Washington State Health Care Authority

Slides & Notes from Roundtable with Tribes on Healthier Washington Initiatives

March 16, 2015

Attendees

Tribal Attendees

Chehalis Confederated Tribes – Charlene Abrahamson
Colville Confederated Tribes – Alexandria Desautel
Kalispel Tribe – Ron Poplawski
Lummi Nation – Cheryl Sanders, Vanda Patterson, Stephanie Williams, Maureen Kinley
NATIVE Project – Toni Lodge
Port Gamble S'Klallam Tribe – Ed Fox, Kerstin Powell
Puyallup Tribe – Jennifer LaPointe
Quileute Tribe – Andrew Shogren
Sauk-Suiattle Tribe – Rhonda Metcalf
Seattle Indian Health Board – Aren Sparck
Spokane Tribe – Ann Dahl
Suquamish Tribe – Leslie Wosnig, Lisa Rey Thomas, Sharon Henson
Stillaguamish Tribe – LaJune Rabang
Swinomish Tribe – Cheryl Rasar
Upper Skagit Tribe – John Miller

Non-Tribal Attendees

HCA	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/BHSIA	Jane Beyer – Assistant Secretary
	David Reed – Office Chief, Mental Health
	Tiffany Villines – Behavioral Health Administrator
	Candace Goehring – Office Chief, Services Integration
	Karen Fitzharris – Project Manager
CMS	Deb Sosa – Native American Contact

Table of Contents

This deck of slides is the final record of the Roundtable between HCA and the Tribes on March 17, 2015. These slides are organized as follows:

**Slides presented on March 17, 2015 are indicated in the upper left corner of the slide.*

Slides presented on March 17, 2015 on

Healthier Washington Initiatives

Slide Presented on March 17, 2015

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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Healthier Washington: 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
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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Healthier Washington: Policy Direction

Washington enacted legislation furthering delivery system reform:

- **SB 5732/HB 1519 (2013)**
  Cross-system performance measures for health plan contracting and system monitoring
- **HB 2572 (2014)**
  Value-based purchasing reform; increased transparency; empowered communities, standardized performance measures
- **SB 6312 (2014)**
  Whole-person integrated managed care

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Healthier Washington: SIM Initiative

State Innovation Models (SIM) Initiative. Under SIM, Washington is launching key initiatives that invest in Washington's infrastructure to support multi-payer health transformation:

- **Community Empowerment and Accountability**
  Start-up support for Accountable Communities of Health
- **Practice Transformation Supports**
  Development of a Practice Transformation Support Hub for providers
- **Payment Redesign**
  Four payment models that drive health system purchasers and payers toward greater accountability for improved health outcomes and reduced cost of care
- **Analytics, Interoperability, Measurement and Transparency**
  Development of analytic and measurement capacity and tools that translate data from multiple sectors into actionable information
- **Project Management**
  Establishment of a public-private leadership council and accountable project management practices to ensure real-time evaluation and continuous improvement

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Healthier Washington: Medicaid Flexibility

Complementary Medicaid flexibility, authority, and investment to pay for non-traditional services that advance care models statewide and accelerate improvements in health and quality while reducing future Medicaid costs trends

- Helps to implement the policy direction set by the Governor and the legislature

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Healthier Washington: Vision for 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

Sustainable funding streams for a transformed health system through value-based purchasing, with 80% of payments to (non-Tribal) providers on the value-based continuum by 2019

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Slides presented on March 17, 2015 on

Integrated Medicaid Purchasing

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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 • Above "access to care" standard	 MCOs 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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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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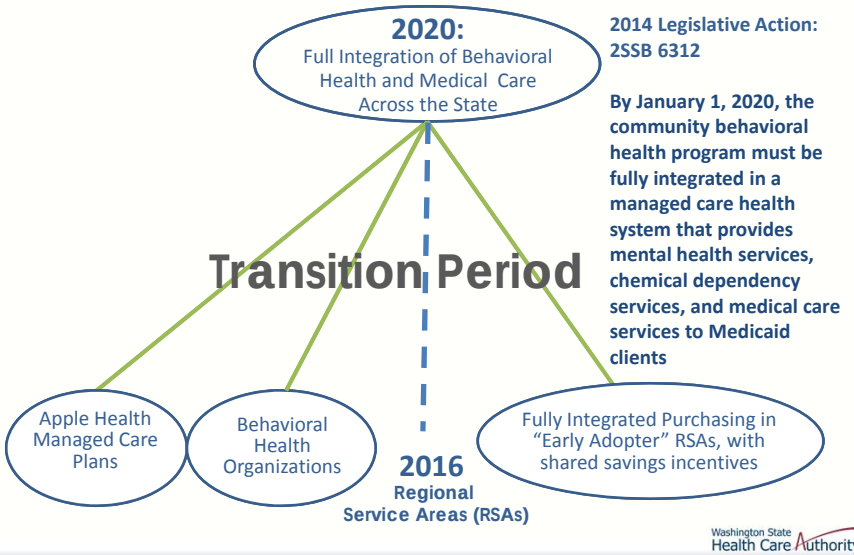
Parallel Paths to Integrated Managed Care



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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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 • Above "access to care" standard	MCOs RSNs	MCOs BHOs	MCOs*
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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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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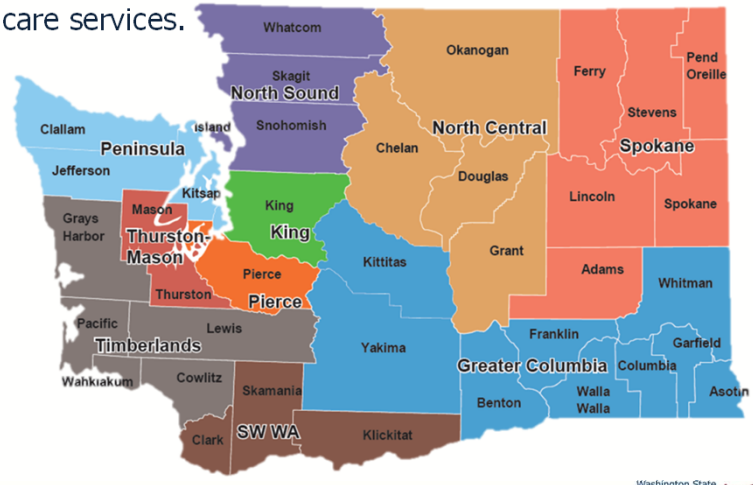
Regional Service Area Designations

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



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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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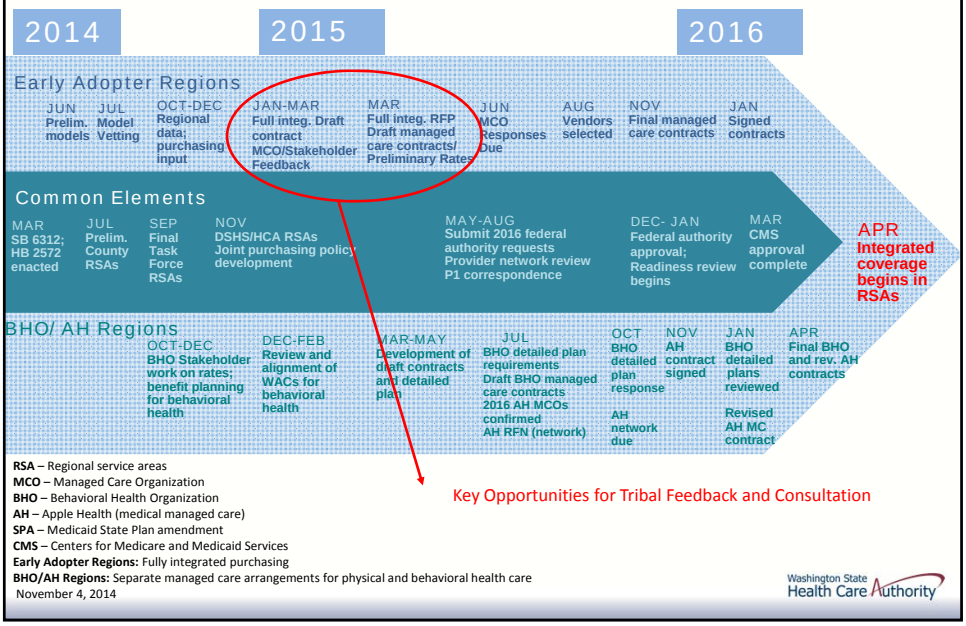
Medicaid Integration Timeline



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
November 4, 2014

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HCA Calendar for Early Adopter Planning & Implementation

	Key Purchasing Milestones
January 2015	• Early Adopter Model Options completed for discussion • Draft MCO Contract available for review • Non-binding letters of intent due from potential Early Adopter RSA counties
Late March 2015	• RFP to be issued for MCO vendor selection, using MCO Contract
June – August 2015	• MCO vendor selection process *(Note: County decisions on Early Adopter RSAs to be made prior to final vendor selection)*
December 2015 – March 2016	• Early Adopter RSA implementation readiness review process
April 2016	• Performance monitoring begins

Tribal consultation/ comments on:
- Draft MCO Contract,
- Early Adopter Model Options, and
- Criteria for MCO vendor selection (part of RFP process).

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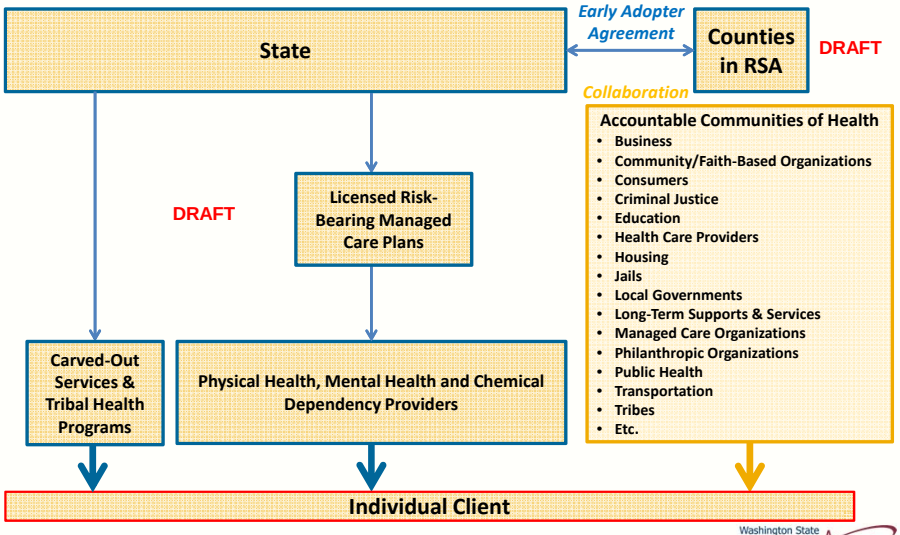
Potential Early Adopter RSA Model: Fully Integrated Physical & Behavioral Health Purchasing with Standard Managed Care Arrangements



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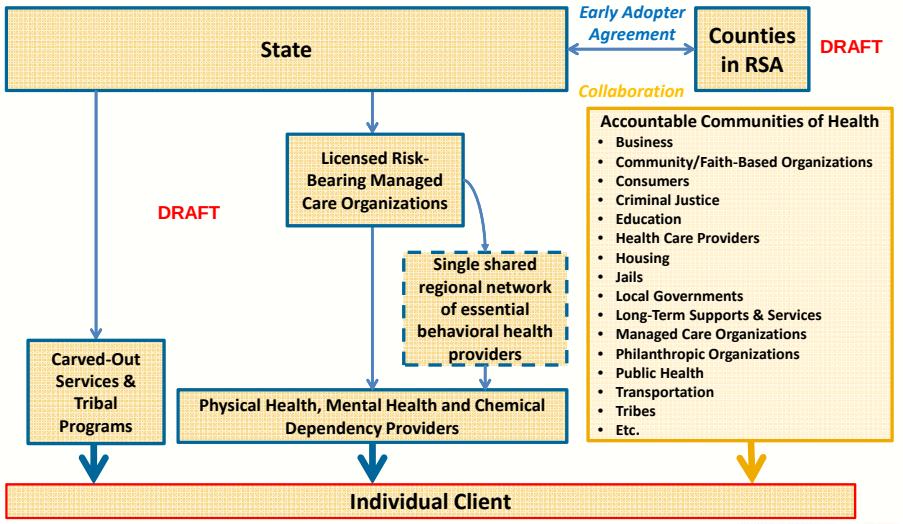
Potential Early Adopter RSA Model : Fully Integrated Physical & Behavioral Health Purchasing with Single Shared Regional Behavioral Health Network



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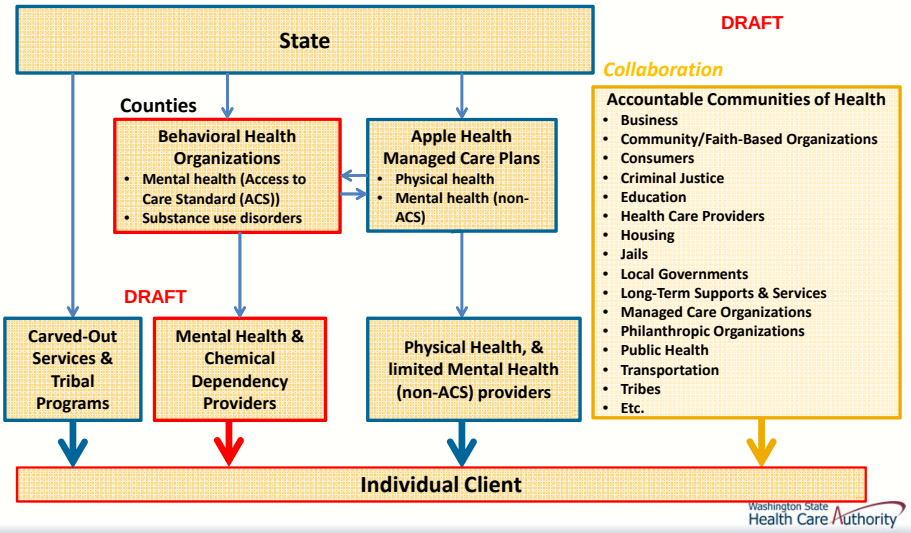
Potential BHO RSA Model: Physical & Behavioral Health Purchasing with Separate Managed Care Arrangements



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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:	
		Mental health	RSN	• Involuntary Treatment Act	• RSN
		Chemical dependency	County FFS	• Therapeutic Courts	• County
	No	Physical + some mental health	FFS	• Transitional Care Coordination from Prison or IMDs	• RSN/ County
		Mental health	RSN + FFS	• Inpatient chemical dependency treatment	• State
		Chemical dependency	County FFS		
Not Eligible for Medicaid				• IMD/State Mental Health Hospital inpatient care	• State

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What is not changing?

- MCO clients travelling in another RSA will have access to **urgent care**.
- MCO clients will have access to **specialty care outside RSA** by referral.
- **IHS encounter rate**
  - Four encounter categories will continue.
  - Wraparound payment will continue to be paid for AI/ANs enrolled in MCO.
- **Tribal-MCO contracts** will not force Tribes to see non-AI/AN patients.
- **Federal exemptions** for AI/ANs and I/T/Us will continue.

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What is HCA currently working on?

- **New quarterly Tribal-MCO meetings**
  - Meeting on February 13 appears to have helped some Tribes overcome challenges in contracting with MCOs and helped Tribes and MCOs better understand their processes and requirements.
  - Next meeting on May 8, 1 p.m. – 3 p.m.
- HCA is working on requesting **health equity plans of MCOs.**
- HCA is preparing **Early Adopter MCO contract**.
- HCA is reviewing **standard MCO contract** for amendments.
- HCA is preparing a **list of Tribal issues** related to integrated Medicaid purchasing.
- HCA is reviewing how to engage Tribes in **MCO oversight**.
- HCA is working with MCOs on **FQHC encounter rate pass-through**.

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Possible Topics for Today

- Current status of Early Adopter planning:
  - How will services jointly supported by Medicaid and non-Medicaid funds (such as crisis services) be administered in Early Adopter RSAs?
  - How will those services be coordinated with Medicaid services for MCO clients in Early Adopter RSAs?
- With integrated Medicaid purchasing, how do we ensure:
  - Quality and appropriate care for AI/ANs?
  - AI/AN access to behavioral health services in Early Adopter RSAs?
  - I/T/Us are better incorporated into the delivery system?
- Could Tribes that serve only AI/AN clients become an MCO?

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Notes from Discussion on

Integrated Medicaid Purchasing

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Integrated Medicaid Purchasing

Tribal Thoughts/Concerns	HCA's Response
Government-to-Government: xxxxx	xxxxx

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Accountable Communities of Health

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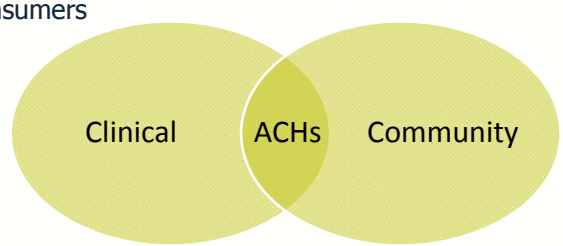
Accountable Communities of Health

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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What is an ACH supposed to do?

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.

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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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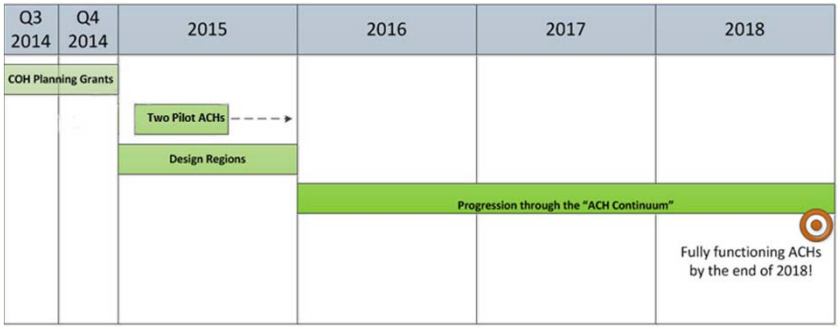
Accountable Communities of Health

The ACH Timeline



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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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Possible Topics for Today

- Status Update on ACHs
  - Two pilot grants: North Sound and Timberlands
  - Design grants: All other regions
- Design for ACH-Tribal Coordination Planning Effort
  - Tribal requirements for ACH engagement
  - Outreach and education
  - Development of ACH coordination resources
  - Exploration of Tribal data analysis function
  - Quarterly reports to Tribes
  - Sustainability plan

Notes from Discussion on

Integrated Medicaid Purchasing

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Accountable Communities of Health

Tribal Thoughts/Concerns	HCA's Response
[TOPIC]: xxxxx	xxxxx

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Slides presented on March 17, 2015 on

Medicaid Waivers

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Medicaid Waivers

- RSN Reorganization
  - Transfer of Cowlitz County out of Southwest Washington Behavioral Health RSN and into Grays Harbor RSN.
  - Chelan-Douglas RSN reorganization will not occur.
- Waiver plans for:
  - Behavioral Health Organizations
  - Early Adopter RSAs
- Global 1115 Waiver
  - Webinar presentation

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Global 1115 Waiver

Webinar presentation

https://attendee.gotowebinar.com/recording/4072587036299781890

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Notes from Discussion on

Medicaid Waivers

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Medicaid Waivers

Tribal Thoughts/Concerns	HCA's Response
[TOPIC]: xxxxx	xxxxx

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