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HCA-BHA Monthly Tribal Meeting

December 12, 2016

Jessie Dean
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Office of Tribal Affairs

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Division of Behavioral Health & Recovery

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Agenda

9:00 AM	Welcome, Blessing, Introductions
9:10 AM	Update: Mental Health Fee-for-Service Implementation
9:40 AM	Update: Medicaid Transformation 1115 Waiver
10:00 AM	Medicaid Suspension and Care Coordination for the Institutionalized
10:30 AM	Update: Scheduling of BHO-Tribal-State Meeting
10:40 AM	Update: Medicaid Provider Ownership and Disclosure Requirements
11:00 AM	Review Tribal Issues Grid
Noon	Closing

Welcome, Blessing, Introductions

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Update:
Mental Health Fee-for Service Implementation

Update: Mental Health FFS Carve Out

- DSHS and HCA are still aiming for July 1, 2017
- Inter-agency work so far:
  - Establish a timeline for major milestones
  - Beginning process to establish rates for mental health services
  - Continue to build the data system (no decommission date yet for TARGET)

Update: Mental Health FFS Carve Out

- **General Timeline**
  - **January 1, 2017**: Update 1915(b) Waiver to include mental health carve out for Medicaid-eligible AI/ANs
  - **February 2017:** Letter of Interest to mental health providers
  - **March 31, 2017**: DSHS to submit 1915(b) Waiver to CMS
  - **March 31, 2017**: DBHR will send out a State Plan Amendment notification to tribes about setting the mental health services rates for the FFS system
  - **July 1, 2017**: Mental Health FFS system implemented

Update: Mental Health FFS Carve Out

- DSHS/HCA will request tribal input on 1915(b) Waiver language (Consultation in February 2017?)
- DSHS/HCA will be giving updates on process at least monthly

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Update:
Medicaid Transformation 1115 Waiver

1115 Waiver: History

January – May 2015: Concept Development, which led to a Concept Paper

- March 16, 2015: Tribal Roundtable
- April 17, 2015: Tribal Consultation
- May 29, 2015: HCA sent Concept Paper to Tribes and IHCPs

June – August 2015: Preparation of 1115 Waiver Application

- Tribal Workgroup – Multiple meetings in June, July, and August
- July 22, 2015: Tribal Roundtable
- August 5, 2015: Tribal Forum
- August 12, 2015: Tribal Consultation
- August 24, 2015: HCA submitted application submitted to CMS

August 24, 2015 – October 7, 2016: Negotiation between CMS and State

- Tribal Workgroup – Multiple meetings in late 2015 and January 2016
- October 7, 2016: HCA announced principled agreement with CMS

1115 Waiver: Special Terms & Conditions

October 7, 2016 – Present: Special Terms & Conditions (STCs) and Planning

- October 26, 2016: Tribal Roundtable #1
- November 4, 2016: Tribal Roundtable #2
- November 8, 2016: Tribal Roundtable #3
  - Discussed tribally proposed 1115 STCs for Initiative #1
- November 28, 2016: CMS sent first draft of 1115 STCs to HCA
- December 5, 2016
  - 9:00 AM – HCA sent revised first draft of 1115 STCs to CMS
  - 11:00 – 1:00 PM – Tribal Consultation
  - 6:00 PM – HCA sent revised first draft of 1115 STCs plus new STCs to Tribes and IHCPs

Continued HCA-CMS-Tribal Discussions on STCs

January 3, 2017: Target Date for 1115 Waiver Approval

Continued HCA-CMS-Tribal Discussions on Protocol

1115 Waiver: Status of Tribally Proposed STCs

#	STC Title	Status
1	Definitions (1915(b) + 1115)	HCA will update definition of ACH
2	MCE-State Agreement (1915(b))	STC 2(a): HCA agreed STC 2(e)(iv): HCA did not agree to new change STC 2(f): HCA agreed STC 2(i): HCA agreed STC 2(k): HCA agreed with addition of "subject to release" language in last sentence and moving of last sentence into a subsection (ii).
3	State Maintenance of an IHCP List (1915(b))	Newly proposed STC: HCA agreed
4	Separate Issue Resolution Mechanism (1915(b))	*No change since October 26 Consultation*
5	State IHCP Reimbursement (1915(b))	STC 5(a): HCA agreed to July 1, 2018 deadline STC 5(h): HCA did not agree; legislature has appropriation authority – Move to Tribal issues grid

1115 Waiver: Status of Tribally Proposed STCs

#	STC Title	Status
6	AI/AN Mandatory Managed Care (1915(b))	*No change since October 26 Consultation*
7	Data Reporting (1915(b))	*No change since October 26 Consultation*
8	State Consultation & Engagement Requirements (1915(b))	*No change since October 26 Consultation*
9	Other AI/AN & IHCP Protections (1915(b))	*No change since October 26 Consultation*
10	Health Performance Measures (1115)	HCA agreed and proposed to include in 1115 STC #30
11	Accountable Communities of Health (1115)	11(a)(i): HCA agreed and proposed to include in 1115 STC #24 11(a)(ii): HCA agreed to require each ACH decision-making body to include one representative of tribes and IHCPs and proposed language in 1115 STCs #23 and 24; HCA has also adopted same requirement in Model ACH Tribal Collaboration Policy

1115 Waiver: Status of Tribally Proposed STCs

#	STC Title	Status
11	Accountable Communities of Health (1115)	11(b): HCA proposed to negotiate this for the Tribal Engagement and Collaboration Protocol
12	Tribal Coordinating Entity (1115)	12: HCA proposed to negotiate this for the Tribal Engagement and Collaboration Protocol but included language in 1115 STC #25
13	Long-term Services and Supports (1115)	13: DSHS proposed to negotiate this for the Tribal Engagement and Collaboration Protocol
14	Supportive Housing and Employment Support Services (1115)	14: HCA proposed to negotiate this for the Tribal Engagement and Collaboration Protocol; HCA has not yet received from CMS the 1115 STCs for this initiative

1115 Waiver: Next Steps

- 1115 Waiver STCs
  - Initiatives 1 – 2
    - Tribal comments
  - Initiative 3
    - Still waiting for CMS draft
- Tribal Engagement and Collaboration Protocol
- Implementation Planning and Preparation

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Medicaid Suspension and Care Coordination for the Institutionalized –SSB 6430

Sarah Michael
December 12th, 2016
Office of Medicaid Eligibility and Policy

Background

- ✓ SSB 6430 is the result of two previous legislative outcomes and extensive stakeholder engagement:
  - Substitute HB 1290 (2005)

    Directed DSHS to expedite the enrollment or re-enrollment of eligible persons leaving state or local correction facilities and institutions of mental health
  - Recommendations by the Adult Behavioral Health Taskforce (2014-2016)

    Over 100 individuals provided testimony, information or participated in stakeholder work groups which resulted in a recommendation to suspend Medicaid
- ✓ The proposed policies and implementation plan of SSB6430 is the result of three workgroups with over 60 stakeholders

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The Intent

To provide continuity of care for recipients of Apple Health (Medicaid) during periods of institutionalization by:

An individual is considered institutionalized if they are residing involuntarily in a public institution

- Suspend, not terminate existing coverage
- Applying for health care coverage in suspense
- Pursuing authority to waive some current CMS rules
- Identification and communication of Behavioral Health (BH) best practices to promote a smooth transition into the community

Current Situation

Center for Medicare and Medicaid (CMS) Policies:

1. Inmate Exclusion - Prohibits the use of federal funding to provide Medicaid services to persons who are inmates of a public institution

   ✓ **The recent CMS State Health Official letter #16-007 states the ability to receive Federal Financial Participation (FFP) for approved work release programs**

2. Institution for Mental Diseases (IMD) Exclusion – Prohibits the use of federal funds for treatment costs for persons aged 22-64 who are hospitalized more than 15 days in a calendar month

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What does it mean to Suspend?

Today when an individual is institutionalized for over 30 days their coverage is ended

If an inpatient hospitalization lasting over 24 hours occurs the confinement facility can apply to have that inpatient stay covered

What does it mean to Suspend?

In the future institutionalization will not affect eligibility but it will determine the scope of coverage:

- Coverage will not be ended but placed in a Recipient Aid Category (RAC) in our payment system which will only cover inpatient hospitalizations lasting over 24 hours
- When the individual is released full scope coverage is reinstated automatically without the need for action by the individual

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Why Suspend Rather than Terminate?

- ✓ Persons with mental illness and substance use disorders need seamless access to treatment networks, services and health care coverage upon release.
- ✓ Access to care increases the chance of successful re-entry and is critical to reduce recidivism and reduce cost associated with:

Relapse | **Decompensation** | **Crisis Care**

- ✓ Suspension allows for quicker and easier reinstatement of coverage resulting in reduced work load and fewer incidences of uncompensated care.

The Rationale

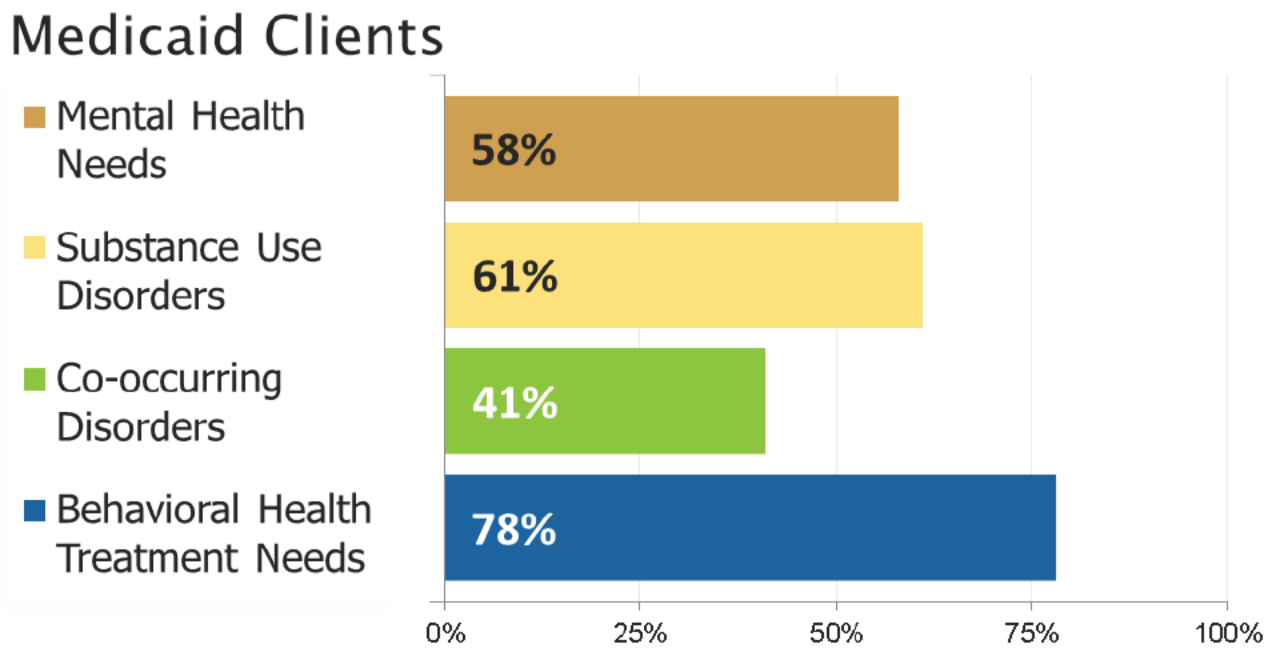
Characteristics of WA Adult Jail Inmates:

- A study of WA adult jail inmates followed those who were booked in 2013. Looking retrospectively and following this population into the future the study found that:
  - ✓ **86% of those had received DSHS or HCA services between 1999-2015 (not just medical)**
  - ✓ **In 2013, 31% were actively enrolled in Medicaid, this number expanded to 58% by 2014 due to the implementation of the ACA and continued growth is expected**

Source: DSHS, RDA Behavioral Health Needs of Jail Inmates in Washington State, January 2016

The Rationale

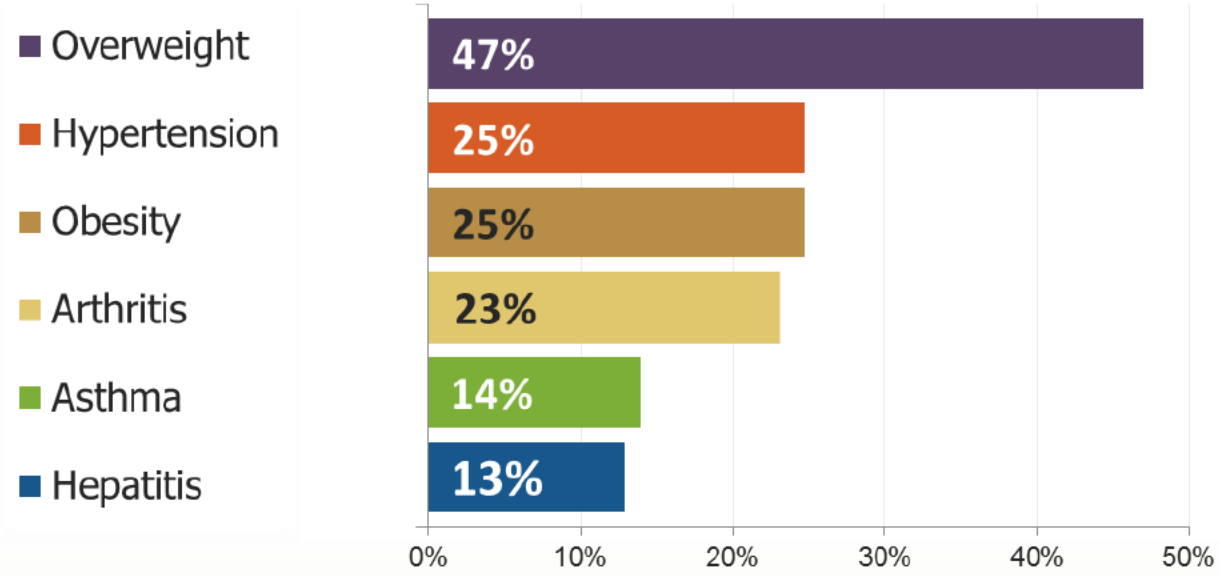
Characteristics of WA Adult Jail Inmates:



Source: DSHS, RDA Behavioral Health Needs of Jail Inmates in Washington State, January 2016

The Rationale

The prevalence of chronic medical conditions among U.S. adult jail and prison inmates is high:

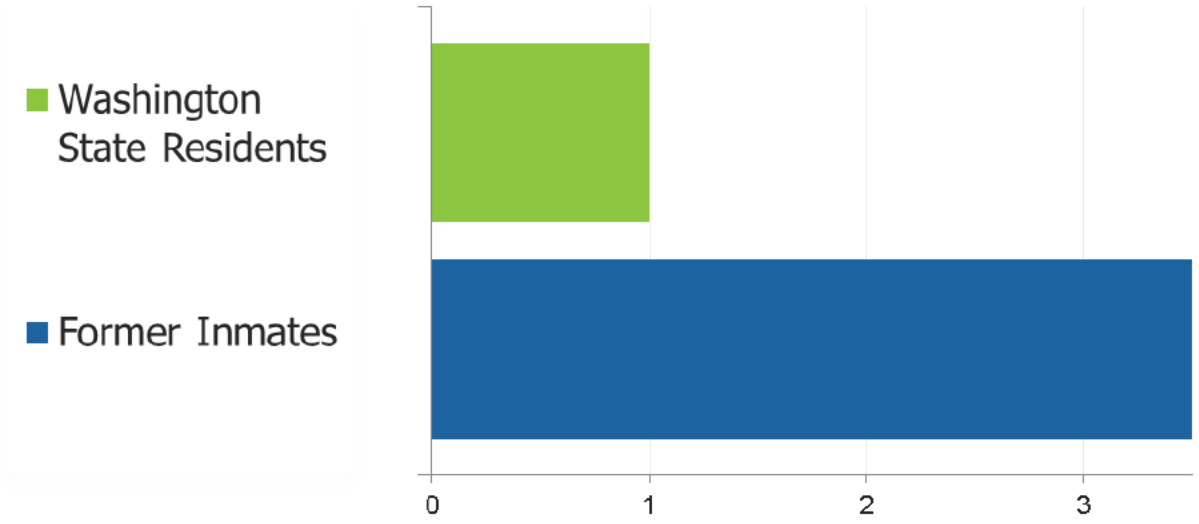


American College of Correction Physicians, 2010
http://societyofcorrectionalphysicians.org/corrdocs/corrdocs-archives/winter-2010/chronic-medical-diseases-among-jail-and-pris

The Rationale

High Mortality Rates Following Release from Prison (WA):

- Risk of Death: 3.5 times that of other WA state residents

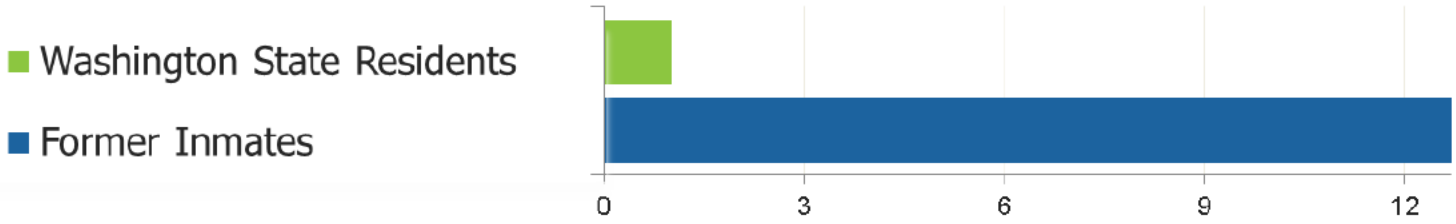


Release from Prison – A High Risk of Death for Former Inmates, New England Journal of Med. January, 2007 WA inmates vs. general pop

The Rationale

High Mortality Rates Following Release from Prison (WA):

- Risk of Death (within 2 weeks of release):
  12.7 times that of other WA state resident



- ✓ **Drug overdose due to a decrease in tolerance**
- ✓ **Cardiovascular disease**
- ✓ **Homicide**
- ✓ **Suicide, cancer, car accidents (all relatively equal)**

Release from Prison – A High Risk of Death for Former Inmates, New England Journal of Med. January, 2007 WA inmates vs. general pop

The Rationale

High Mortality Rates Following Release from Prison (WA):

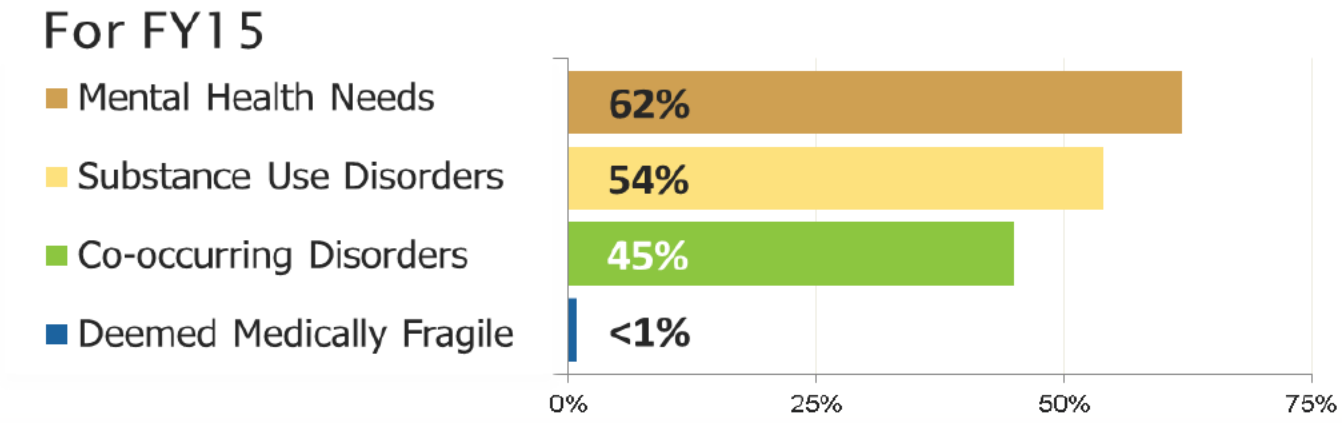
Persons with mental illness may have particular difficulty obtaining care and medications once they have returned to the community

Release from Prison – A High Risk of Death for Former Inmates, New England Journal of Med. January, 2007 WA inmates vs. general pop

The Rationale

Medicaid Eligibility for Youths in Juvenile Rehabilitation (JR) is high:

- During a 12 month review 84% of JR youth were found to be Medicaid eligible
- JR youth have an increased need for access to care.



Source: JRA – Chronic Medical Conditions not tracked

The Rationale

Incarceration and Health

- Not only do justice involved tend to have greater health issues but incarceration itself may have a lasting and significant impact on health
- The strongest negative effects that appear to be associated with incarceration emerge after release:

Immediate impact

- Suicide, depression and difficulty coping

Long term impact

- Prolonged stress and its physical implications
- Exposure to infectious diseases
- Affects on marriage and unemployment which are closely tied to health outcomes

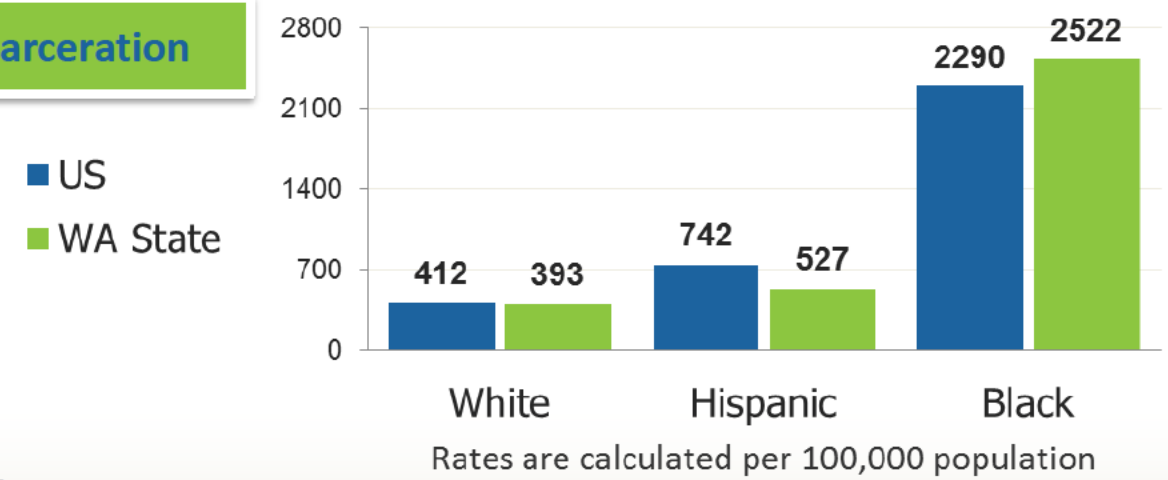
Incarceration, Health and Racial Disparities in Health, Law & Society Review Vol 42, Number 2, (2008)

The Rationale

Incarceration and Health Disparities

- Terminating benefits due to incarceration has a much greater impact on access to health care for people of color
- Medicaid suspension is process that while applied to all, may be one opportunity for addressing health disparities

Rates of Incarceration



BJS Prison and Jail Inmates 2005

The Scope

Setting	# of Facilities	Average Daily Population
WA DOC*	12	18,299
WA City/County Jails	59	12,014
Detention Centers	32	373
Special Commitment Center	3	280
Juvenile Rehabilitation Facilities	3	301
Tribal Jails	Approx. 8	Varies by facility
Institutions for Mental Diseases	4	Western State: 800 beds Eastern State: 287 beds Maple Lane: 30 beds Yakima: 24 beds

DOC * not including work release

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Policy Proposals

Suspension of both MAGI and classic Medicaid in all populations (Jails, DOC, JR, state hospitals, detention centers and SCC)

Suspend immediately and indefinitely – We will suspend upon incarceration and will not terminate coverage regardless of how long incarceration will be, unless other eligibility factors change.

Policy Proposals

MAGI Medicaid will auto renew

Classic Medicaid renewals will continue to follow the current process

MAGI Medicaid notifications regarding coverage changes will be handled electronically and at the time of incarceration when feasible

Medicaid eligibility notices will have a statement that coverage will be suspended if incarcerated

Required changes to family coverage will be addressed manually*

*Manually = by an HCA / DSHS worker

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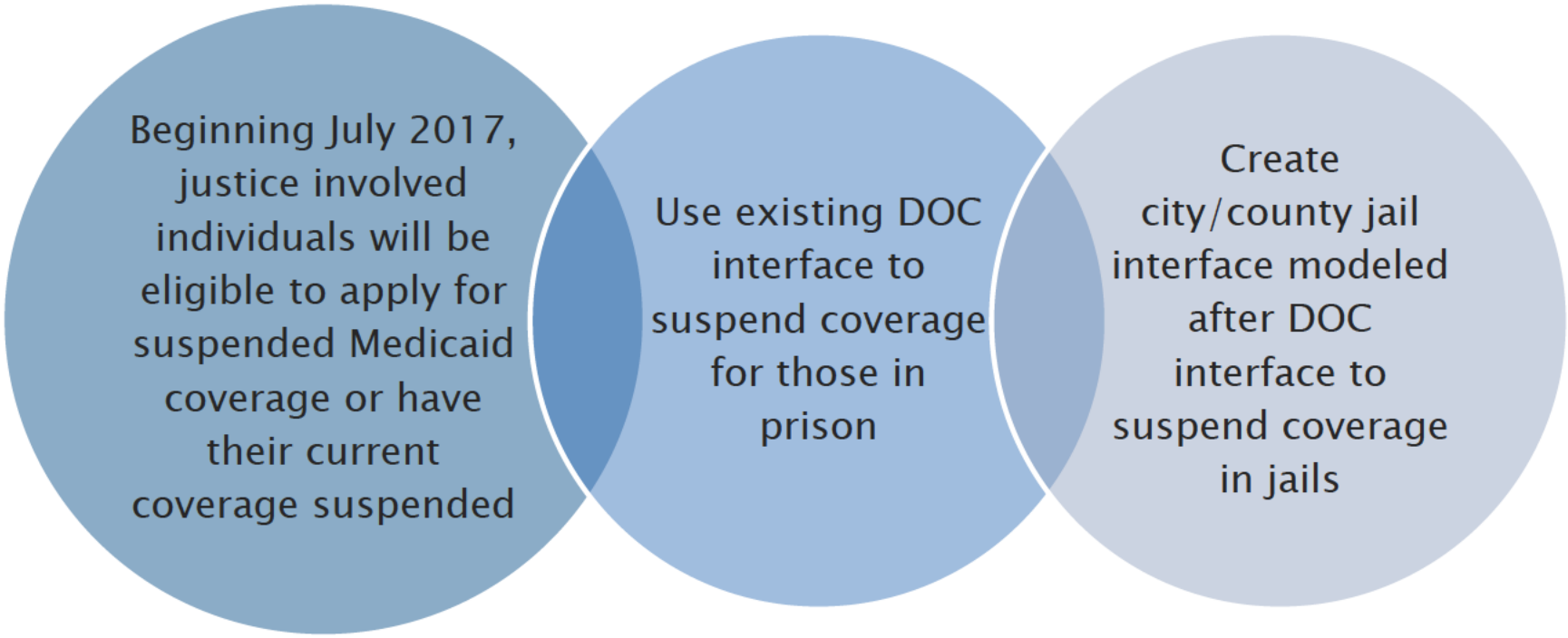
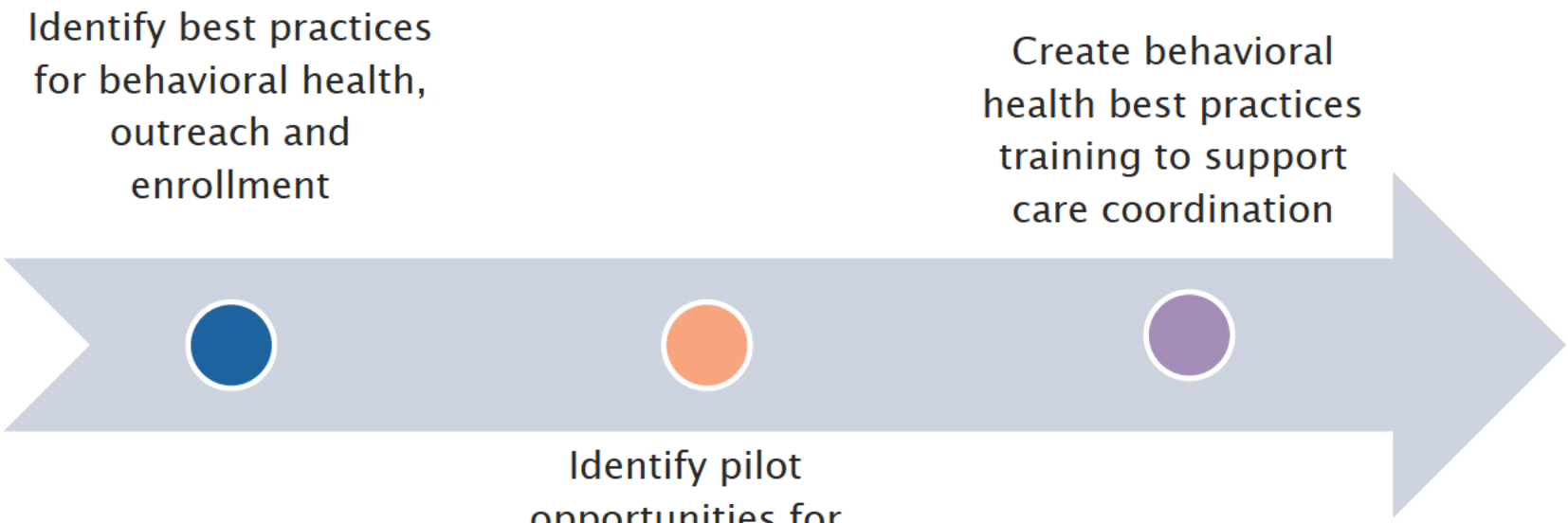
Proposed Implementation Plan

Phase One: Spring 2016 – July 2017



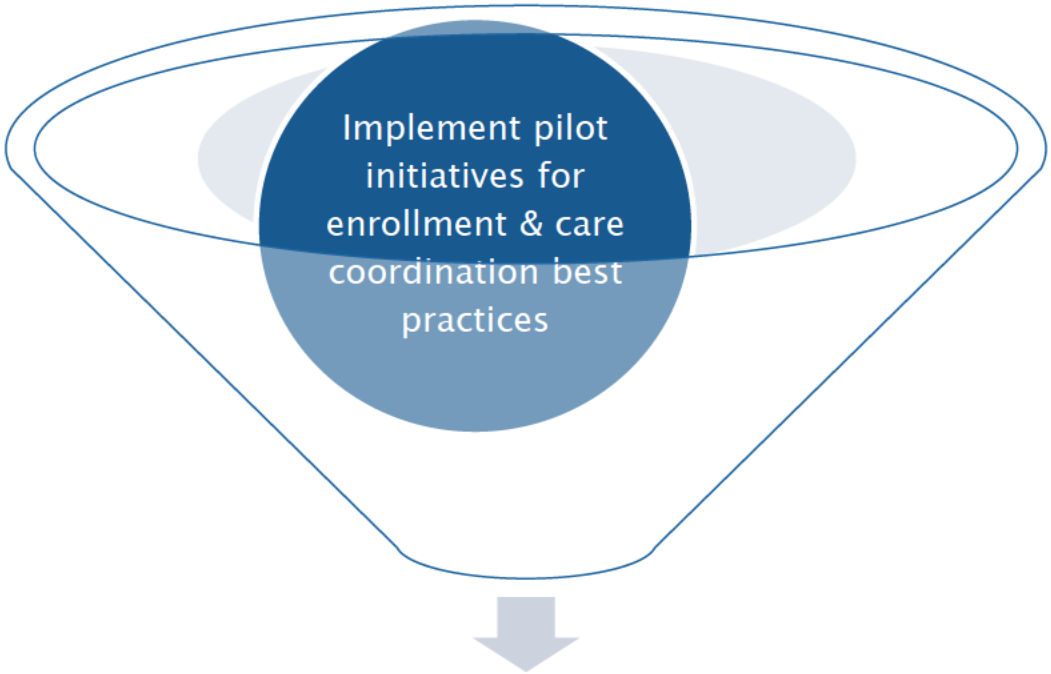
Proposed Implementation Plan

Phase One: Spring 2016 – July 2017



Proposed Implementation Plan

Phase Two: July 2017 and beyond



Deliver best practices training to support enrollment & care coordination

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Next Steps

Booking Data

- In order to suspend, booking data is needed

Outreach and Training

- Participation needed

Outreach and Training Workgroup

The purpose of the Outreach and Training workgroup is to work with stakeholders and subject matter experts to determine:

- Behavioral health and care coordination best practices
- Content of trainings
- Delivery method of training
- Timelines
- Necessary resources

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Outreach and Training Workgroup

Areas of scope identified by the Outreach and Training workgroup :

Type of Care

Behavioral health/physical health/supportive services

Populations (not location):

- Juvenile Rehabilitation
- DOC
- Juvenile Detention
- Special Commitment Centers
- Jails
- Tribal Jails
- Institutions for Mental Disease

Outreach and Training Workgroup

Areas of scope identified by the Outreach and Training workgroup :

Avenues for implementing best practices

Juvenile Rehabilitation

Judicial

Juvenile Detention

Special Commitment Center

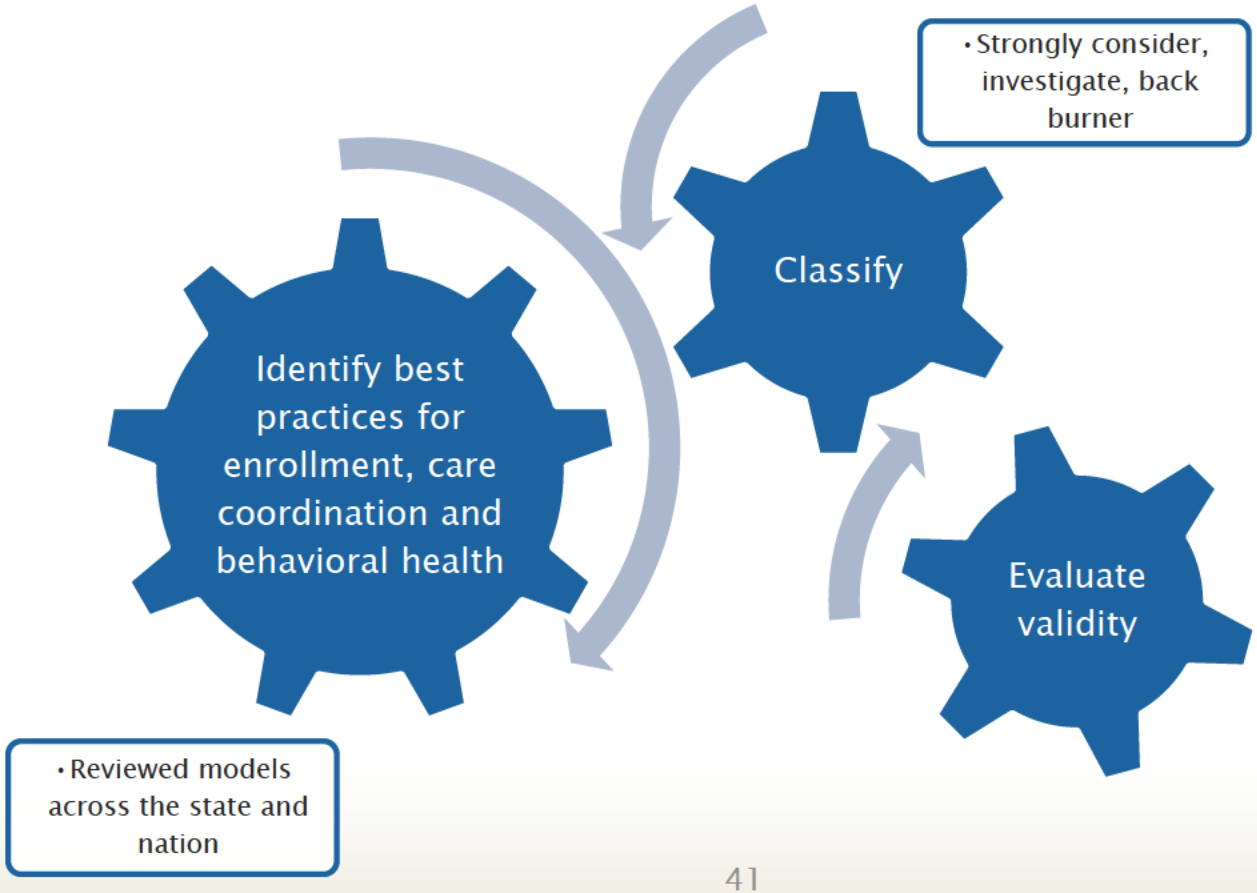
City/County Jails

DOC

Institutions for Mental Disease

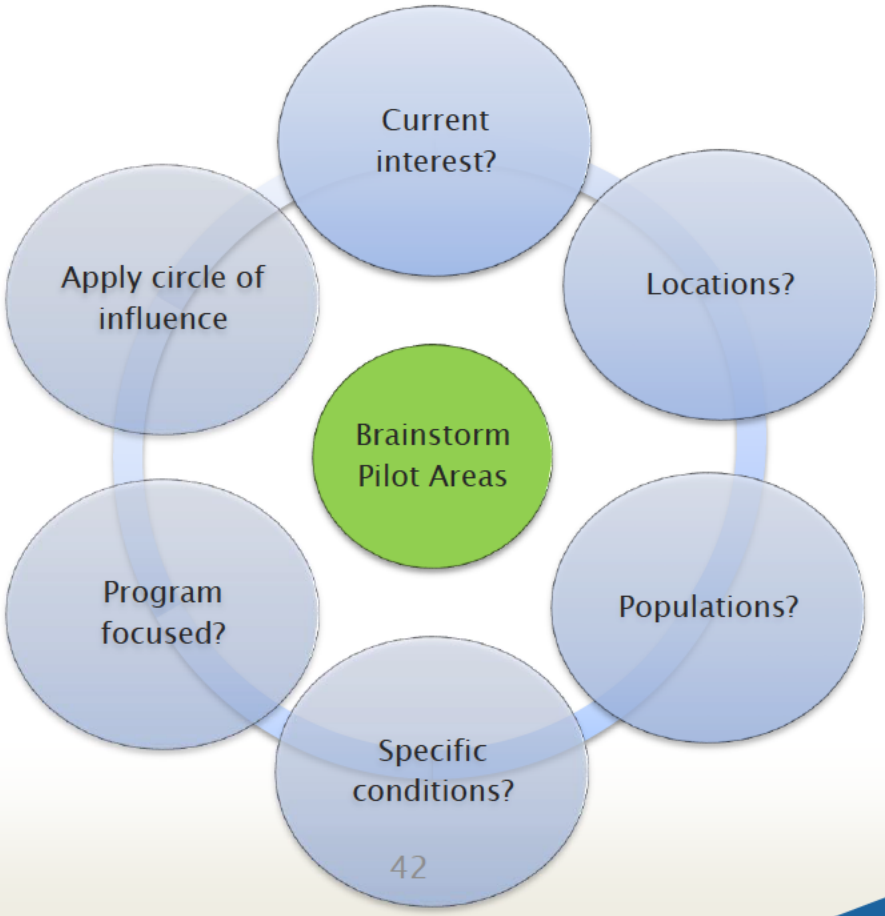
Outreach and Training Workgroup

Next steps - Identification & classification of best practices:



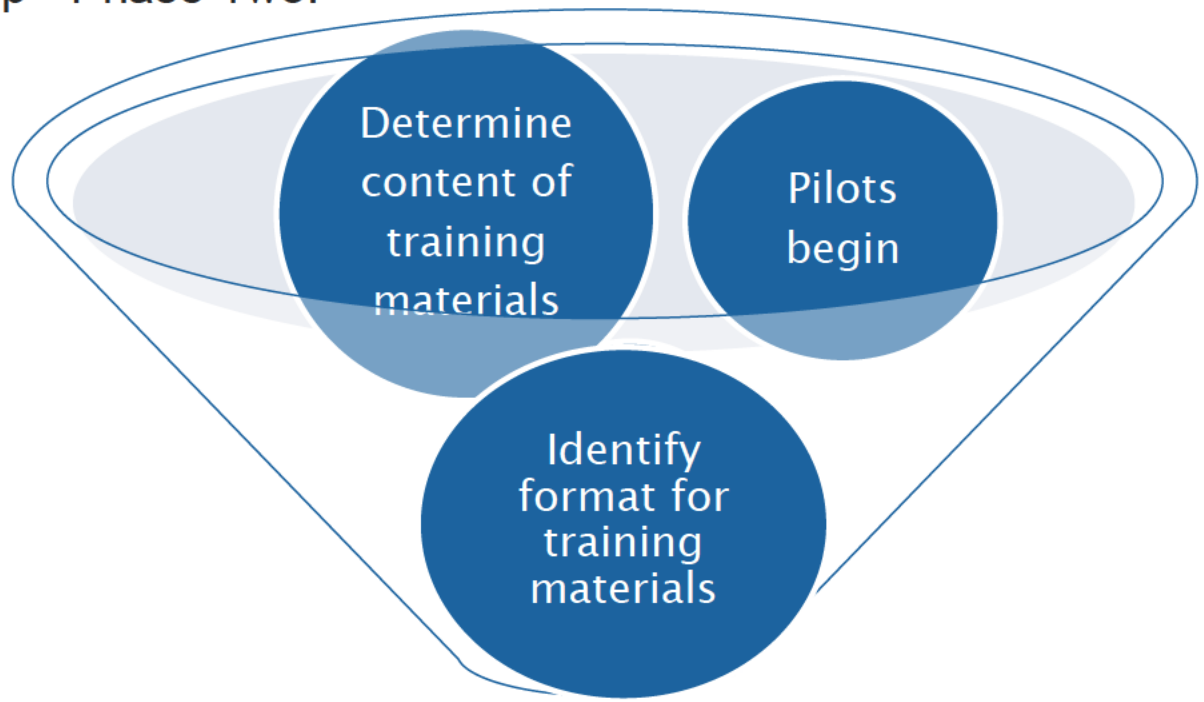
Outreach and Training Workgroup

Next steps - Identification of pilot opportunities:



Outreach and Training Workgroup

Next step - Phase Two:



Deliver trainings & communicate key learnings from pilots

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Questions?

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(360) 725-1919

Update:
BHO-Tribal-State Meeting

Update: Follow Up Meeting for BHO-Tribal-State Breakout Session

- BHO-Tribal-State breakout session held at the AIHC's Biennial Tribal Leaders Health Summit on November 1, 2016.
  - Six BHO's present
  - DBHR (Chris Imhoff/Loni Greninger), HCA (Jessie Dean) present
  - 10 tribes present
  - 1 UIHO present
- Group Discussion
  - Current relations and access to services (how can we strengthen these?)
  - What does the future hold (Mental Health Carve Out, Integration by 2020)?
- Group Consensus
  - Follow up meeting should be scheduled
  - Loni sent out a Doodle Poll for availability on 12/02/2016

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Update:
Medicaid Provider Ownership and Disclosure Requirements

Disclosure: History

During the second quarter of 2015, HCA received queries from multiple Indian health care providers about being required to provide SSNs and dates of birth for managing employees, board members, and officers.

HCA submitted requests to CMS Program Integrity in 2015 and to CMS Tribal Affairs in 2016

CMS Tribal Affairs helped give HCA definitive guidance on September 28, 2016.

Disclosure: Requirements

42 C.F.R. § 455.104 requires HCA to obtain from every Medicaid provider (except individuals or groups) (including through Managed Care Entities) the name, address, date of birth, and SSN of:

- Any managing employee of the provider; and
- Any person with an ownership or control interest in the provider.
  - Additional disclosure requirements apply to persons with an ownership or control interest in the provider.

Disclosure: Definitions

42 C.F.R. § 455.101 defines:

- "Managing employee"
  - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the provider.
- "Person with an ownership or control interest"
  - A person or corporation that:
    - Has total direct and indirect ownership interest ≥ 5%,
    - Owns 5% or more of any loan secured by the provider,
    - Is an officer or director of the provider organized as a corporation, or
    - Is a partner of the provider organized as a partnership.

Disclosure: Scenarios for Indian Health Care Providers

- IHS and Tribal 638 facilities typically disclose for:
  - Managing employee - Tribal health director or tribal clinic administrator.
  - No requirement to disclose information about any person with an ownership or control interest because IHS and Tribal 638 programs are not corporations or partnerships.
- Urban Indian Health Programs typically disclose for:
  - Managing employee - Executive director or chief executive officer.
  - Members of Board of Directors.
  - Officers.

Disclosure: Timing Requirements

42 C.F.R. § 455.104 requires these disclosures from providers to be made at any of the following times:

- When the provider submits the provider application.
- When provider signs the provider agreement.
- When HCA asks the provider during the revalidation of enrollment process under 42 C.F.R. § 455.414.
  - HCA must revalidate the enrollment of every provider at least every 5 years.
- Within 35 days after any change in ownership of the provider.

Review Tribal Issues Grid

Questions?

Issues?

Concerns?

Thank you.

HCA

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