



# HCA-BHA Monthly Tribal Meeting January 23, 2017

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Division of Behavioral Health & Recovery





# Agenda

9:00 AM	Welcome, Blessing, Introductions
<b>9:10</b> AM	Health Care Related Tribal Liaisons and 2017 HCA Meetings
<b>9:20</b> AM	Some Federal Updates
9:20 AM	1915(b) Waiver – BHOs and Carve-Out
<b>9:30</b> AM	Mental Health Fee-for-Service Implementation
9:55 ам	BHO-Tribal-State Meeting – Scheduling
<b>10:00</b> AM	ADAI/NWTTC: Tribal Feedback on Training Needs
<b>10:30</b> AM	1115 Waiver
	<ul> <li>Tribal Terms in 1115 Waiver Terms and Conditions</li> </ul>
	<ul> <li>Next Steps: Requirements for Tribal Specific Projects</li> </ul>
	<ul> <li>Next Steps: Tribal Engagement and Collaboration Protocol</li> </ul>
<b>11:15</b> AM	Health Home Program – Overview & Tribal Opportunities
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# Welcome, Blessing, Introductions







# 2017 Contact Information & Tribal Meetings





# Introduction: Libby Watanabe

- Position: Healthier Washington Tribal Liaison
- Experience:
  - Chief Operating Officer, Toiyabe Indian Health Project
    - ➤ HRSA-funded 638 Tribal FQHC
  - Administrative and Clinical Positions, Southeast
     Alaska Regional Health Consortium
    - ➤ 638 Tribal health consortium of 18 Native communities of Southeast Alaska

# Tribal Liaisons

Dept. of Health





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Public Health + Professional Licensing

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Healthier WA

**Health Care** 

Loni Greninger

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Long-Term

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Medicaid + PEBB

**Health Care Authority** 





## 2017 HCA-BHA Monthly Tribal Meetings

Fourth Monday of each month, 9:00-12:00.

Date	Webinar Registration Link
January 23	https://attendee.gotowebinar.com/register/6789508866406136579
February 27	https://attendee.gotowebinar.com/register/980777941749258499
March 27	https://attendee.gotowebinar.com/register/7527850715667034371
April 24	https://attendee.gotowebinar.com/register/1158830655728061443
May 22	https://attendee.gotowebinar.com/register/5803288717732946691
June 26	https://attendee.gotowebinar.com/register/763986134589062403
July 24	https://attendee.gotowebinar.com/register/6877808450054212609
August 28	https://attendee.gotowebinar.com/register/68348221284001025
September 25	https://attendee.gotowebinar.com/register/1775186091778381569
October 23	https://attendee.gotowebinar.com/register/2921005850781489921
November 27	https://attendee.gotowebinar.com/register/8185769890270663681
December 11*	https://attendee.gotowebinar.com/register/2602785195471032066





#### 2017 HCA Tribal Compliance & Operations Workgroup Meetings

Second Wednesday of each month, 9:00-11:00.

Date	Webinar Registration Link
January 11	https://attendee.gotowebinar.com/register/645460983944651011
February 8	https://attendee.gotowebinar.com/register/8499216466055612163
March 8	https://attendee.gotowebinar.com/register/6429526564255656963
April 12	https://attendee.gotowebinar.com/register/3479508279630334467
May 10	https://attendee.gotowebinar.com/register/6877758971992974339
June 14	https://attendee.gotowebinar.com/register/2083214274261795075
July 12	https://attendee.gotowebinar.com/register/3681071850745879299
August 9	https://attendee.gotowebinar.com/register/4112191459508483075
September 13	https://attendee.gotowebinar.com/register/4799488481449873923
October 11	https://attendee.gotowebinar.com/register/1545454132232859139
November 8	https://attendee.gotowebinar.com/register/6915059903965318915
December 13	https://attendee.gotowebinar.com/register/6634143479161580803





### **Some Federal Updates**







### 2017 IHS Encounter Rates

	Lower 48 States	Alaska
Inpatient Hospital Per Diem (excludes professional services)	\$2,933	\$3,235
Outpatient Per Visit Rate (excludes Medicare)	\$391	\$616
Outpatient Per Visit Rate (Medicare)	\$349	\$577
Medicare Part B Inpatient Ancillary Per Diem	\$679	\$1,046







#### Four Walls Limitation

- In December, CMS told the states and tribes that tribal clinics are not permitted to provide services outside of their four walls unless the client is homeless.
- On January 18, 2017, CMS issued guidance (see Q&A #13) that CMS has no present intention to review claims by Tribal "clinical services" providers for services furnished outside of the "four walls" before January 30, 2021.
- The State is still reviewing this guidance and considering sending a letter to CMS for reconsideration.





#### Exemption Certificate Number (ECN)

A number the Marketplace provides when you qualify for a health insurance exemption. When you fill out an exemption application, the Marketplace will review it and determine if you qualify. The Marketplace will mail you a notice of the exemption eligibility result. If you qualify for an exemption, the notice will include your unique identifier, called the exemption certificate number (ECN). You'll need your ECN when you file your federal taxes for the year you don't have coverage. Each member of your household who qualifies for the exemption will get their own ECN. You'll use the numbers to complete IRS Form 8965—Health Coverage Exemptions (PDF).

- HCA has been receiving calls from AI/AN clients asking for their ECN.
- The Health Benefit Exchange is the agency that issues ECNs.
- If a Healthplanfinder call center employee says otherwise, please ask for a supervisor.







# 1915(b) Waiver — BHOs & Carve-Out





# 1915(b) Waiver: Timeline

Currently, State is operating Medicaid through BHOs under an extension of the previous 1915(b) waiver as amended on April 1, 2016.

#### March 2017

 State will submit 1915(b) waiver renewal application to CMS for July 1, 2017 effective date

#### June 2017

 State will submit State Plan Amendment for the Medicaid Fee-for-Service (FFS) rates to CMS for July 1, 2017 effective date

#### July 1, 2017

Mental Health FFS program implemented





# 1915(b) Waiver: Language

#### Current 1915(b) Waiver Language for MH FFS Carve Out

The Medicaid-eligible American Indian/Alaska Native population is exempted from the Waiver for substance use disorder services in the BHO Regions only until July of 2017. Beginning in July of 2017 the American Indian/Alaska Native population will be exempted from the Waiver for mental health and substance use disorder services in all Regional Service Areas (RSAs). For any Medicaid-eligible Al/ANs who do not select a managed care plan or a FFS plan at the time of application, they will be auto assigned to the FFS program but will have the option to request to be enrolled in managed care for behavioral health services.

This is the same language that resulted from the tribal consultation in 2016.









## 1915(b) Waiver: Question

For the State's Dear Tribal Leader Letter for the 1915(b) waiver renewal application, should the State:

Include dates for a tribal roundtable and/or tribal consultation

or

 Follow standard protocol and leave it to tribes and Indian Health Care Providers to request tribal consultation?







# Mental Health Fee-for Service Implementation





# Mental Health FFS Implementation

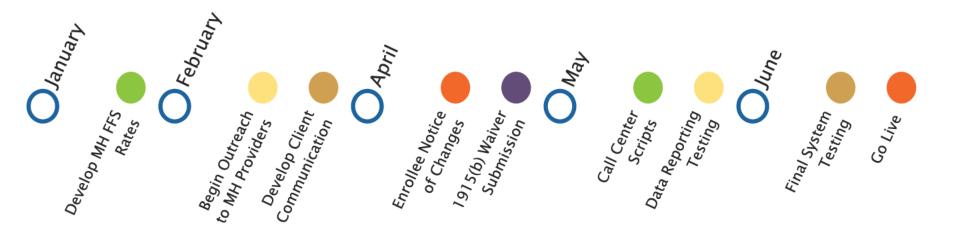
- On track to implement MH FFS on July 1, 2017
- Tribal requests to:
  - ➤ Involve IPAC, and
  - ➤ Include tribal representatives on State's implementation workgroups
- No decommission date yet for TARGET
  - Once Behavioral Health Data Store is more operational,
     State will work to transition away from TARGET







### 2017 MH FFS Implementation Timeline







# MH FFS Implementation Workgroups

- Mental Health Provider Enrollment
- Communications
  - ➤ Providers
  - **≻**Clients
- Rates/Budget Development
- Data Structure
- Information Sharing
- Systems Configuration
- Waiver/SPA Development





# MH FFS Implementation Workgroups

- State agency executive workgroup will meet this week to discuss tribal requests for tribal representation on MH FFS Implementation Workgroups
- If approved, State will send solicitation for tribal representatives







#### MH FFS Implementation – Policy Questions

- How to support referrals from Indian health care providers to MH providers in BHO networks
- How to support tribal care coordination for clients receiving care from MH FFS providers
- How to support AI/AN choice of FFS and managed care
  - ➤ AI/AN clients of tribes
  - > AI/AN clients of urban Indian health programs
  - Other AI/AN clients





# **BHO-Tribal-State Meeting**





### **BHO-Tribal-State Meeting**

- During the Behavioral Health Breakout Session at the AIHC State-Tribal Leaders Health Summit, the participants agreed to schedule a BHO/MCO-Tribal-State meeting
- DBHR (Loni) will be sending out a new Doodle Poll by January 27<sup>th</sup> for availability of Tribal, State, and BHO representatives (Jessie will forward to MCOs)
  - ➤ Please keep an eye on your email inboxes.







# **ADAI/NWTTC:** Tribal Feedback on Training Needs





#### The ATTC Network

#### **Ten** Regional Centers

Four National Focus Centers

 SBIRT: Screening, Brief Intervention and Referral to Treatment

Hispanic & Latino

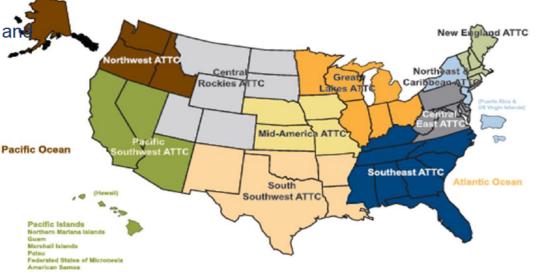
 Native American-Alaska Native

Rural & Frontier

#### Two Centers of Excellence

• YMSM + LGBT: Young Men Who Have Sex With Men + Lesbian, Gay, Bisexual, Transgender

PPW: Pregnant and Postpartum Women



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#### Mission of the ATTC Network

- Accelerate the adoption and implementation of evidencebased and promising addiction treatment and recoveryoriented practices and services;
- Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders; and
- Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.



Selected NWATTC Course Topics

Interviewin

Medication
Assisted
Treatment

Treatment Planning MATRS

**ASAM** 

Clinical Supervision

**Ethics** 

Occurring
Disorders

**SBIRT** 

Support Technologi

MET/CBT:

Encompass

© model

Telehealth

Cannabis





### A few useful resources



Marijuana Lit



Listserv(s)



Taking Action to Address Opioid Misuse





# Opportunities for WA State Tribal Treatment Providers, Agencies, and Communities

- WA State listserv for AI/AN tribal treatment providers, agencies, and other key stakeholders
- Survey of training and technical assistance needs
- 3 major training opportunities during 2017
  - Advanced MI with focus on working with AI/AN clients
  - Medication Assisted Treatment for opioid use disorder
  - 3.5



# How might NWATTC support your training and technical assistance needs?







#### Visit Us Online!

- Upcoming trainings
- The range of training and technical assistance services we offer
- Resources and links on key topics

## www.attcnetwork.org/northwest









### Waiver





## CMS Approval of 1115 Waiver

CMS sent approval to the State on January 9, 2017

- Terms and conditions at <a href="http://www.hca.wa.gov/sites/default/files/program/Medicaid-demonstration-terms-conditions.pdf">http://www.hca.wa.gov/sites/default/files/program/Medicaid-demonstration-terms-conditions.pdf</a>
- Effective date: January 1, 2017

**Initiative 1:** Projects to transform the Medicaid delivery system within each region to care for the whole person.

Initiative 2: Services to (a) expand options for people receiving long-term services and supports so they can stay at home and delay or avoid the need for more intensive services, and (b) increase the well-being of unpaid family caregivers.

*Initiative 3:* Targeted housing and employment support services to help vulnerable Medicaid clients get and stay healthy.





### Tribal Terms in 1115 Waiver T&Cs

- 8(a), 9 State extension, suspension, or termination of waiver must comply with tribal consultation requirements.
- 14 CMS withdrawal of waiver authority requires tribal consultation within 30 days of publishing CMS notice on its website.
- Compliance with tribal consultation requirements of 42 C.F.R. § 431.408(b)(2).
- Compliance with managed care protections and exemption from DOH professional licensing.





#### Tribal Terms in 1115 Waiver T&Cs

- Compliance with exemption from mandatory managed care for AI/AN clients.
- 23(f) ACH decision-making body must include voting partners from one or more representatives from the tribes, IHS facilities, and UIHPs in the region.
- 24 Tribal Engagement and Collaboration Protocol
  - State, tribes, and IHCPs must develop and submit Tribal Protocol no later than 60 days after January 1, 2017.





- 24 Tribal Engagement and Collaboration Protocol
  - ACHs must adopt State's Model ACH Tribal Collaboration & Communication Policy or an alternative agreed by all parties in region.
  - ACH governing boards must make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local tribes and IHCPs and on the needs of both tribal and urban Indian populations.





## 24 Tribal Engagement and Collaboration Protocol

- Tribal Protocol must outline the objectives that the state and tribes seek to achieve tribal specific interests in Medicaid transformation.
- Tribal Protocol must specify process, timelines, and funding mechanics for tribal specific demonstration activities, including the potential for financing tribal specific activities through alternative sources of nonfederal share.





- Tribal Coordinating Entity (TCE). State will facilitate a TCE and work with the TCE:
  - To provide opportunity to review programs and projects implemented through delivery system reform efforts under the waiver.
  - For the TCE to coordinate with affected tribes and IHCPs to provide an assessment of potential impacts as a result of delivery system reform activities on affected IHCPs and AI/ANs populations and report to CMS, ACHs, and the State.





- Tribal Coordinating Entity (TCE). State will facilitate a TCE controlled by tribes and urban Indian health programs and work with the TCE:
  - To coordinate with tribes and IHCPs to establish a cross-walk of statewide common performance measures to the GPRA measures used by tribes and IHCPs.
  - To support other tribal-specific projects implemented through this demonstration to the extent appropriate.





# 25 Tribal Specific Projects

- Tribes and IHCPs may apply for tribal specific projects without ACH or TCE involvement.
- Develop a tribal specific project, subject to CMS approval, that will enhance capacity to (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with state systems, and (iii) support tribal PCMH models.





# 25 Tribal Specific Projects

- State will work with tribes on tribal specific projects, subject to CMS approval, that align with the objectives of this demonstration, including requirements that projects reflect a priority for financial sustainability beyond the demonstration period.
- Tribal Protocol will provide further specifications for process, timeline, and funding mechanics for tribal specific projects.





- 25 Tribal Specific Projects
  - To the extent applicable, the Tribal Protocol must align with project requirements set forth in these STCs.
- 41(e) All thresholds for Value-Based Payment incentive payments exclude payments for services provided by or through IHCPs.
- 45(a)(ii) Process to certify ACHs as lead Medicaid transformation projects will require ACHs to describe their tribal engagement process.





56(a)(i) Presumptive Eligibility for Initiative 2

State may designate tribal entities as "Qualified Entities" able to determine presumptive eligibility for Medicaid Alternative Care (support for unpaid caregivers) and Targeted Supports for Older Adults (limited services and supports to help individuals avoid or delay the need for Medicaid-funded long-term care).







#### 86 Sources of Non-Federal Share

 State provides assurance that the matching non-federal share of funds for the demonstration is state/local/tribal monies.

# 87(d) State Certification of Funding Conditions

 State may use intergovernmental transfers for state, tribal, and local monies.







## **Next Steps: Requirements for Tribal Specific Projects**

# 1115 Waiver







# Organizing Principles

- Respect for the government-to-government relationships
- CMS expectations regarding consistency of approach
- Importance of the ACH role
- Recognition of tribal needs



# Project Planning Activities & Resources Transforming lives

- Regional Health Needs Inventory
  - Based on Community Health Assessment and Improvement Plans
- Statewide Value Based Payment Transition Taskforce
  - Tribal representation on taskforce
  - Additional resources available
- Statewide Workforce Development Taskforce
  - Tribal representation on taskforce
  - Community Health Workers/Community Health Representatives
- Practice Transformation Support Hub
  - Evidence-Based Practices/Promising Practices
- Statewide Performance Measures
  - Comparable GPRA measures will be accepted to minimize administrative burden
- Tribal Coordinating Entity as Resource

# Overview of the Care Authority



Transforming lives

#### Domain 2: Care Delivery Redesign

Goal: Innovative models of health care that improve quality, efficiency, and effectiveness, emphasizing person-centered and integrated care delivery.

**Requirement**: Implement 2A. Bi-directional integration of primary and behavioral health care plus one of the following:

- 2B. Community-based care coordination
- 2C. Transitional care
- 2D. Diversion interventions

# Domain 3: Prevention & Health Promotion

**Goal:** Prevention and health promotion to eliminate disparities and achieve health equity across regions and populations.

**Requirement**: Implement *3A. Strategies to reduce, treat, and prevent opioid use disorder* plus one of the following:

- 3B. Maternal and infant health
- 3C. Access to oral health care
- 3D. Chronic disease prevention and control

#### 1A. Financial Sustainability

Goal: 90% state payments tied to value by 2021

#### 1B. Workforce:

Goal: Improve and innovate how health care workforce meets community health needs

#### 1C. Population Health Mgmt

Goal: Use HIT/EHR tools to capture, analyze, and share clinical and claims data for Value-Based Payment

DOMAIN 1: HEALTH & COMMUNITY SYSTEMS CAPACITY BUILDING

# Overview State Authority



Transforming lives

#### **Domain 2: Care Delivery Redesign**

# Domain 3: Prevention & Health Promotion

2B.
CommunityBased Care
Coordination
(Optional)

2C. Transitional Care (Optional)

2D. Diversion Intervention (Optional)

3B. Maternal & Child Health (Optional) 3C. Access to Oral Health Services (Optional) 3D. Chronic Disease Prevention & Control (Optional)

2A. Bi-Directional Integration of Primary and Behavioral Care (Required)

3A. Strategies for Opioid Use Public Health Crisis (Required)

1A. Financial Sustainability

1B. Workforce

1C. Systems for Population Health Management

DOMAIN 1: HEALTH & COMMUNITY SYSTEMS CAPACITY BUILDING





# 1A: Financial Sustainability through Value-Based Payment (required)

Goal: 90% of State Payments Tied to Value by 2021

#### **Annual Benchmarks:**

End of 2017: 30%

End of 2018, 50%

End of 2019, 75%

End of 2020, 85%

End of 2021, 90%

#### **VBP Transition Plan:**

Strategies to be implemented in the region to support attainment of statewide VBP targets







# 1B: Workforce Transformation to Support Redesigned Care (required)

**Goal**: Improve and sustain alignment between health services workforce capacity and community health needs.

#### Strategies:

- Training of existing workforce, using the Practice Transformation Support Hub as appropriate
- Development and deployment efforts
- Recruitment and retention incentives and efforts to address workforce shortages (e.g., family practitioners, behavioral health providers, community health workers, dentists)
- Cultural competency/cultural humility training for providers and patient-facing staff







# 1C: Systems for Population Health Management (required)

**Goal**: Support expansion, evolution, and integration of health information technology (HIT) to improve speed, quality, safety, and cost of care and to use clinical and claims data to advance Value Based Payment (VBP) models and achieve the Triple Aim.

#### Strategies:

- Providers access and use population health data to advance VBP
- Use of population health, social service, and social determinants of health data to drive local resources
- ACHs create Population Health Management Transformation Plans that define a path toward information exchange for community-based, integrated care





# 2A: Care Delivery Redesign: Bi-Directional Integration of Primary and Behavioral Health Care (required)

**Goal**: Implement advanced team-based models that are person-centered, rely on evidence-based guidelines, and use health information technology meaningfully to support care integration and coordination.

#### Options:

- Evidence-based approaches for integrating behavioral health into primary care setting
  - Patient-Centered Medical Home
  - Collaborative Care Model
- Approaches based on emerging evidence for integrating primary care into behavioral health setting
  - Off-site, Enhanced Collaboration
  - Co-located, Enhanced Collaboration
  - Co-located, Integrated





# 2B: Community-Based Care Coordination (optional)

**Goal**: Implement a centralized approach to coordinating care coordination to ensure that clients are connected to evidence-based services that improve their outcomes (without replacing existing care coordination services under the State Plan or existing contracts).

#### Options:

- Pursue certification as a Pathways Community HUB
- Similar HUB-like centralized care coordination system (without certification) that includes the core elements of the Pathways Community HUB model







# 2C: Transitional Care (optional)

**Goal**: Implement strategies to eliminate avoidable admissions and readmissions into intensive settings of care or institutional settings, including transitions between home and inpatient care, residential treatment, supportive housing, prison, or jail.

#### **Evidence-Based Approaches for Care Management and Transitional Care:**

- Interventions to Reduce Acute Care Transfers
  - A quality improvement program that focuses on the management of acute change in resident condition
- Transitional Care Model
  - ➤ A nurse-led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up
- The Care Transitions Intervention
  - A multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives
- Care Transitions Interventions in Mental Health
  - A set of components of effective transitional care for persons with serious mental illness





# 2D: Diversion Interventions (optional)

**Goal**: Implement strategies to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care planning and case management to help lead the individual to more positive outcomes.

#### **Some Evidence-Supported Diversion Strategies:**

- · Emergency Department Diversion
  - ➤ A systematic approach to re-directing and managing persons who present at the Emergency Department for non-emergent conditions
- Community Paramedicine Model
  - ➤ An evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to care for medically underserved populations
- Law Enforcement Assisted Diversion
  - A community-based diversion approach with the goals of improving public safety and public order and reducing criminal behavior by participants in the program





# 3A: Addressing the Opioid Use Public Health Crisis (required)

#### 1. Goal: Prevent opioid misuse and abuse

- Strategy: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain
- b. Strategy: Raise awareness and knowledge of possible adverse effects of opioid use, including overdose, among opioid users
- Strategy: Prevent opioid misuse in communities, particularly among youth
- d. Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse
- e. Decrease the supply of illegal opioids

#### 2. Goal: Link individuals with opioid use disorder to treatment support services

- a. Strategy: Build capacity of health care providers to recognize signs of possible opioid misuse, effectively screen for opioid use disorder, and link patient to care
- b. Strategy: Expand access to, and utilization of, opioid use disorder medications in communities and in the criminal justice system
- c. Strategy: Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including nousing

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# 3A: Addressing the Opioid Use Public Health Crisis (required)

#### 3. Goal: Intervene in opioid overdoses to prevent death

- a. Strategy: Educate individuals who use heroin and/or prescription opioids, and those who witness an overdose, on how to recognize and appropriately respond to an overdose
- b. Strategy: Make system-level improvements to increase availability and use of naloxone
- c. Promote awareness and understanding of Washington State's Good Samaritan Law

# 4. Goal: Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions

- Strategy: Improve Washington State's Prescription Monitoring Program functionality to document and summarize patient and prescriber patterns to inform clinical decision making
- b. Strategy: Utilize the State's Prescription Monitoring Program for public health surveillance and evaluation
- Strategy: Continue and enhance efforts to monitor opioid use and opioid-related morbidity and mortality
- d. Strategy: Monitor progress toward goals and strategies and evaluate effectiveness of interventions





# 3B: Maternal & Child Health (optional)

**Goal**: Implement strategies to improve maternal and child health through (a) home visit models to help mothers recognize risk factors and promote prenatal health and healthy practices and positive parenting practices, (b) child health promotion strategies to increase use of well-child visits and child immunizations, and (c) improve family planning.

#### Some Evidence-Based Approaches:

- Home Visiting Models, such as:
  - Nurse Family Partnerships
  - Early Head Start Home-Based Model
- Strategies to improve regional well-child visit rates and childhood immunization rates
  - Bright Futures
- Implement recommendations to Improve Preconception Health and Health Care
  - Family Planning Pathway







# 3D: Chronic Disease Prevention and Control (optional)

**Goal**: Implement strategies to prevent and control chronic health conditions, including strategies to reduce cultural, linguistic, and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health.

#### **Chronic Care Model:**

- This model is applicable to most preventive and chronic care issues and, once applied to implement system changes, paves the way for new guidelines or innovation
- Within the Chronic Care Model, there is opportunity to include specific change strategies
  that target the regionally defined health disease/condition and to address the identified
  barriers to care for Medicaid beneficiaries experiencing the greatest burden of chronic
  disease

#### Specific Strategies to Consider Including within the Chronic Care Model Approach:

- The Community Guide
- Million Hearts Campaign
- Stanford Chronic Disease Self-Management Program
- CDC-recognized National Diabetes Prevention Programs (NDPP)
- Community Paramedicine Models





### **Next Steps: Tribal Engagement and Collaboration Protocol**

# Waiver







# **Next Steps: Tribal Engagement & Collaboration Protocol**

- 1. TCE funding
- 2. Tribal specific projects (including the project that will enhance capacity to (i) effectively coordinate care between IHCPs and non-IHCPs, (ii) support interoperability with state systems, and (iii) support tribal PCMH models):
  - a. Objectives
  - b. Process
  - c. Timeline
  - d. Funding mechanics, including alternative sources of nonfederal share
- **3. Provider eligibility** Protocols for tribal providers of personal care, employment support, and housing support services.





## **Next Steps: Tribal Engagement & Collaboration Protocol**

- **4. Client eligibility determinations** Protocols for tribes/IHCPs to conduct financial and functional eligibility assessments, including Initiative 2 presumptive eligibility determinations
- 5. Training on Tribes/IHCPs Non-IHCP providers of Initiative 2 and 3 services receive sufficient training, information, and direction to work with their tribal and IHCP counterparts to provide warm hand-off of cases







# WA State Health Home Program Presentation for Monthly Tribal Meeting

January 2017







# **Need for the Health Home Program**

<sup>66</sup>I diagnosed 'abdominal pain' when the real problem was hunger, I confused social issues with medical problems in other clients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes clients to miss pills or appointments as noncompliance. In one older client, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my clients' lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether. 99

> Laura Gottlieb, MD University of California San Francisco





# **Health Home history**

- Section 2703, Affordable Care Act/Financial Alignment Demonstration
- Originally launched in July 2013
- Currently in 37 counties
- Addition of King and Snohomish in April 2017
- Collaboration between WA Department of Social and Health Services and the Health Care Authority





# **The Basics**

- New set of Medicaid medical services
- Not to be confused with "Home Health"
- No cost to the client funded by Medicaid
- Voluntary participation
- Does not duplicate or change any current providers or benefits
- Community based intensive care coordination across the existing delivery system





# **Health Home goals**

- Establish a person-centered Health Action Plan, or HAP, to improve health-related outcomes and reduce avoidable costs
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health
- Bridge our systems of care







# **Health Home services**

#### Services include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care Planning
- Individual and Family Supports
- Referrals to Community and Social Support Services





# **Health Home services**

#### Services include:

Comprehensive Care Management





# **Health Home services**

#### Services include:

- Comprehensive Care Management
- Care Coordination





- Comprehensive Care Management
- Care Coordination
- Health Promotion





- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care Planning





- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care Planning
- Individual and Family Supports





- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Transitional Care Planning
- Individual and Family Supports
- Referrals to Community and Social Support Services





## Focus on high-risk clients

- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective and achieves a return on investment





## Who is eligible?

- All ages; children and adults
- Qualifying chronic conditions:

**Asthma** 

**Behavioral Health** 

Cancer

Cerebrovascular Disease

**Chronic Respiratory Conditions** 

Coronary Artery Disease

Dementia

Diabetes

Gastrointestinal

**Heart Disease** 

**Hematological Conditions** 

**HIV/AIDS** 

Intellectual Disability

**Musculoskeletal Conditions** 

Neurological Disease

Renal Failure

Substance Use Disorder





## Who is eligible?

- PRISM is an acronym for Predictive Risk Intelligence SysteM
- Medicaid clients with risk scores of 1.5 or greater may qualify for the Health Home program





## Who is not eligible?

- Clients enrolled in other care management programs such as Hospice or PACE (Program of Allinclusive Care for the Elderly)
- Clients enrolled in a Primary Care Case Management (PCCM) program.
- Clients with comparable health insurance such as Medicare Part C, Tricare, or commercial insurance





## **Care Coordinators Role**

- Provide person-centered care using a Health Action Plan
- Develop client identified goals and action steps to help achieve the goals
- Care Coordinator qualifications include:
  - RNs, PAs, Psychologists, Mental Health Specialists, Licensed Social Workers, Chemical Dependency Professionals
  - Others may qualify on an exception basis provided they have the education, training, and experience.
- All Care Coordinators must attend the state approved two-day training course and 6 mandatory webinars





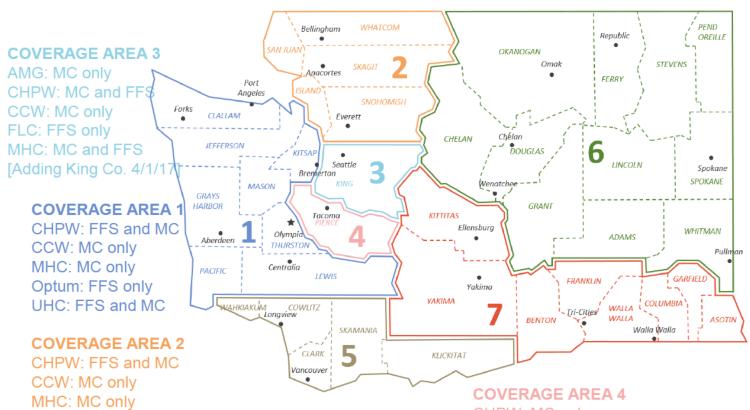
## **ADMINISTRATIVE STRUCTURE**







## Lead organizations by coverage area



**COVERAGE AREA 5** 

NWRC: FFS only

Optum: FFS only

UHC: FFS and MC

[Adding Snohomish Co. 4/1/17]

CHPW: FFS and MC

CCW: FFS only Optum: FFS only MHC: FFS and MC

CHPW: MC only CCW: MC only MHC: MC only Optum: FFS only UHC: FFS and MC

#### **COVERAGE AREA 6**

Community Choice: FFS on

CHPW: MC and FFS

CCW: MC only MHC: MC only

UHC: FFS and MC

#### **COVERAGE AREA 7**

CHPW: MC only CCW: MC only MHC: MC only Optum: FFS only

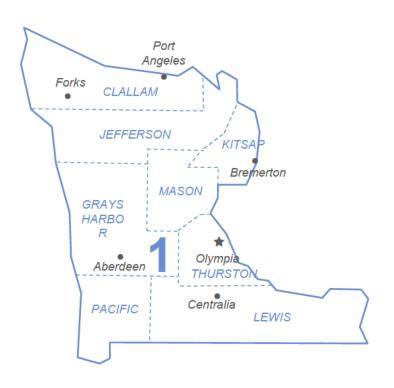
SE WAALTC: FFS only

UHC: FFS and MC





## **Lead organizations**



#### **COVERAGE AREA 1**

Community Health Plan of WA

Coordinated Care of WA

Molina Health Care

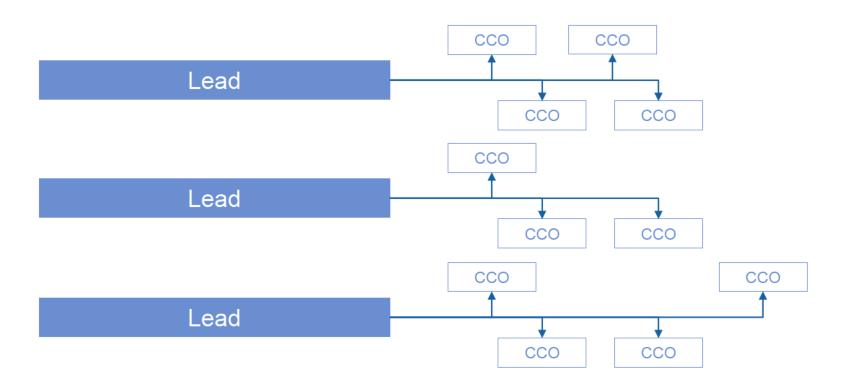
Optum

**United HealthCare** 





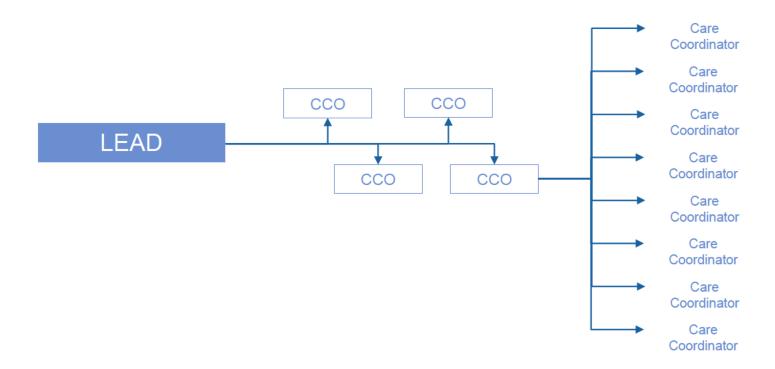
## **Care Coordination Organizations**







## **Administrative structure**







## **Tribal Opportunities**

- Al/AN clients must request to be enrolled in the Health Home program
- Tribe contracts as a Lead or as a CCO
- When contracting, Tribes can specify which Health Home eligible clients they wish to serve:
  - Al/AN clients only?
  - Dual-eligible clients only?
  - All eligible clients?





#### **TIER ONE**

Initial engagement & action planning

\$252.93 - Lead \$227.64 - CCO

#### **TIER TWO**

Intensive level of care coordination

\$172.61 - Lead \$155.35 - CCO

#### **TIER THREE**

Low level of care coordination

\$67.50 - Lead \$60.75 - CCO

Lead agencies keep up to 10% of the total rate to cover administrative costs





## TIER ONE

Initial engagement & action planning

Initial contact with the client, to include:

- Face-to-face meeting
- Confirmation of desire to participate
- Completing required assessment
- Developing initial Health Action Plan (HAP)





TIER TWO

Intensive level of care coordination

Ongoing care coordination, to include:

- Monthly face to face visit
- Covers all care coordination services during any month in which this level of care was provided





## TIER THREE

Low level of care coordination

Maintenance for clients with higher level of selfmanagement, to include:

- Periodic home visits and/or telephone calls
- Reassessment of client's health care needs





## **SUCCESS STORIES**







## "Lilly"

### Lilly was having the following difficulties:

- 13 year old female with Asperger's, sensory disorder, depression, environment and food allergies
- Recurring illnesses have set her back
- Multiple failures in school





## "Lilly"

Lilly's Health Home care coordinators helped with:

- Mom getting organized
- Mom joined support group
- Occupational Therapy started
- Expanded 504 plan
- Implemented reward system to address school and health compliance
- Daily transfusions that Mom can do herself for autoimmune





## "Lilly"

### Lilly's progress so far:

- Passed the eighth grade and doing better academically
- Health periods last longer





## "Sam"

#### Sam's difficulties:

- 56 year old with Schizophrenia, Pancreatitis, Diabetes, Hypertension
- Not taking medications regularly including the insulin
- At risk to lose benefits
- Delusional and considering suicide
- Frequent Emergency Room visits





## "Sam"

#### After a year in the Health Home program:

- No Emergency Department or inpatient visits
- Taking medications regularly
- Mental health services provided in the home
- Started working with diabetes specialist
- Attending church





## Is it working?

# YES!

- Health Home services are changing lives
- Health Home services are reducing healthcare costs





### **Health Home resources**

- HCA website: <a href="http://www.hca.wa.gov/billers-providers/programs-and-services/health-homes">http://www.hca.wa.gov/billers-providers/programs-and-services/health-homes</a>
- DSHS website: <u>https://www.dshs.wa.gov/altsa/washington-health-home-program</u>
- Email us: <u>Healthhomes@hca.wa.gov</u>





## **Other Business**



#### Division of Policy, Planning & Performance Office of Tribal Affairs & Analysis

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<u>tribal/Pages/index.aspx</u>

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#### Transforming lives

# Behavioral Health Administration Division of Behavioral Health & Recovery

Web: <a href="https://www.dshs.wa.gov/bha/">https://www.dshs.wa.gov/bha/</a> division-behavioral-health-and-recovery

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