Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Monthly Tribal Meeting

July 25, 2016

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Agenda

9:00 AM	Welcome, Blessing, Introductions
9:10 AM	Medicaid State Plan Amendments: FQHCs and Rural Health Clinics (HCA)
9:45 AM	1915(b) Waiver – Substance Use Disorder Fee-for-Service (HCA + DBHR)
10:00 AM	1915(b) Waiver – Mental Health Fee-for-Service (DBHR) • Project Plan and Workgroup
10:15 AM	Statewide BHO-Tribal Convening (DBHR) • Planning and Workgroup
10:30 AM	BHO Governing Boards – Attorney-General's Office (AGO) Opinion (BHA)
11:00 AM	Medicaid Managed Care vs. Fee-for-Service: Comparison (HCA)
11:15 AM	Medicaid Medical Necessity: Alert for Tribal PRC/CHS Programs (HCA)
11:30 AM	Medicaid Eligibility: HCA Community-Based Specialists (HCA)
11:45 AM	Questions, Issues, Concerns
Noon	Closing

WELCOME, BLESSING, INTRODUCTIONS

MEDICAID STATE PLAN AMENDMENTS: FQHCs And Rural Health Clinics

FQHC/RHC Payment Structure

Encounter-based care delivery:

"The encounter rate includes covered services provided by an RHC/FQHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies."

~ CMS Guidelines

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FQHC/RHC Payment Structure

Prospective Payment System (PPS):

- Replaced the traditional cost-based reimbursement system for FQHCs and RHCs with a new prospective payment system (PPS)

- Rate based on each FQHC's/RHC's fiscal years 1999 and 2000 reasonable cost per visit rates

- Federal minimum requirement that FQHCs and RHCs be reimbursed for services provided to Medicaid patients

- ***States have an Alternative Payment Methodology (APM) option***

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Alternative Payment Model (APM) 3

- APM 1: January 1, 2009 – April 6, 2011
  - APM methodology developed
  - Encounter reimbursement rates were increased annually by a Washington-specific healthcare index
- APM 2: April 7, 2011 – June 30, 2011
  - PPS rate inflated by 5 percent
- APM 3: July 1, 2011 to Present
  - 2008 rates as calculated under APM 1 inflated by Medicare Economic Index from 2009-2010

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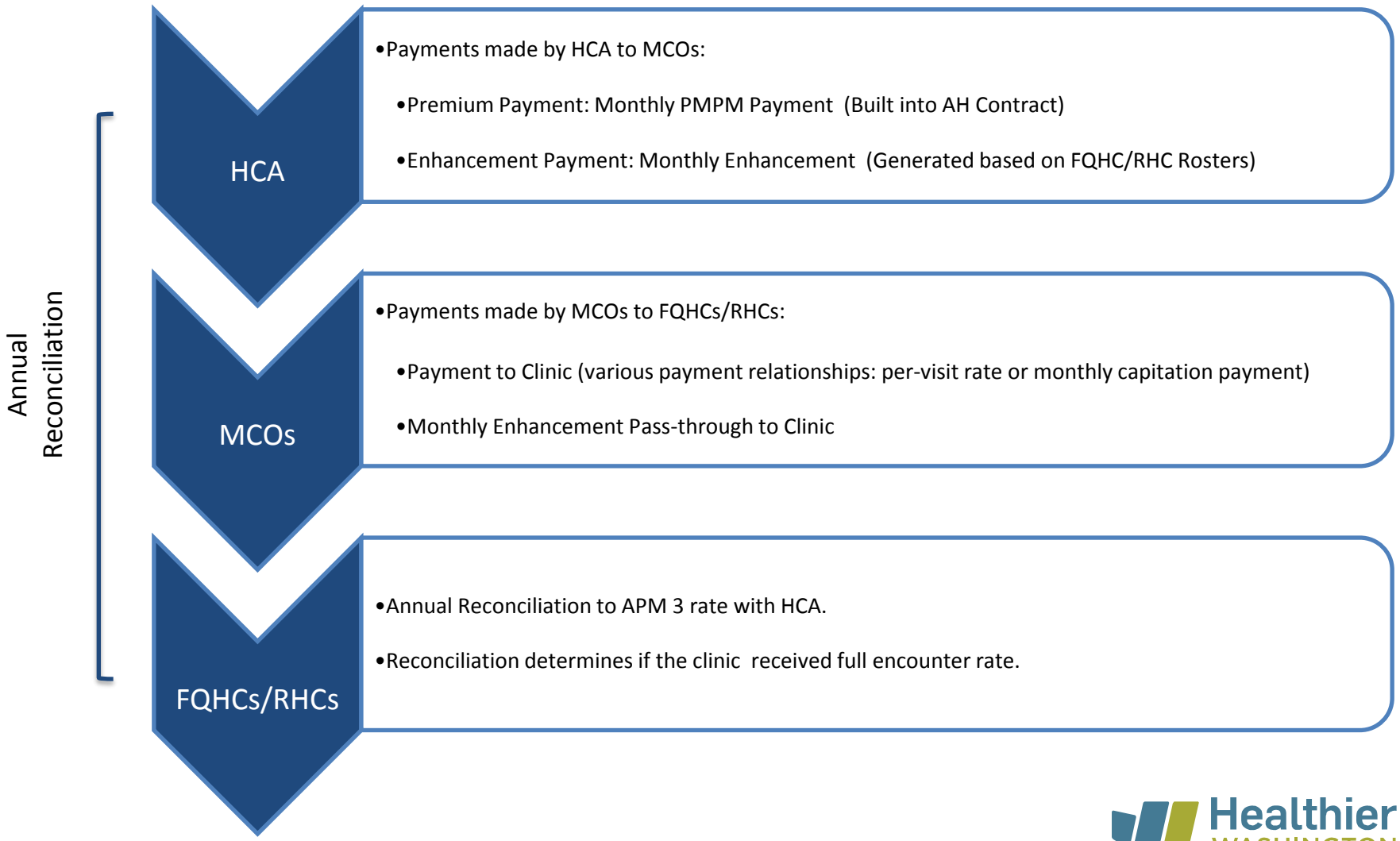
Current Payment Relationship



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SIM Grant Objectives of APM 4

- Paying for Value
  - Shift from Encounter-based to Value-based
  - Quality/Performance Incentives with Shared Savings
  - Bend Cost Trend Over Time
  - Increased Financial Flexibility/Practice Transformation
    - Group Visits
    - Telemedicine
    - Non-traditional workforce

- ***Opting into an APM 4 will be voluntary***

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Desired Elements of an APM 4

- Simplified FQHC/RHC Reconciliation Process to reduce administrative burden
- Budget Neutrality
- Incentives Tied to Quality
- Seeking Upside and Downside Risk in a Phased Approach

Basic Construct for APM 4

- Calculate an individual PMPY budget neutral amount for each FQHC/RHC
- Pay a prospective PMPM amount for each managed care enrollee assigned to an FQHC or RHC
- Tie quality improvement to subset of the Washington State Common Measure set
    - FQHCs and RHCs that demonstrate quality improvement will continue to receive their PMPM payment
    - Non-performance may result in reduced payment through prospective adjustment
- FQHC/RHC reconciliation to demonstrate full encounter rate is paid

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APM 4 Example Scenario

State portion of the payment

FQHC/RHC performance against the WA Common Measure set

- Assumes quality and access metrics are met

	Base Year	Year 1	Year 2
Reconciliation Information -			
Total Encounters	2450	2450	2450
APM 3 Rate	$180.00	$180.00	$180.00
Payment Received from Health Plans	$151,200	$165,375	$176,400
Member Months	8,400	9,188	9,800
PMPY Visits	3.5	3.2	3.0
Amount Due Under APM 3	$441,000	$441,000	$441,000
Enhancement Due Under APM 3	$289,800	$275,625	$264,600
APM 4 Total PMPM	$52.50	$52.50	$52.50
Enhancement Due APM 3 PMPM	$34.50	$30.00	$27.00
Enhancement Due APM 4 PMPM	$34.50	$34.50	$34.50
Annual Revenue Due APM 4	**$441,000**	**$482,344**	**$514,500**
Performance Based Revenue	**$0**	**$41,344**	**$73,500**

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Intended Outcomes of the Model

- Allows FQHCs/RHCs to improve their access to care by focusing on improving center/clinic-specific quality metrics
- Allows clinicians to work at the top of their license
- Allows FQHCs/RHCs to have a larger member panel without the burden of increasing the total number of patient encounters they provide
    - Expands PCP capacity in medically underserved areas
- Incents alternatives to face-to-face visits
        - Allows FQHCs/RHCs to offer more member-centric access to primary care
- Has the potential to reduce avoidable ED visits
- No downside to health centers adopting APM4 rather than retaining APM3

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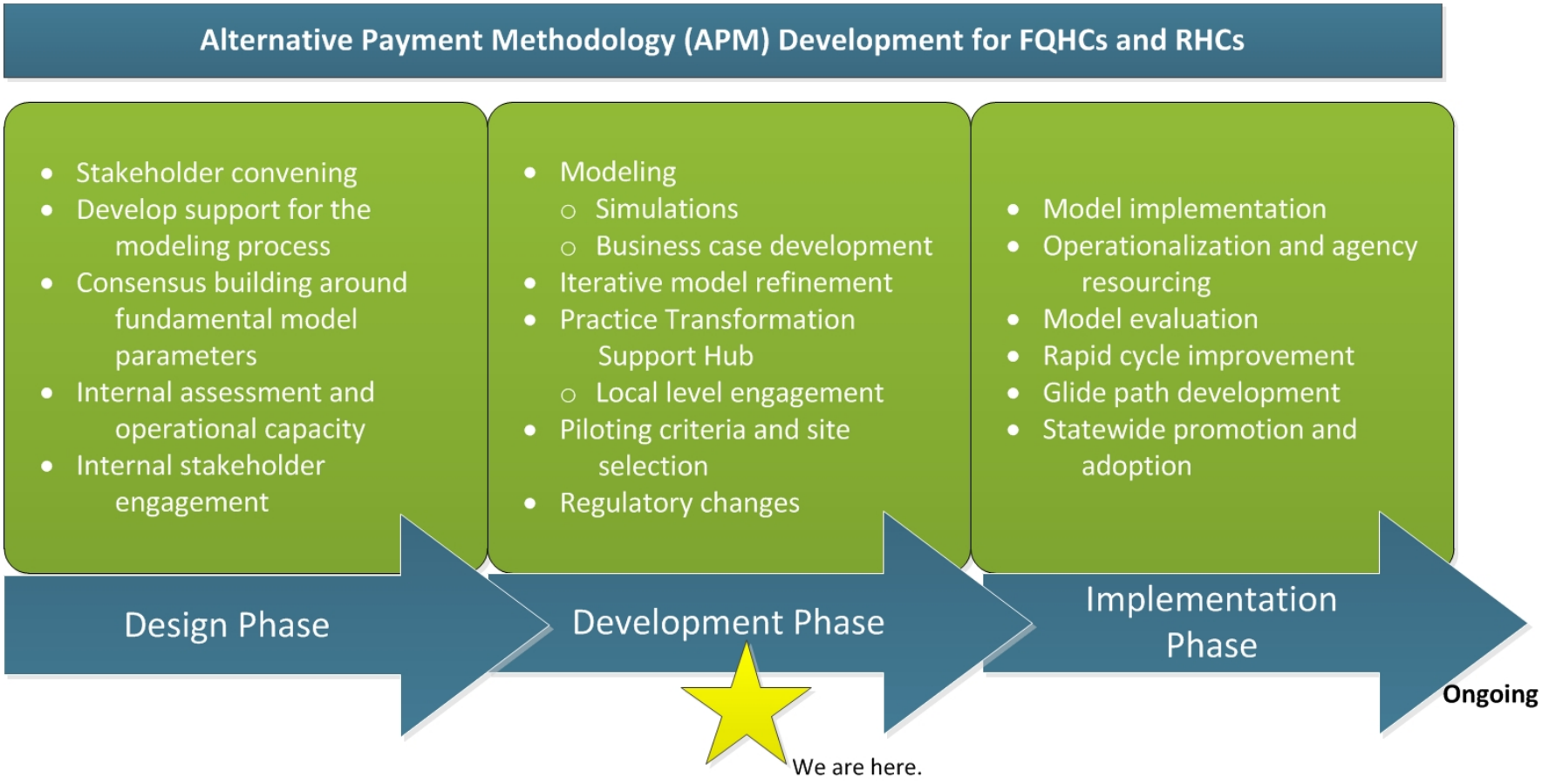
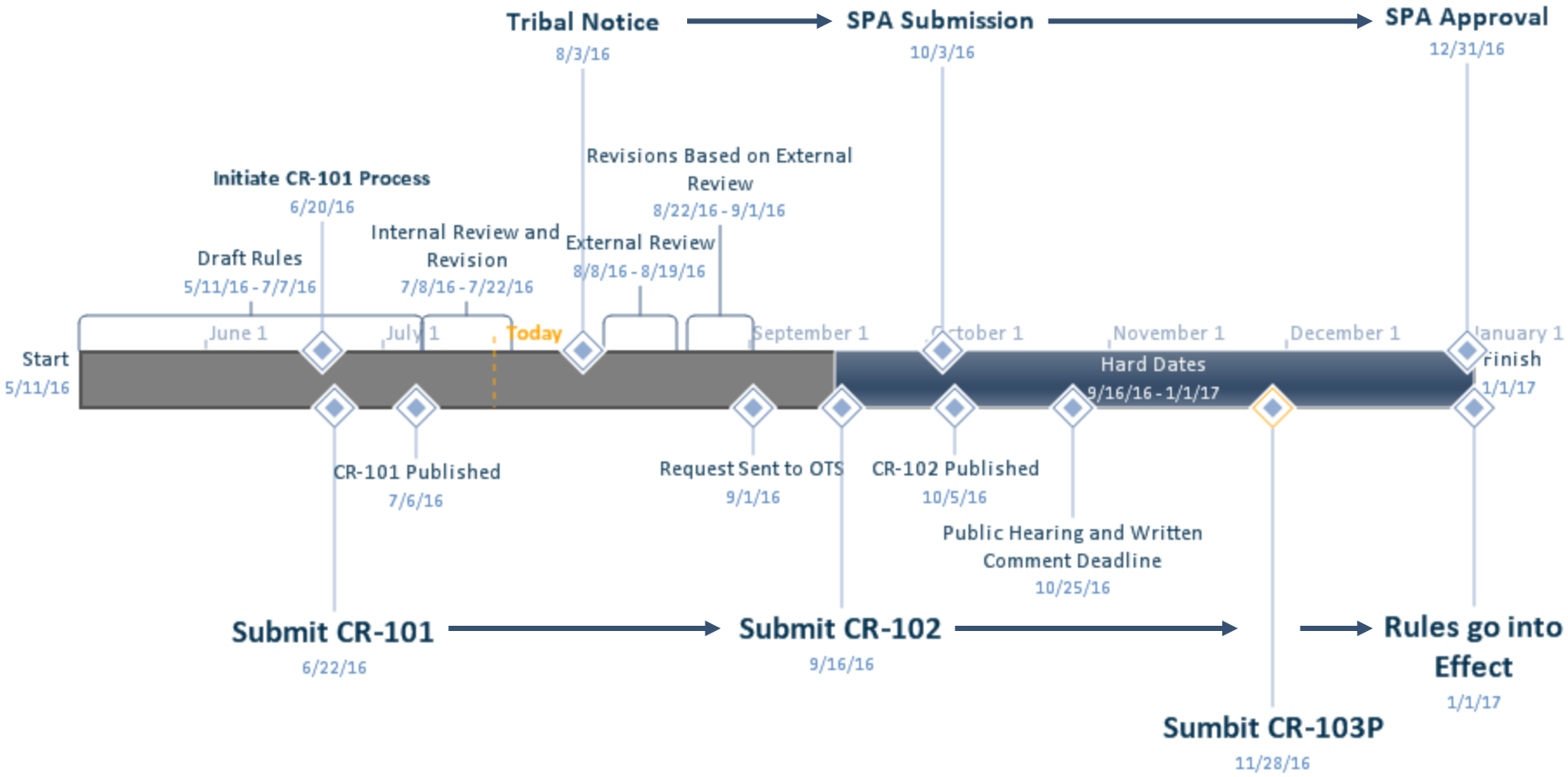
APM 4 Development Status



APM 4 Timeline



1915(B) WAIVER – SUD: ProviderOne Update

ProviderOne Update

ProviderOne is not yet set up to show non-HCA staff that AI/AN clients have SUD FFS.

- Unanticipated technical issues have delayed implementation.

HCA now anticipates completing the reconfiguration of ProviderOne for October 2016.

When completed, HCA expects to start showing SUD FFS coverage as “BHO MH Only”.

- Until ProviderOne is reconfigured, there is no way for providers to confirm SUD FFS coverage in ProviderOne.

Until then:

- HCA and DBHR are developing guidance for non-Tribal providers to accept client self-attestation of AI/AN status.
- HCA is also developing a website option for non-Tribal SUD providers to communicate the client’s self-attestation of AI/AN status to HCA if a non-Tribal SUD claim is denied to bill the BHO and the client who received the service attested that he or she is AI/AN.

To minimize these issues, please make sure that AI/AN clients are indicated as such in Healthplanfinder or Washington Connection.

1915(B) WAIVER – MENTAL HEALTH: Project Plan for Fee-for-Service

1915(b) Waiver Extension

CMS has granted the State's request for a temporary 90-day extension of the current waiver.

- New Waiver Expiration Date: December 31, 2016
- The State will use this extension to work with tribes to develop a project plan and timeline for implementing the mental health fee-for-service (FFS) program (full AI/AN carve-out from BHOs).
- The State will include the implementation date in the waiver renewal request.

Mental Health FFS Project Plan

Scope: Implementation of mental health fee-for-service benefit

Tasks:

- ProviderOne/Systems
- State Agency Processes (including Call Center Guidance)
- Budgeting/Forecasting
- Communication Plan for Different Parties
- Timeline

Question: Any other expectations for the Project Plan?

Mental Health FFS Project Plan: Workgroup

Question: Would anyone like to participate in the joint-agency workgroup?

- Meetings by webinar/phone and in-person
- Work will start in earnest in the first week of August

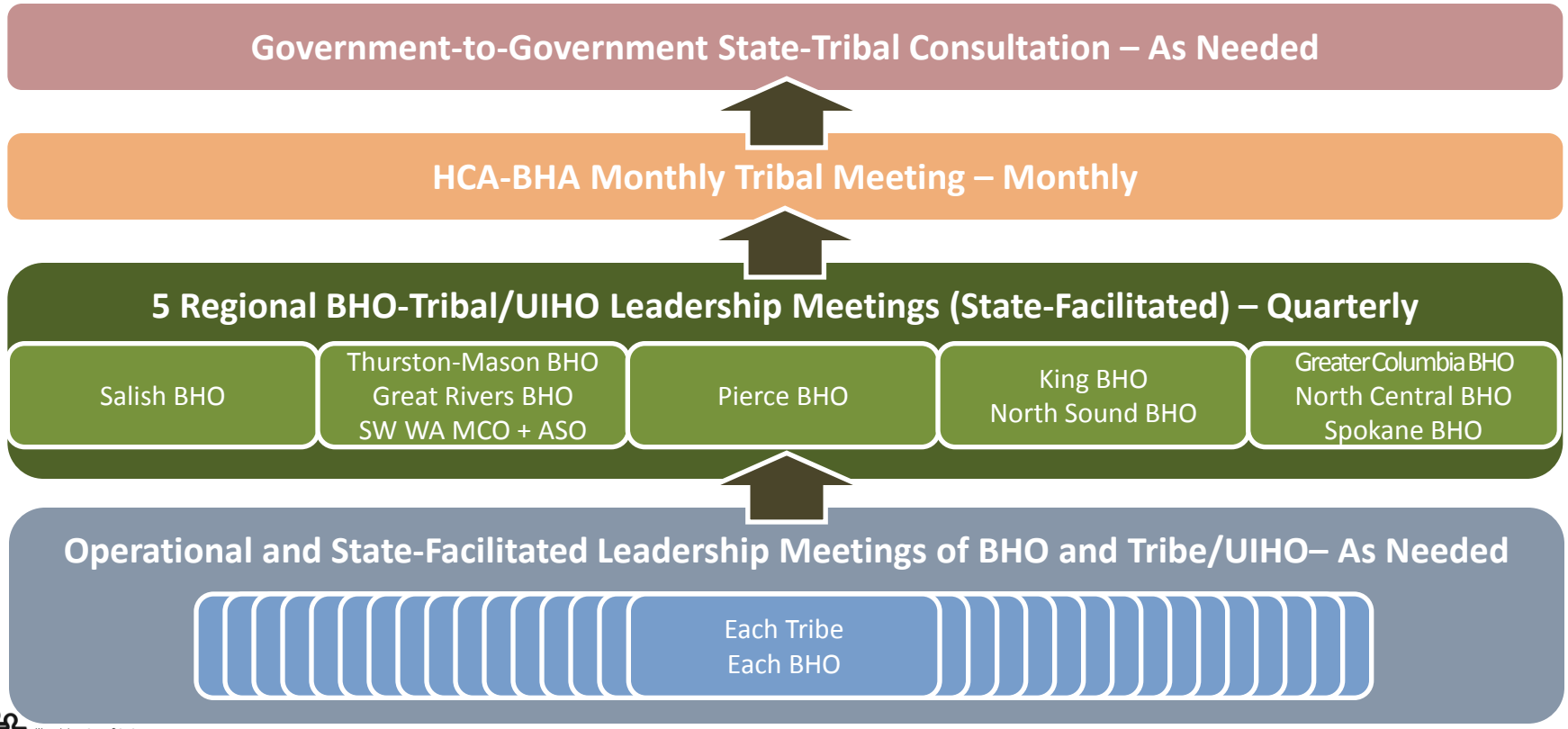
Question: How would you like the workgroup to give updates?

- HCA-BHA Monthly Tribal Meeting
  - Any other meetings?
- Email: Minutes of workgroup meetings
  - Who should receive these emails?

STATEWIDE BHO-TRIBAL CONVENING: Planning

Proposal: BHO-Tribal Engagement Structure

Last month, DBHR/HCA proposed 5 regional leadership meetings of BHOs and Tribes:



Statewide BHO-Tribal Convening

Tribal representatives had concerns that these proposed meetings might be duplicative of existing meetings.

DBHR/HCA and the Tribal representatives agreed to move forward by holding a statewide convening of Tribal/UIHO and BHO leadership with the goal to:

- Developing a BHO-Tribal engagement structure that works for each Tribe and each BHO

Statewide BHO-Tribal Convening: Planning

Target Date for Convening: September or October

Question: Would anyone like to participate in the joint-agency workgroup?

- Meetings by webinar/phone and in-person

Question: How would you like the workgroup to give updates?

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BHO GOVERNING BOARDS:
Follow-up on Tribal Request for AAG Opinion

Follow-up on Tribal Request for AAG Opinion

RCW 71.24.300(1) – Originally passed in 1994 SB 6408 and revised in 2014 SB 6312:

> *Upon the request of a tribal authority or authorities within a ~~regional support network~~ behavioral health organization the joint operating agreement or the county authority shall allow for the inclusion of the tribal authority to be represented as a party to the ~~regional support network~~ behavioral health organization.*

AGO provided prior guidance to the State that the statute as written does not provide the state authority to require that the BHO's include Tribal representation on Governing Boards.

At the request of Tribes, DSHS asked the AGO to look at the issues again. The AGO sent us the original bill reports and we were informed that the guidance has not changed.

The intention of the statute is that, if a Tribal authority wishes to be a party to the joint operating agreement that establishes the BHO, they must be included. This agreement must include determination of tribal authority membership on the governing board and advisory boards.

SB 6408 Bill Reports

From the 1994 SB 6408 bill reports:

BACKGROUND:

Under current law, a county or a group of counties whose population is greater than 40,000 persons may enter a joint operating agreement to form a regional support network (RSN) to plan, organize and deliver mental health services according to a contract with the state Department of Social and Health Services.

Under current law, no statutory requirement exists for a tribal authority to be party to such a joint operating agreement.

SUMMARY:

The term "tribal authority" is defined as a federally recognized Indian tribe or a major Indian organization recognized by the Secretary of Social and Health Services.

Upon request, a tribal authority must be included as a party to a joint operating agreement to establish a regional support network. The joint operating agreement must include a determination of tribal authority membership on the governing board and advisory boards and must include provision for culturally competent services to the tribes served.

MEDICAID MANAGED CARE VS. FEE-FOR-SERVICE: Comparison

Medicaid Managed Care vs. Fee-for-Service

	Managed Care - MCO	Managed Care - BHO	Fee-for-Service
Federal Authority	SSA §1932	SSA §1915(b)	SSA §§1902, 1905
Payments	Actuarially-based capitated monthly premium; MCO/BHO negotiates rates with providers to create a network		Fee schedule for each service performed
Case Management/ Care Coordination	MCO/BHO provides and/or pays for case management/care coordination as they deem appropriate		State Plan Benefits: • PCCM • Health Home
Utilization Management	MCO/BHO manages patient utilization		None
Quality Review	External quality review of care		None
Risk-Bearing	Yes		Not Applicable

MEDICAID MEDICAL NECESSITY: Alert for Tribal PRC/CHS Programs

Medicaid Medical Necessity: Alert for PRC Programs

In fee-for-service, HCA processes requests for authorization of service by requesting information from providers.

If a provider does not provide the requested information, HCA will issue a denial of the request.

It appears that some providers may not be submitting the information but using the denial to ask a Tribe's PRC/CHS program to pay for the service.

Medicaid Medical Necessity: Alert for PRC Programs

HCA's denial language for failure to submit information:

Your healthcare provider was sent a request for more information and did not respond within the required timeline, so this request is denied (see WAC 182-501-0165).

A copy of this request was also sent to you so you would know what was needed.

Your provider may request a reconsideration of this decision by submitting the requested information. We encourage you to contact your provider regarding the requested information.

Medicaid Medical Necessity: Alert for PRC Programs

We recommend Tribes require a copy of HCA's denial letter for any provider who seeks Tribal payment for services because HCA denied authorization.

Reason for Denial	Next Steps
Provider failed to provide the requested information	Provider should provide the requested information
Provider failed to refer the client to a specialist	Provider should refer the client to a specialist for confirmation that the service is in the best interest of the client
HCA determined that the service is not medically necessary (provider submitted the information)	Provider may submit additional information for a new review OR Tribe could decide to use PRC/CHS funds

MEDICAID MAGI ELIGIBILITY: Tribe-Based HCA Specialists

Medicaid MAGI Eligibility: Tribe-Based Specialists

For post-eligibility issues with Apple Health coverage, please contact the following HCA Community-Based Specialists – Tribal if you cannot get resolution from HCA's MEDS call center:

HCA Community-Based Specialists - Tribal			
Colville Service Unit (Nespelem)	Andrea Carden	Muckleshoot Wellness Center	Erik Simonsen
Port Gamble S'Klallam Health Center	Andrea Hall	Puyallup Tribal Clinic	Anthony Alconaba
SPIPA (Shelton)	Julie Liles	Tulalip Health Center	Carly Swanson
Swinomish Tribal Health Clinic	Shaunie McLeod		

http://www.hca.wa.gov/hcr/me/Documents/Community_Based_Staff_Contact.pdf

Questions?

Issues?

Concerns?

Thank you!

HCA

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