dentist	State implements new, cost-based Tribal daily rates for certain types of Tribal facilities that have higher operating costs 1. Residential SUD 2. Evaluation & Treatment (E&T) 3. Long-Term Care

3. Amendments to Medicaid State Plan Payments	**A. Three-Tiered Care Coordination** State implements new care coordination rates for AI/AN clients who are not in managed care	**B. Updates to IHS Encounter Rate** State amends encounter rate to include more provider types and encounter categories and exclude Tribal labs	**C. New Tribal Daily Rates** State implements new cost-based daily rates for certain Tribal health care facilities
	Clients in PCCM will not be eligible for the Medicaid Health Home program Note: These rates support Tribes in meeting CMS requirements for 100% federal payment	Chemical Dependency Prof'l Psychiatrist Psychologist Mental Health Professional *Clinical Nurse Specialist* *Nurse Anesthetist* *Pharmacist* *Behavior Analyst* *Dietitian* *Nutritionist* *Dental Therapist* *Dental Hygienist* *Denturist* *Home Care Aide/Visiting Nurse* *Personal Care Assistant* 2. Following categories of encounter for the outpatient IHS encounter rate (new categories in *italics*): Medical Mental Substance Use Disorder Dental *Home Health Agency/Visiting Nurse* 3. Tribal laboratory services excluded from outpatient IHS encounter rate	
Steps to Implement			
Legislation	Authorization and budget	Authorization and budget	Authorization and budget
Budgeting	Standard process	Standard process	Standard process
Financing	Federal and/or state	Federal (CMS approval needed)	Federal (CMS approval needed)

4. Tribal Facility Construction	**A. Tribal Evaluation & Treatment (E&T) Facility** State works with one or more Tribes to appropriate funding for construction of E&T facility on Tribal land	**B. Tribal Specialty Care Facility** State works with one or more Tribes to appropriate funding for construction of specialty care facility	**C. Tribal Residential Substance Use Disorder (SUD) Treatment Facility** State works with one or more Tribes to appropriate funding for construction of residential SUD facility on Tribal land
Explanation	E&T facilities are able to admit patients for inpatient mental health care under the Involuntary Treatment Act. The State has a shortage of E&T beds for individuals who, as a result of mental illness, are gravely disabled or may be a danger to themselves or others. AI/ANs are at higher risk of mental illness and suicide than the majority population – requiring E&T facility care.	Specialty care facilities provide outpatient medical specialty care. The State has a shortage of specialty care providers, particularly outside of the Seattle metropolitan area. AI/ANs have greater and more complex health needs than the majority population – requiring specialty care.	Residential SUD treatment facilities are able to admit patients for inpatient SUD treatment. The State has a shortage of residential SUD treatment beds. AI/ANs are at higher risk of mental illness and suicide than other populations. AI/ANs are at higher risk of substance use disorder than the majority population – requiring residential SUD treatment.
Risks	Inadequate project management leads to inability to construct facility within appropriation and timeframe allotted Inadequate planning or management of facility operations to ensure facility is sustainable.		
Benefits	More E&T beds, reducing the statewide shortage. Enables E&T facility specialization in care that is culturally appropriate for this particularly vulnerable AI/AN patient population Transfers Medicaid costs from the State General Fund to the federal government Supports Tribal sovereignty and Tribal jurisdiction over Tribal members in need of involuntary treatment.	More specialty care providers, reducing the statewide shortage in specialty care. Enables specialty care providers who can specialize in providing culturally appropriate services to AI/AN patients with chronic conditions Transfers Medicaid costs from the State General Fund to the federal government	More residential SUD beds, reducing the statewide shortage. Enables residential SUD facility specialization in care that is culturally appropriate for this particularly vulnerable AI/AN patient population Transfers Medicaid costs from the State General Fund to the federal government Supports Tribal sovereignty and Tribal jurisdiction over Tribal members in need of involuntary treatment.

4. Tribal Facility Construction *Steps to Implement*	**A. Tribal Evaluation & Treatment (E&T) Facility** State works with one or more Tribes to appropriate funding for construction of E&T facility on Tribal land	**B. Tribal Specialty Care Facility** State works with one or more Tribes to appropriate funding for construction of specialty care facility	**C. Tribal Residential Substance Use Disorder (SUD) Treatment Facility** State works with one or more Tribes to appropriate funding for construction of residential SUD facility on Tribal land
Summary of Legislation	Funding for construction of E&T facility on Tribal land, with payback from future savings to the State for transferring the cost of these E&T services onto the federal government due to the 100% federal payment.	Funding for construction of specialty care facility which meets requirements for designation as IHS or Tribal 638 facility, with payback from future savings to the State for transferring the cost onto the federal government.	Funding for construction of residential SUD facility on Tribal land, with payback from future savings to the State for transferring the cost of these services onto the federal government due to the 100% federal payment.
Budgeting	Standard construction budgeting for facility of this type		
Financing	Possibilities: 1. State appropriations 2. Municipal bond financing 3. IHS funding 4. Grant or other foundation funding 5. Congressional appropriations	Possibilities: 1. State appropriations 2. Municipal bond financing 3. IHS funding 4. Grant or other foundation funding 5. Congressional appropriations	Possibilities: 1. State appropriations 2. Municipal bond financing 3. IHS funding 4. Grant or other foundation funding 5. Congressional appropriations

5: Other Funding Proposals	**A. Report on AI/AN Data and State/Tribal Data Systems** Legislature appropriates funds to compile information for report and recommendations, with Tribal collaboration, on statewide AI/AN data collection and Tribal and State systems	**B. Research to Establish Evidence-Based Practices** Legislature appropriates funds to (a) incentivize and support evidence-based research focused on interventions for AI/ANs and (b) create mechanism for Tribes to prioritize areas for financial support
Risks	Compilation effort fails to capture all of the data and systems, resulting in an incomplete report and potentially inappropriate recommendations Recommendations are not acted upon	Research funds fail to establish evidence-based practices for AI/AN population which can be broadly applied
Benefits	Creates plan for ensuring that population health inventories and needs assessments are based on complete AI/AN data	Creates Tribal mechanism for directing funding for evidence-based practices for AI/ANs Funds AI/AN evidence-based practices
Summary of Legislation	Requirements and funding to compile information, prepare report, and develop recommendations with Tribal collaboration	Requirements and funding to develop a plan for prioritizing areas for financial support, with Tribal direction, and funding to support research
Budgeting	Non-Standard (will require cost estimate)	Non-Standard (will require cost estimate)
Financing	State funds	State funds
Interim Steps	January 31, 2017 – State works with Tribes to determine how to inventory the sources of AI/AN data and the systems (federal, state, and Tribal) which handle and/or transfer AI/AN data June 30, 2017 – Legislation enacted	January 31, 2017 - State works with Tribes to determine how the Practice Transformation Hub will incorporate and communicate limitations of research used to establish evidence-based practices. June 30, 2017 – Legislation enacted