Washington State Health Care Authority

Washington State Department of Health

Washington State Department of Social & Health Services

Transforming lives

HCA Monthly Tribal Meeting
and
Tribal Roundtable #2 on House Bill 1388
(Agency Behavioral Health Integration)

April 5, 2018

9:00 a.m. – Noon

Welcome, Blessing, Introductions

Agenda

9:00 AM Welcome, Blessing, Introductions

9:10 AM Tribal Affairs Projects
- Overview and Discussion

10:00 AM Programs being moved from DSHS to HCA
- Consultation and Communication Protocols
- Government-to-Government Planning
- Consolidated Contracting with Tribes
- Intergovernmental Transfer for Substance Use Disorder

11:30 AM Programs being moved from DSHS to DOH
- Mental Health Licensing/Certification and Tribal Attestation

11:50 AM Planning for Roundtables #2 and #3 and Consultation

Noon Closing

Tribal Affairs Projects

HCA Monthly Tribal Meeting

Tribal Affairs Projects

	2018				2019				2020				2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Medicaid Transformation	Approved 1115 Medicaid Transformation Waiver															
• Complete ACH and IHCP/Tribal Project Plans	31 tribes/IHCPs															
• Tribal systems transformation			90:10 health IT investments + EHR meaningful use + pop. health management													
• Various ACH project transformations by tribes				Varies across tribes/IHCPs and ACHs												
• IHCP/Tribal specific behavioral health projects				Varies across tribes/IHCPs												
Tribal Clinic Encounter Rules	Approved SPA 17-0042 (eff. 9/29/2017)															
• Policy clarifications: 5 encounters/day	Webinars															
• Extend encounter rate to pharmacy dispensing		Determine how to pay encounter rate for drug dispensing; submit SPA														
Medicaid Coverage: DHAT + Community Health Aides	Submitted SPA 17-0027 (CMS deadline 5/15/2018) – CMS approval not clear															
• If CMS approves or denies SPA 17-0027			SPA or 1115 waiver for community/behavioral health aides													

Tribal Affairs Projects (cont'd)

	2018				2019				2020				2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Tribal FQHC (SPA approval expected)	Submit SPA 18-0007 in Q2 2018 for CMS approval in Q3 2018															
• Develop plan and tribal briefings	Workgroup															
• Meet with tribes to help them decide on FQHC			27 tribes													
• Implement Tribal FQHC program				Technical assistance to tribes (HCA Finance + OTA)												
Governor's Indian Health Council			2018-19 supplemental budget proviso, report due 12/1/2018													
• Support Council, prepare report and bill language		Workgroup														
MCO Payment of Encounter Rate		Implement MCO payment of IHS/tribal encounter rate														
• MCOs update their claims systems	Technical assistance to MCOs															
• MCOs pay IHS/tribal encounter rate					Transition IHS/tribes and MCOs											

Tribal Affairs Projects (cont'd)

Discussion

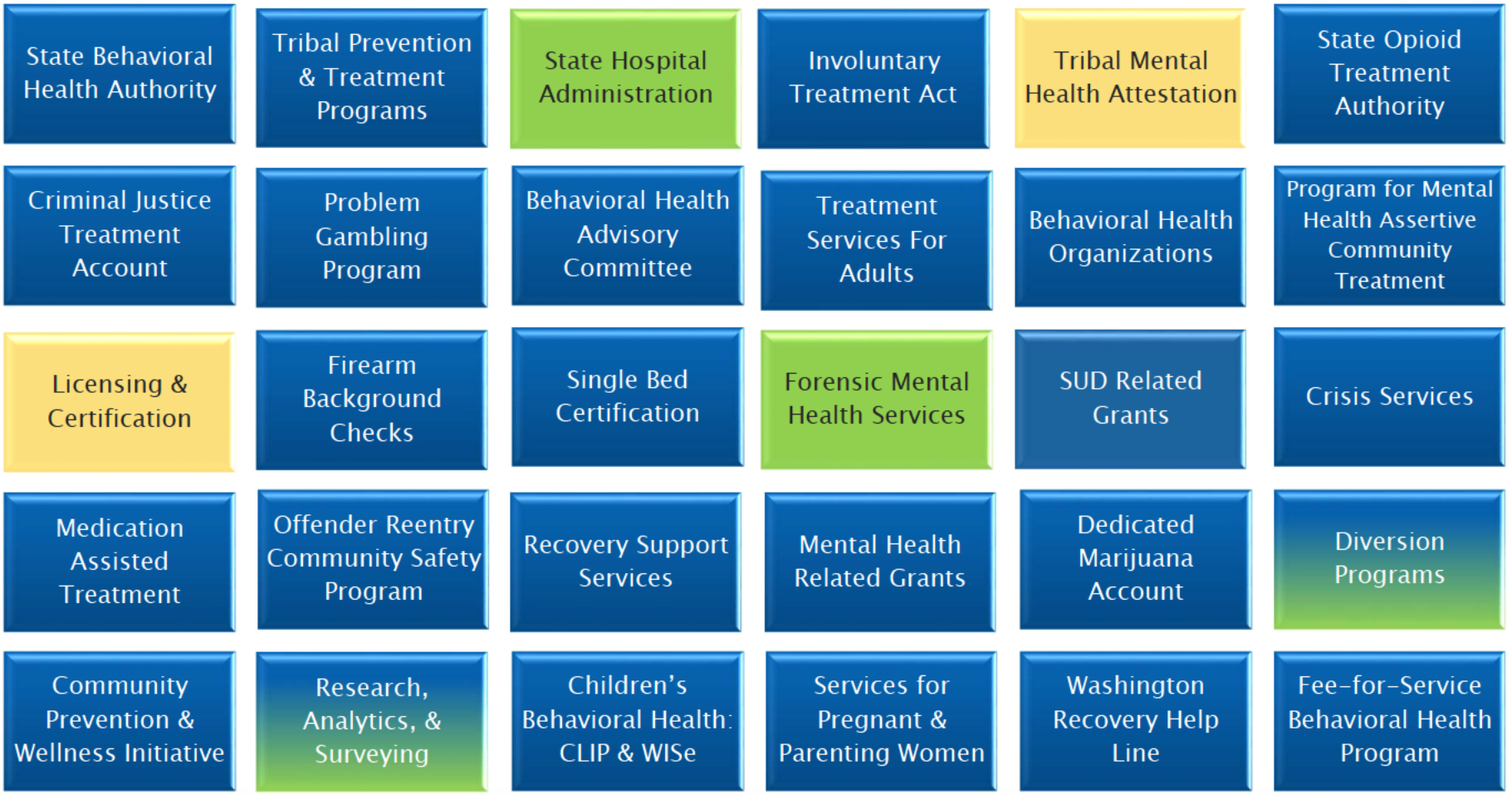
- Updates on individual projects
- Timing of existing projects
- Other projects
- Key considerations
- Resources
- Technical assistance for tribes and other Indian health care providers

Tribal Roundtable #2: HB 1388 – Agency Behavioral Health Integration

Background on HB 1388

- Enacted during 2018 legislative session.
- Integrates and consolidates oversight and purchasing of state behavioral health care into a single state agency at the Health Care Authority to align core operations and provide better, coordinated, and more cost-effective services, with the ultimate goal of achieving whole person care.
- Consolidates the licensing and certification of behavioral health providers and facilities into a single state agency at the Department of Health.
- Designates the Health Care Authority as the state's Behavioral Health Authority.

2ESHB 1388 Transfers – At A Glance



Consultation and Communication Protocols

Consultation and Communication Protocols: Differences

DSHS	HCA
7.01 planning meetings with each tribe	No similar requirement, no staffing
Tribal representatives on interview panels for key positions	No similar requirement
7.01 training for key staff	Gov-to-gov training with AIHC input for all staff
Consultation request may come from DSHS, IPAC, individual tribe(s) by tribal council resolution	Consultation request may come from HCA, AIHC, or individual tribal chairs
Written notices of tribal consultation: First notice 45-60 days prior, second notice 15-30 days prior	Written notices of tribal consultation: One notice 60 days prior (7 days for expedited circumstances)
Consultations and IPAC meetings in person	All meetings in person and by webinar/phone call
Quarterly meetings with Indian Policy Advisory Committee (IPAC)	Quarterly meetings with American Indian Health Commission (AIHC) Executive Committee/staff
Monthly IPAC subcommittee meetings	Monthly HCA-AIHC workgroup
IPAC membership extended to Recognized American Indian Organizations	Federal law requires solicitation of advice from Urban Indian Health Programs and IHS

Consultation and Communication Policy

Proposal: Amend HCA Consultation and Communication Policy with input from tribes/Indian Health Care Providers (IHCPs) for adoption during Centennial Accord in October 2018.

Consultation and Communication Policy

Proposal - New policy to include:

- Annual/quarterly meetings of each tribe and HCA staff to prepare/revise government-to-government plans
- Quarterly meetings of HCA Director or Deputy Director with AIHC
- Monthly HCA workgroup meetings
- A tribal representative (through AIHC) on interview panels for Division Director and Division Deputy Director positions
- Consultation request may come from HCA, AIHC, or individual tribal chairs
- Consultation requires agency decision makers and subject matter experts
- Tribes, AIHC, IPAC, and HCA may request consultation; Urban Indian Health Program may request meet and confer
- Notice requirements:
  - 1st Notice: 45-60 days in advance except in exceptional circumstances
  - 2nd Notice: 15-30 days in advance
  - Exception for special circumstances
- Meetings, roundtables, and consultations in-person and by webinar and/or phone
- HCA tribal liaison reports to the agency director and is a member of the agency's executive leadership team
- HCA executive leadership team receives annual training on government-to-government relations with tribes and Indian health care

Government-to-Government Planning

Government-to-Government Planning

DSHS 7.01 policy requires (a) a program manager, (b) the applicable administration tribal liaison, and (c) the Office of Indian Policy regional staff person to meet in person with every tribe's program staff every year to complete the tribe's 7.01 plan.

HCA policy has no equivalent; HCA does not have regional staff. HCA will honor the 2018-19 7.01 plans that have been adopted.

Proposal:

Work with tribes during summer 2018 to develop similar process and prepare decision package and budget for 2019 legislative session – HCA decision package due dates are under review.

Government-to-Government Planning

Proposal - New capacity/process to include:

- **Staffing**: 4 FTEs - Regional Tribal Liaisons
  i. 1 for Eastern Washington and Idaho/ Oregon border regions
     - 7 tribes + Healing Lodge
     - 3 IHS Service Units with 4 clinics
     - 1 urban Indian health program
  ii. 1 for North Sound region
     - 8 tribes
  iii. 1 for King and Olympic Peninsula regions
     - 9 tribes
     - 1 urban Indian health program
  iv. 1 for Southwest WA and Portland regions
     - 8 tribes
     - 1 urban Indian health program
- **Staffing**: 1 FTE – Admin. Assistant
- **Protocols/Procedures**:
  i. Regular meetings
     - At tribe/IHS/urban program
     - Staggered/coordinated schedules
     - HCA program managers
  ii. Agreed upon plans for government-to-government collaboration
     - Contact information for both tribe and HCA
     - Goals for year
     - Review of previous year, both successes and how to improve

Consolidated Contracting with Tribes

Consolidated Contracting with Tribes

- ***Single form contract*** with each tribe, with statement of work for each program
- ***Funding*** upfront to tribe (state general fund dollars); then state is reimbursed with federal funds when tribe satisfies reporting requirements
- ***Reporting*** requirements on annual cycle; if tribe does not complete reporting by deadline, state stops all future funding until tribe completes reporting
- ***Contract administration*** by state staff who understand tribal programs

Consolidated Contracting with Tribes

Total 2017 DBHR consolidated contract budget:

Program	Amount
Substance Abuse Prevention and Treatment *Amount to each tribe varies based on funding algorithm; tribe submits plan to use funds for prevention, treatment, or both* • SAMHSA block grant = $1,268,133 • State general funds = $110,272	$1,378,405
Dedicated Marijuana Account *Up to $20,000; tribe submits application to use funds for youth cannabis use prevention, treatment, or both*	$386,000
Mental Health Promotion Projects *Up to $10,000; tribe submits application for mental health promotion projects*	$290,000
Total	$2,054,405

Consolidated Contracting with Tribes

Current DSHS Process for Program Planning

1. Tribe submits program plan to OIP
2. Agency reviews and responds to program plan within 20 calendar days of tribal submission
3. Tribe responds to agency comments within mutually agreed timeframe
4. Agency completes administrative approval within 15 calendar days
5. Agency completes final approval within 90 days after administrative approval

Unexpended funds can reduce future funding amounts.

Consolidated Contracting with Tribes

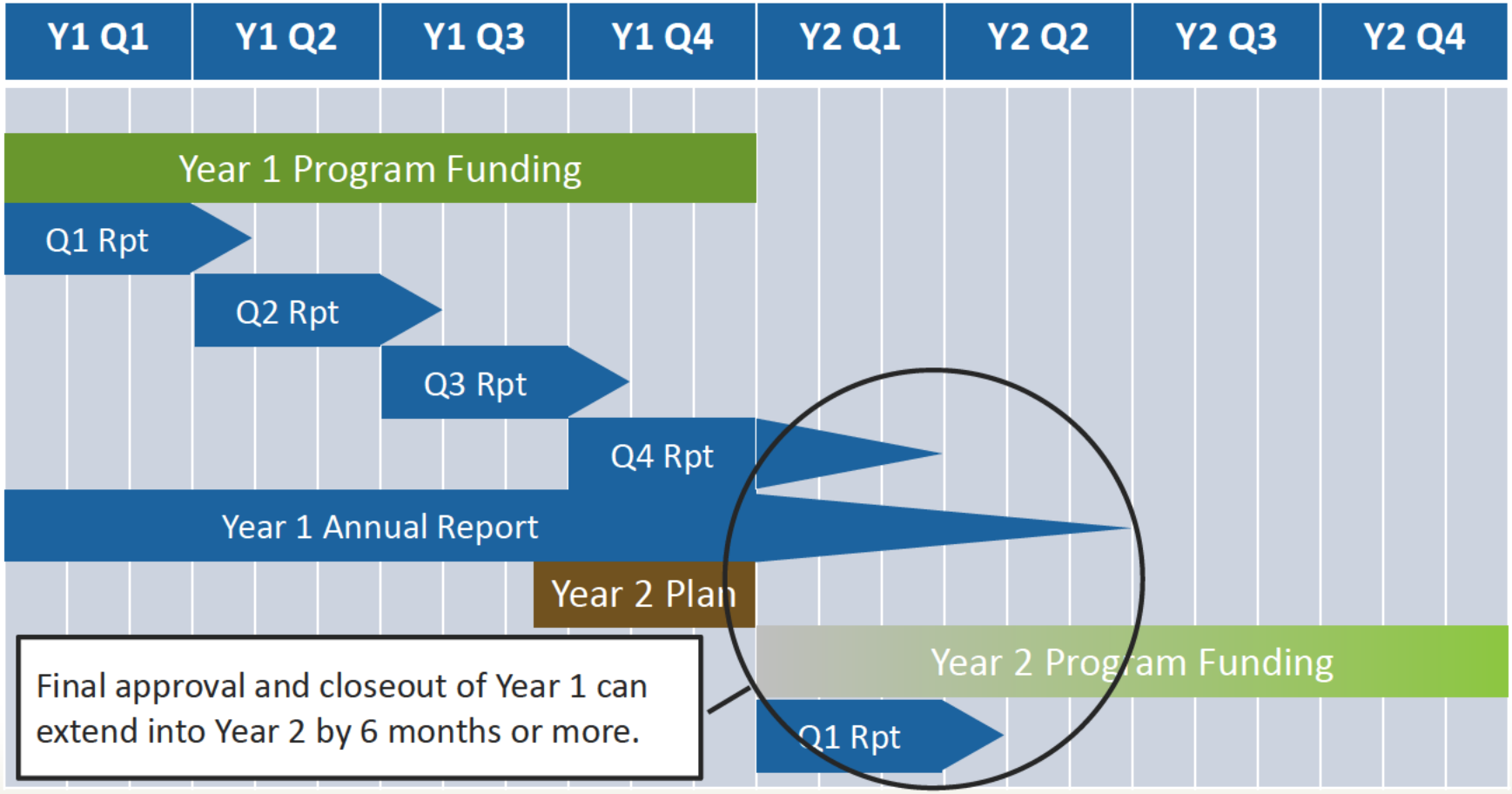
Current DSHS Contract Administration

Office of Indian Policy Contract Manager:

- Receives reports and coordinates with program staff for approval of reports
- Provides technical assistance to DBHR staff on culturally appropriate communication and services, contract or program issue mitigation, and scheduling of all meetings between DBHR staff and tribal staff
- Provides technical assistance to tribal staff on completing required reports
- Serves as ombuds on behalf of each tribe when issues arise

Consolidated Contracting with Tribes

DSHS Contracting Timelines/Potential Dependencies



Consolidated Contracting with Tribes

	Consolidated Contracting	Separate Contracting

Pros	• ***Upfront funding***. Tribes receive program funds upfront instead of after program costs are paid
	• ***Reduced administrative burden*** with coordinated reporting requirements
	• ***Tribal relations contract manager*** (OIP):
	  ○ Provides technical support to DBHR
	  ○ Provides technical support to tribes
		• ***Separate programs*** with separate contracts are not dependent on compliance by all programs
		• ***No reconciliation of upfront payments*** or after-the-fact amendments
		• ***Less complex accounting and contract amendments***

Cons	• ***Program dependencies***. Missed requirements for any individual program in one year delay funding start dates for all programs in next year • ***Need to reconcile*** upfront payments to permitted program expenses, with after-the-fact amendments • ***Complex contract amendments*** needed to keep program plans current	• ***Requires working capital***. Tribes must spend tribal dollars upfront and then be reimbursed by the state • ***Greater administrative burden*** from uncoordinated reporting requirements • ***Potentially inadequate technical support*** if contract manager is not familiar with Indian health care

Consolidated Contracting with Tribes

Proposal:

- One-year Memorandum of Understanding (MOU) between HCA and DSHS to maintain current funding flow through June 30, 2019.
- Work with tribes during 2018 to establish contract and develop funding, reporting, and reconciliation processes that help tribes to:
  - Avoid delayed funding across program years, and
  - Minimize administrative burden for tribes.

Consolidated Contracting with Tribes

Proposal - New contract/process to include:

[To be completed]

Intergovernmental Transfer for Medicaid Substance Use Disorder Services

Intergovernmental Transfer for Medicaid SUD

Currently, DSHS receives tribes' intergovernmental transfer (IGT) payments for substance use disorder (SUD) treatments that are covered by Medicaid.

Effective July 1, 2018, HCA will be responsible for this process.

Proposal:

Work with tribes during 2018 to develop an IGT or alternative process that reduces administrative burden and complies with CMS requirements.

Intergovernmental Transfer for Medicaid SUD

Proposal - New process to include:

- Use of Certified Public Expenditure (CPE) process rather than Intergovernmental Transfer (IGT) process
- Quarterly tribal certification of tribe's public expenditures at the federally required amount
- Suspension of ProviderOne payments for services requiring tribal matching funds if tribal certification not received; suspension lifted upon receipt of tribal certification
- Future Medicaid program integrity review of tribal compliance with federal CPE requirements

Mental Health Licensing/Certification and Tribal Attestation

CONSULTATION AND COMMUNICATION PROTOCOLS: Comparison

DSHS	DOH
7.01 planning meetings with each Tribe	No similar requirement - Consultations may be subject matter based
Tribal representatives on interview panels for key positions	Tribal representative on recruitment and selection process for DOH Tribal Liaison
7.01 training for key staff	No similar requirement
Consultation request may come from DSHS, IPAC, individual tribe(s) by council resolution	Consultation request may come from DOH leadership, tribe(s) from tribal leadership or authorized representative, AIHC, NPAIHB, urban Indian organization, or recognized organizations named in DOH Consultation and Collaboration Procedure
Written notice of tribal consultation: First notice 45-60 days prior; second notice 15-30 days prior	DOH: Written request 15-30 days prior to scheduled consultation. Tribe/Organizations: Written request; DOH to respond within 15 days; Consultation within 45 days.
Consultations and Indian Policy Advisory Committee (IPAC) meetings in person	In-person consultation preferred, or request alternate forum within 10 days of receiving consultation request
Quarterly meetings with IPAC	Quarterly DOH-AIHC leadership calls; DOH participation at AIHC meetings; Consultation at Leaders Health Summit
Monthly IPAC subcommittee meetings	No similar requirement
IPAC membership extended to Recognized American Indian Organizations	Recognized American Indian Organizations included as parties to DOH Consultation and Collaboration Procedure

Mental Health Licensing/Certification and Tribal Attestation

- Tribal Attestation is entered into a recognition of tribal sovereignty and in accordance with Section 408(a) of the Indian Health Care Improvement Act and 42.C.F.R 4331.110.
- DSHS Secretary recognizes tribes that attest to meeting the applicable requirements of the Washington Administrative Code (WAC) governing behavioral health agency licensing requirements standing to provide Medicaid outpatient mental health services to American Indians/Alaska Natives and their clinical family members.
- Required behavioral health agency standards - WAC 388-877 (New Rules Effective April 1, 2018):
  - Agency Administration
  - Personnel
  - Clinical
  - Outpatient Standards
  - Involuntary Court Ordered
  - Crisis Mental Health Services
  - MH Inpatient Services

Mental Health Licensing/Certification and Tribal Attestation

- All tribal attestations will remain in effect
  - New attestations signed this year for the next 3 years.
- DOH will maintain tribal attestation process
  - Licensing and certification staff moving to Department of Health.
- Some tribes chose state licensure; other tribes chose mental health attestation

Licensing, Certification, Field Operations: Differences

DSHS	DOH
Attestation Process for MH Services	Attestation Process for MH Services
Attestation process in place; 3 year renewal cycle	No attestation process; will adopt DSHS process
Residential Treatment Facilities Initial Certification	Residential Treatment Facilities Initial Licensing
Complete application for certification; include priorities, procedures & WATCH report for Administrator	Complete application for licensure; including policies, procedures & WATCH report and disclosure statement for Administrator
Collect licensing fee	Collect licensing fee
Receive DOH verification that facility meets licensing requirements	Construction Review Services approval of facility plan
	Verification from State Fire Marshall of approved inspection
Policy and procedure review at DSHS office	Policy and procedure review at DOH office
Residential Treatment Facility Certification Renewal	Residential Treatment Facility Licensing Renewal
Complete renewal application	Complete renewal application; WATCH report & disclosure statement for Administrator
Submit renewal fee	Submit renewal fee
No late renewal fee	Late renewal fee assigned if renewal application and fee are late

Licensing, Certification, Field Operations: Differences

DSHS	DOH
Residential Treatment Facility Field Operations	Residential Treatment Facility Field Operations
Letter to tribe announcing upcoming inspection	Unannounced visit
Initial review within 9 months of opening; request policies and procedures for review prior to visit	Initial on-site visit conducted 3 months after license issued; review policies and procedures on site
Evaluation & Treatment facility inspected every 2 years	On-site, unannounced inspection every 12 months for all RTFs
Other RTFs inspected every 3 years	
Draft report and scoring document on-site/conduct exit meeting	Report is drafted upon return to the office and sent within 10 days to provider (no scoring document)
Corrective Action Plan (CAP) given at exit; response due in 30 days	Plan of Correction issued within 10 days; provider respond in 10 days
Send letter of approval to facility; or if poor score, plan for early re-inspection	Revisits depending upon score and severity of violations
Outpatient Facilities	Outpatient Facilities
Same as above plus submit ADA compliant floor plan; physical plant review on-site	No process – new work come July 1, 2018; DOH will adopt DSHS process in the short term
Technical Assistance	Technical Assistance
TA available upon request and as per 7.01 plan	TA available upon request (no 7.01 plan)

Planning for Tribal Roundtable #3 and Tribal Consultation

Thank you!

Health Care Authority

Jessie Dean
Tribal Affairs Administrator
Phone: 360.725.1649
Email: jessie.dean@hca.wa.gov

Mike Longnecker
Tribal Operations & Compliance Manager
Phone: 360.725.1315
Email: michael.longnecker@hca.wa.gov

Lena Nachand
Tribal Liaison – Medicaid Transformation
Phone: 360.725.1386
Email: lena.nachand@hca.wa.gov

Department of Social and Health Services

Lucilla Mendoza
Tribal Behavioral Health Administrator
Phone: 360.725.3475
Email: mendol2@dshs.wa.gov

Department of Health

Tamara Fulwyler
Tribal Relations Director
Phone: 360.870.8903
Email: tamara.fulwyler@doh.wa.gov