Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Monthly Tribal Meeting

January 25, 2016

Jessie Dean
Administrator, Tribal Affairs & Analysis
Office of Tribal Affairs

Loni Greninger
Tribal Administrator
Division of Behavioral Health & Recovery

WELCOME, BLESSING, INTRODUCTIONS

NEW MEETING FORMAT

Agenda

9:00 am Welcome, Blessing, Introductions
New Meeting Format and Agenda

9:10 am **Requests for Tribal Representatives**
- Healthier Washington AIM Advisory Group: *Two Tribal Representatives*
- Governor's Behavioral Health Integration Task Force: *Three Tribal/Urban Representatives*

9:30 am **Medicaid**
- EHR Incentive Program + WA Link4Health
- Apple Health for Foster Children – Managed Care
- MCO and BHO contracts and Indian Addenda – Planning for Consultation

10:15 am **Behavioral Health**
- Tribal-Centric Behavioral Health Updates
- Behavioral Health Contracts
- Collaboration between Tribes, RAIOs, and BHOs

11:00 am **Healthier Washington & Medicaid Transformation Waiver**
- Payment Redesign Initiative: Critical Access Hospitals, FQHCs, and Rural Health Clinics
- Job Opening: Healthier Washington Tribal Liaison
- Medicaid Transformation Waiver – Update

11:50 am **Miscellaneous**

Noon Closing

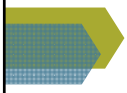
- Analytics, Interoperability, and Measurement (AIM) Advisory Group – Request for Two Tribal Representatives

REQUEST FOR TRIBAL REPRESENTATIVES

Healthier Washington – Analytics, Interoperability and Measurement (AIM) Update

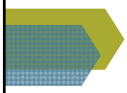
Presented by Adam Aaseby, Chief Information Officer
WA State Health Care Authority

January 25, 2016



Introduction

- Thank you for this opportunity to speak and present on the topic of AIM
- Recent completion and approval of our Year 2 Operations Plan:
  - The state maintains a government-to-government relationship with tribes. Tribes' ongoing involvement with Healthier Washington is and will continue to be essential for achieving the aims of the initiative as a whole.



Operations Plan Highlights

Regarding Tribal involvement:

- American Indian Health Commission will provide recommendations to the state and ACHs on how the Tribes want to be engaged in the ACHs
- State will work with Tribes to help determine how they wish to engage with the transformation of the non-tribal system
- State is exploring communicating Healthier Washington stories and updates in Tribal newsletters

Washington's vision for creating healthier communities and a more sustainable health care system by:

- Building healthier communities through a collaborative regional approach
- Ensuring health care focuses on the whole person
- Improving how we pay for services

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Better Health, Better Care, Lower Costs

SS(2

Analytics, Interoperability and Measurement (AIM)

- With our Healthier Washington initiative, we are working across state agencies and cultures to achieve the triple aim: better health, better care, lower costs.
- AIM is the largest investment area of Healthier Washington and is an inter-agency project.
- We are implementing population health strategies to improve health and address regional health assessment needs.
- AIM will build an interoperable data system across state agencies that will have business intelligence and shared analytics capabilities sitting on top of it.
- AIM has an inter-agency privacy work group

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Slide 10

SS(2 Tribes on any committees we should highlight? Privacy workgorup?
Steck, Stacy (HCA), 1/21/2016

AIM Key Elements

•Make targeted investments to standardize clinical information, integrate data across health delivery and social service systems

•Enhance the state Health Information Exchange (HIE) services that will operate as a shared community asset

•Develop mapping and "hot spotting" tools to support health disparities interventions and community-based health improvement

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AIM Governance Structure

- **Healthier Washington Executive Governance:** Agency directors for HCA, DOH, DSHS, the Governor's office
- **AIM Steering Committee:** inter-agency group that makes leadership decisions on anything impacting AIM scope or budget.
- **AIM Operations Team:** inter-agency working group that meets weekly.

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AIM Stakeholders and Partners

Primary Stakeholders:

- Tribes
- Accountable Communities of Health

AIM Technology Partners:

- Center for Outcomes Research Education (CORE)
- Washington Health Alliance: Community Check-up Tool to report on state Common Measure Set
- University of Washington: Institute for Health Metrics & Evaluation, UW Evaluation Team
- Clinical Data Repository: Link4Health

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What is CORE?

- Interim AIM solution to provide HCA and ACHs with actionable data and analytics for internal HCA needs and community needs assessments/identifying health disparities
- CORE will provide analytics derived from Medicaid, Public Employee Benefits and DOH survey data
- Support ACH desire for population health data and social determinants of health data
- Provide ACHs and DOH (non-HIPPA covered entities) with data in an aggregated, de-identified manner, visualized via Tableau software in interactive dashboards.

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AIM Advisory Group: Coming Soon

- AIM team is planning to launch an **"Advisory Group"** of all our consulted stakeholders across all agencies and groups both internally to HCA and externally across partner organizations
- **ASK**: We are seeking two Tribal representative(s) on the AIM Advisory Group. The first Advisory Group meeting will be sometime in later February.
- To supplement the Advisory group, the HW team is putting together a monthly newsletter with AIM news

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Questions?

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- Governor's Behavioral Health Integration Work Group

REQUEST FOR TRIBAL AND URBAN INDIAN HEALTH REPRESENTATIVES

Governor's Behavioral Health Integration Work Group

- Dear Tribal Letter sent January 8, 2016.
- Governor's Behavioral Health Integration Work Group
- Purpose:
  - To determine next steps needed to migrate from the BHOs configuration to the fully integrated financing that supports needed clinical integration.
- Goals:
  - To make recommendations on budget, policy, and administrative realignments that are needed to support fully integrated care.

Governor's Behavioral Health Integration Work Group

- Members:
  - Chair: Bob Crittenden, Senior Special Assistant for Health Reform
  - Three representatives from DSHS
  - Three representatives from HCA
  - Three representatives from counties
  - Three representatives from Tribes (2) and Urban Indian Health Organizations (1)
- Governor's Office is seeking names by January 31, 2016

- EHR Incentive Program + WA Link4Health

MEDICAID

Electronic Health Records Update
&

Kelly McPherson
HealthIT Program Manager

Electronic Health Records Update

- **2016 is the last year a provider can start the program. After 2016, the program will be cut off to new participants.**
- **For a new provider, the Incentive money over 6 years is $63,750. First year AIU applicants (non-pediatricians) will receive $21,250 and a total of $42,500 for MU during the next 5 years.**
- **Our Eligibility Coordinators are putting together packets for each Tribal Clinic/Provider. It will show where each provider is in the program or if they have even started the program.**
- **We are requesting a meeting with each Clinic/Provider to discuss their participation in the program.**
- **To Date, 88 Hospitals have been paid totaling $125,757,093.**
- **To Date, 5,654 individual providers have been paid totaling $152,691,212.**

RPMS EHR Vendor Letter

- Medicare or Medicaid may request proof that a facility has a certified EHR to demonstrate Meaningful Use. IHS can provide a vendor letter for RPMS EHR users to provide to Medicare or Medicaid.
- The facility may request a vendor letter for either their Eligible Hospital (EH; inpatient), Eligible Provider (EP; ambulatory) or both, by completing the following form.
- https://www.ihs.gov/meaningfuluse/certificationoverview/certificationletter/

RPMS EHR Certification

2014 Certification

- RPMS EHR has been certified, as of August 22, 2014, according to the 2014 ONC Standards. Facilities should contact their area offices about scheduling the 2014 EHR upgrade. Note: All applications and patches must be installed to have the certified version, and EPs and EHs must utilize all associated functionality and patches to demonstrate Meaningful Use.
- (EP) Ambulatory: 1314E01PJHPUEAL
- (EH) In-Patient: 1314E01PJHPQEA1
- https://www.ihs.gov/meaningfuluse/certificationoverview/

WA Link4Health State HIE Provides Solution: Medicaid Data Repository

- **Complete integrated health record that follows consumer across settings and over time regardless of payer, plan, care setting or provider.**
- **On-demand access to shared care plans and health record for patients with complex & chronic conditions.**
- **Early Stage 1: HCA contributes data covered under HIPAA**

Questions? Need additional Information?

Team email: HealthIT@hca.wa.gov , with "HIE" in the subject line with any questions you have.

Website: **HealthIT.wa.gov** - sign up for monthly updates and watch for upcoming webinars and meetings

Melodie Olsen, Washington State HealthIT Coordinator can be contacted at: Melodie.Olsen@hca.wa.gov

WASHINGTON Link4Health

Clinical Data Repository – Tribal Conversation

Ginnie Eliason – HealthIT
Stakeholder Engagement &
Communications Manager

2/5/2016

Background-How did we get here?

National Level – 2009

ARRA- American Recovery and Reinvestment Act

- Development of HIT infrastructure
- Development of the Office of the National Coordinator (ONC)
- *Develop & maintain national certifications for HealthIT equipment*
- *Developing and endorsing national level standard*

HITECH-Health Information Technology for Economic & Clinical Act

- To promote widespread exchange of integrated clinical records between authorized providers

Washington State – 2009 to now

WA ST Substitute Senate Bill 5501 built a partnership:

- HCA Appointed Lead for HealthIT
- OHP (OneHealthPort) awarded state HIE (Health Information Exchange)

2/5/2016

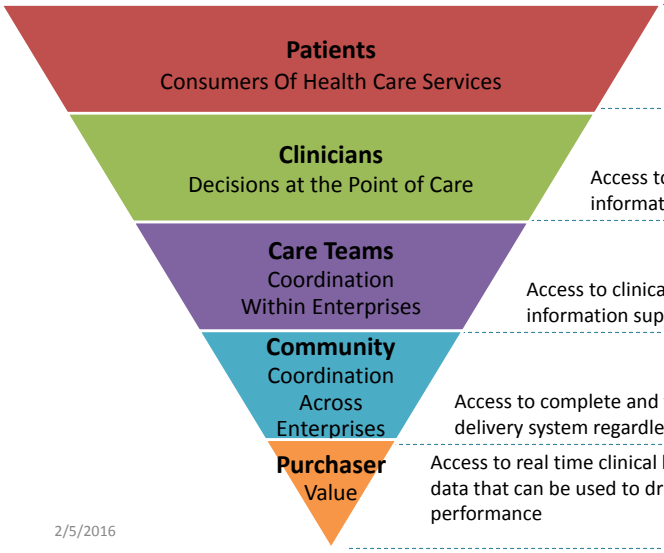
What Is the Problem?

As it is Today: Patient Data Spans Many Silos

An individual's healthcare story cannot be told in pieces

2/5/2016

Health Information Needs Hierarchy



Access to quality care based on complete, clinically relevant record describing care & needs.

Access to clinically relevant and timely information to support decision-making.

Access to clinically relevant, evidence-based information supplied by the entire care team.

Access to complete and timely patient-level data across delivery system regardless of entity delivering care.

Access to real time clinical health outcomes and quality data that can be used to drive value-based payment and performance

2/5/2016

Standards for Data Exchange

- Consolidated Clinical Data Architecture (C-CDA)
  - National standard for clinical data
  - Multiple 'templates' available depending on service
- Includes data not available on standard HIPAA transactions
  - History: Family, Social and Medical
  - Current medications and health problems
  - Lab results
  - Vital signs and other health measures

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Role Based Access

- Access defined by a tiered role
- User level
  - Define access to restricted/very restricted data
- Group level
  - Can enhance access to user level roles (i.e. physician in a psychiatric clinic)
- Health Plan (MCO) level
  - Ensures access to 'own' information

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Milestones-Where are we at now?

- **Sustainability Model Developed (shared cost model)**
- **16 Major Delivery Systems to Leader Meeting 9/2014**
  (Delivery System= all clinics, providers, & hospitals)
- **Contract with Managed Care Organizations Executed 12/2014**
- **Contract with Solution Vendor Executed 1/2015**
- **3 work groups: Communication, Privacy & Access**
- **Individual Meetings with Major Delivery Systems June 2015 – April 2016**
- **Q1 2016 early testing**

2/5/2016

WA Link4Health Clinical Data Repository
Decision Tree: Data Submission Requirement Version 1

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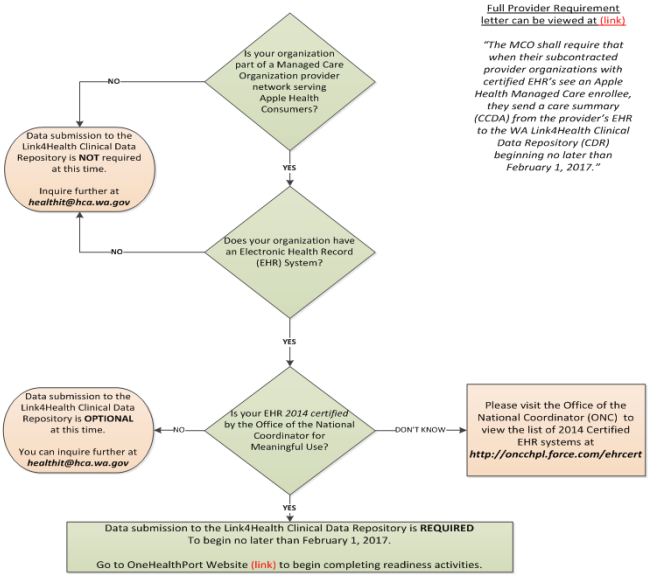
Full Provider Requirement letter can be viewed at (link)

"The MCO shall require that when their subcontracted provider organizations with certified EHR's see an Apple Health Managed Care enrollee, they send a care summary (CCDA) from the provider's EHR to the WA Link4Health Clinical Data Repository (CDR) beginning no later than February 1, 2017."



Notes:
- *A separate decision tree for data viewing will be developed as data becomes available*
- *CFR 42 part 2 covered programs and other behavioral health provider organizations may submit medical data if they choose*
- *HCA encourages all health care organizations serving Apple Health consumers to work with their EHR vendors to prepare to participate in the Link4Health CDR at a future date – even if not required at this time.*
- *For any outstanding questions regarding this requirement place contact HealthIT@HCA.wa.gov*

2/5/2016

What is Next for Tribal Facilities/Providers?

- Use the Decision Tree to identify required providers.
- Review the next steps by visiting the statewide HIE's website sponsored by OneHealthPort:

  http://www.onehealthport.com/hca_cdr

  – (this is hca_cdr)

- Identify benefits, business process simplification opportunities and uses to help your clinics qualify for additional EHR Incentive payments.

2/5/2016

Questions? Need additional Information?

Team email: HealthIT@hca.wa.gov
(please enter "HIE" in the subject line)

Website: HealthIT.wa.gov
-sign up for monthly
-watch for upcoming webinars
-copy of Provider Participation Requirement letter
-copy of EHR Vendor Invitation letter
-copy of the Decision Tree document

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2/5/2016

- Apple Health for Foster Children – Managed Care

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Managed Care for Children/Youth in Foster Care and Adoption Support

Fast Facts

Program Objectives

- **Develop a collaborative approach** between the health care system and the CA care system that ensures provision of coordinated health care services for program enrollees and involves the child's parents, caregivers, social worker(s) and other supports in the enrollee's care.
- **Improve access to care** by establishing a medical home with an assigned Primary Care Provider for children and youth in foster care and adoption support, and young adults aged 18 through 26 who are alumni of the foster care system;
- **Provide health care coordination services** for enrollees with multiple or complex health care needs;

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Program Objectives *(cont'd)*

- **Provide smooth transitions** of health care as children and youth move from home to foster care, from one placement to another, from hospital or other institutional setting to another or from such settings to home;
- **Support enhanced stability** for program enrollees by achieving improved health outcomes;
- **Provide education and assistance** to enrollees who are transitioning from foster care to independence in navigating the health care system, so the enrollee will not lose access to needed health care services;
- **Control the cost of care** by providing more comprehensive and coordinated health care services.

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Populations covered by the AHFC include children and youth in:

- Licensed foster care,
- Relative care,
- Adoption support,
- Extended foster care (18-21), and
- Alumni of foster care system up to age 26.

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Other AHFC fast facts:

- AI/AN children in foster care may enroll but will not be auto-enrolled by HCA.
- Coordinated Care of Washington (CCW) is the Apparent Successful Bidder for the Apple Health Foster Care (AHFC) program.
- CCW will provide a managed care program for children and youth in foster care and adoption support and those young adult alumni of the foster care program who are eligible for enrollment.

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Eligible clients will be enrolled for an April 1, 2016, program implementation date:

- A provider letter went out from HCA in December, notifying them that the program will be implementing, and giving information about how to contact CCW if they want to contract for the foster care program;
- A "heads up" letter will go to eligible clients in all eligibility groups – foster care, adoption support and alumni – in early February;
- Enrollment information from HCA will go out starting February 22, 2016. Coordinated Care will send out member welcome packets beginning April 1, 2016.

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The AHFC benefit package is the same as the Apple Health Managed Care benefit package and includes:

- Primary and preventive care, with additional EPSDT (Early Periodic Screening, Diagnosis and Treatment) well child visits as required by Children's Administration;
- Inpatient and outpatient hospital services;
- Outpatient mental health services for enrollees who do not meet medical necessity (Access to Care) standards to receive services through the RSN/BHO system;
- Pharmacy services and supplies, including durable medical equipment, prescription medications and over the counter medications;
- Health Care Coordination services that include initial assessment and care planning, assistance to enrollees in accessing services, coordination of care between systems (i.e. the MCO and RSNs, long term services and supports, etc.), and continuity of services when a change in placement necessitates a change of provider.

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Transitioning to AHFC

- Priority is getting kids the care they need & maintaining already established health care and behavioral health provider relationships whenever possible.
- 90-day transition period for new enrollees: Remain with existing provider until care needs are assessed and enrollee is assisted in transition by health care coordinator.
- Expanding our Medical provider network and identifying key providers in each community to target for contracting. Will attempt to contract with the health care provider or work with them as a non-participating provider, or transition enrollee to another health care provider.
- Enrollee maintains current prescriptions and care plans until assessment is completed.

Coordinated Care Provides:

- One stop shopping for health care assistance
- Help in resolving access to care barriers
- More help navigating the health care system and finding needed medical/behavioral health providers
- 24/7 Nurse Advice Line
- Health Care Coordinators to help manage chronic conditions, provide coaching, and make arrangements for needed medical services/supplies
- Behavioral Health Care Coordinators to help screen members and connect them to needed RSN/BHO services.

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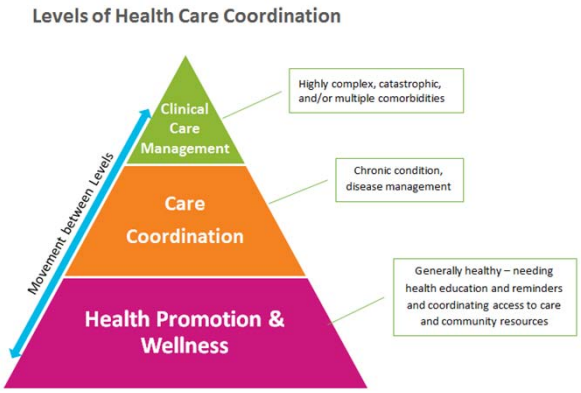
Integrated Health Care Coordination



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Value Added Benefits/Incentives

- **CentAccount® (Rewards Program)** Innovative approach to encourage healthy behaviors by rewarding members with financial incentives through a pre-paid card that can be used for health-related expenses, groceries and more.
- **Start Smart for Your Baby®** Prenatal and Postpartum program that promotes education and communication between members and their case managers, incorporates care management designed to extend the gestational period and reduce pregnancy related risks.
- **SafeLink (Cell Phone Program)** Cell phone at no cost with 250 minutes per month and unlimited text messages. Access to our Coordinated Care team, 24-7 Nurse Advice line and case managers provided at no cost and not counted towards their monthly minutes. **Care Management and Member Connections®** Advocates are assigned to each member in case management to assist with support for dealing with diseases, behavioral/mental health, connections to their community resources and assisting them to reduce barriers to achieving better health

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Value Added Benefits/Incentives

- **Transitioning Youth and a2A (adolescent to Adult)** Outreach and education starting at age 15, will partner with DSHS to support Shared Planning Meeting. All members outreached to the month of 18th birthday and invited to take part in a2A.
- **Adoption Success** Specialized care management initiative staffed by Health Care Coordinators experienced in foster care adoption, BH, and family wrap- around services.
- **Foster Care EDU** Comprehensive educational training initiative endorsed by the National Foster Care Parents Association. Foster care EDU provides free interactive training online, featuring live teleconferencing with a facilitator. Examples include: Mental Health 101, Attachment in Foster Children, Substance Abuse 101, Promoting Placement Stability, and Childhood Traumatic Grief.
- **Healthy Kids Club** Complimentary children's health books with parent guide mailed to each member; Member ID Card; Monthly newsletter for parents; health related coloring pages, word searches, mazes and puzzles

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Questions?

- **Check the Coordinated Care website for AHFC specific information at www.coordinatedcarehealth.com**
- **Send them to the Apple Health Managed Care mailbox**
  - **hcamcprograms@hca.wa.gov**

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- Planning for Consultation on MCO and BHO contracts and attached Indian Addenda

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MCO and BHO Contracts and Indian Addenda

Tribal and Indian health program provisions in:

- HCA contracts with Managed Care Organizations
  - Apple Health (statewide)
  - Fully Integrated Managed Care (Clark and Skamania counties)
- DSHS contracts with Behavioral Health Organizations

All contracts now provide for Indian Addendum

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MCO and BHO Contracts and Indian Addenda

HCA and BHA are planning to seek joint Tribal consultation on:

- Contract provisions related to Tribes and Indian health programs in each contract
- Indian Addendum in each contract

Target Timeframe: MTM in March or April

- BHA and HCA are working on Dear Tribal Leader Letter

- Tribal-Centric Behavioral Health Updates
- Behavioral Health Contracts
- Collaboration between Tribes, RAIOs, and BHOs

BEHAVIORAL HEALTH

Tribal Centric Meeting Updates

- Rule Makings for BHOs, *Trueblood*
- One more TCBH meeting left! (February 16)
- BHSIA Name Change to BHA
- BHO Detailed Plan Results now online
  https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/developing-behavioral-health-organizations
- TARGET update

Behavioral Health Contracts

- Current: Transition contracts to BHOs
- Upcoming: Behavioral Health State Contract for MH and SUD services
  - Includes Tribal Crisis Plan and 7.01 Plan
  - DBHR can share this contract language when finalized

Collaboration between Tribes, RAIOs, and BHOs

- Loni can be a resource to help with collaboration between Tribes and BHOs and RAIOs and BHOs
- In progress: creating a template for the Tribal Crisis Plan for BHOs to use as a starting point

- Payment Redesign Initiative: Critical Access Hospitals, FQHCs, and Rural Health Clinics (Payment Model 2: Encounter to Value)

HEALTHIER WASHINGTON & MEDICAID TRANSFORMATION WAIVER

Payment Model 2: Encounter to Value

January 19, 2016

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Washington's Vision

Creating healthier communities and a more sustainable health care system by:

- Building healthier communities through a collaborative regional approach
- Ensuring health care focuses on the whole person
- Improving how we pay for services

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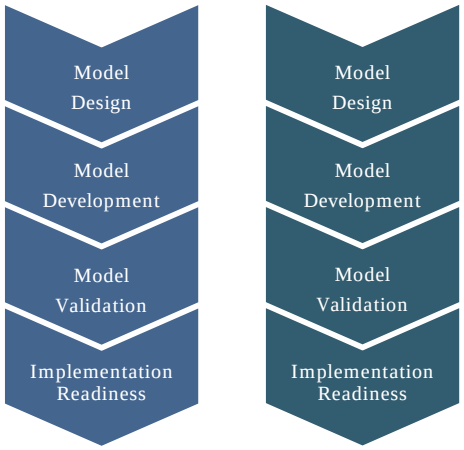
Payment Model 2: Encounter to Value

- Two separate payment models:

- Federally Qualified Health Centers and Rural Health Clinics

Alternative Payment Methodology



- Critical Access Hospitals

New Payment and Delivery System Model

Pilot Implementation

CAH Payment and Delivery

CAH Characterization

- A typical critical access hospital employs 141 employees, generates $6.8 million in wages, salaries and benefits and has a community retail sales impact of $2.5 million.
- Of the 1332 nationally
  - 50 CAHs closed since 2010
  - 283 CAHs vulnerable to closure
- If the vulnerable hospitals close:
  - 700,000 Medicare patients would have to travel farther for medical care
  - Loss of 86,000 jobs, estimated $10.6 billion loss to the GDP
- Of 39 CAH in WA: 8-12 CAHs vulnerable,
  - For at least 3 WA CAHs; 12-18 months lifespan without changes

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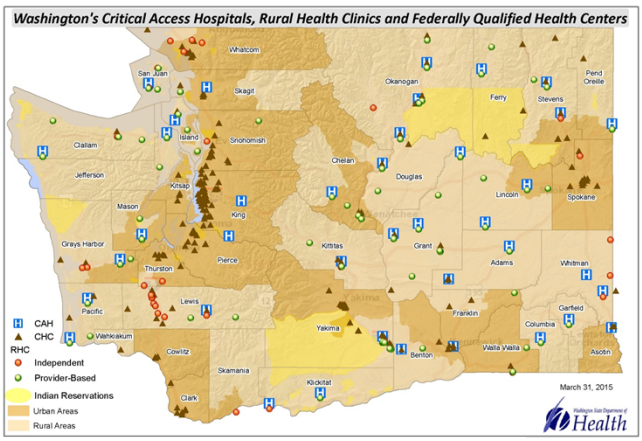
CAH Characterization



Total Service Delivery for CAHs

	Payments ($)	Percentage of Payments	Clients	Percentage of Clients
Tribal Clients	$5,066,578	8%	2,054	5%
Non-Tribal Clients	$59,356,239	92%	35,980	95%
Total	$64,422,817		38,034	

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CAH – Model 2 and WRHAP

- DOH and WSHA - August of 2014, the "New Blue H Report"
  - The Washington Rural Health Access Preservation (WRHAP) Initiative formed out of this work
- Assessing the feasibility of realigning care delivery for Washington's most financially vulnerable Critical Access Hospitals
- Historical Reference:
  - 1989 - RCW 70.175
    - WA Rural Health Care Commission: State shall develop licensing standards for an alternative rural health facility that maintains basic health services, meets state and community outcomes, and is designed by the community…
- SIM grant language:

  "Pursu[ing] new flexibility in financial incentives and delivery models for participating CAHs" and "encourag[ing] sustainability to meet changing community needs"

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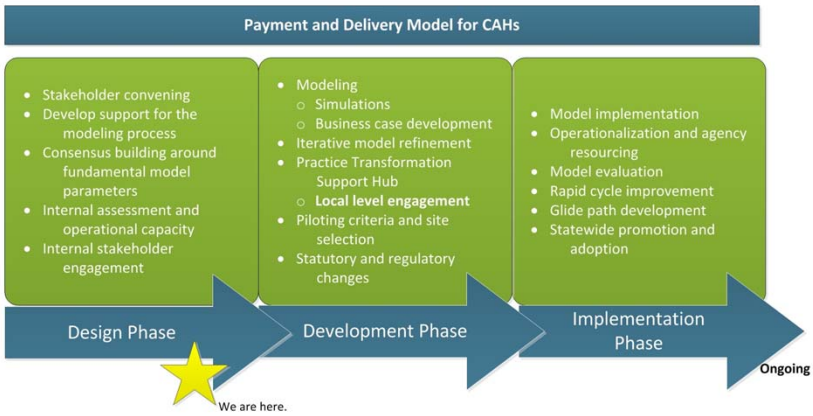
CAH – Status Update



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FQHC/RHC APM 4

FQHC/RHC Payment Structure
Options to States

Prospective Payment System (PPS):

- Replaced the traditional cost-based reimbursement system for FQHCs and RHCs with a new prospective payment system (PPS)
  - Provides a minimum payment standard for FQHCs and RHCs
- Rate based on each FQHC's/RHC's fiscal years 1999 and 2000 reasonable cost per visit rates
  - Annual rate inflated by a Medicare designated factor
  - Unique payment rate for each FQHC/RHC
- Federal minimum requirement that FQHCs and RHCs be reimbursed for services provided to Medicaid patients
- ***States have an Alternative Payment Methodology (APM) option***
  - ***Washington – Premium payment plus an 'Enhancement-payment'***

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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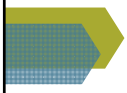
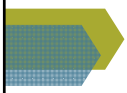


Alternative Payment Model (APM) 3

- APM 1: January 1, 2009 – April 6, 2011
  - 2006 CMS audit found insufficient evidence that Washington's PPS methodology for making enhancement payments met the federal requirements
  - 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 2009-2001



Model 2: Encounter to Value

Options for a new Payment Methodology - January 1, 2014

Third Engrossed Substitute Senate Bill 5034

"The model will test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams."

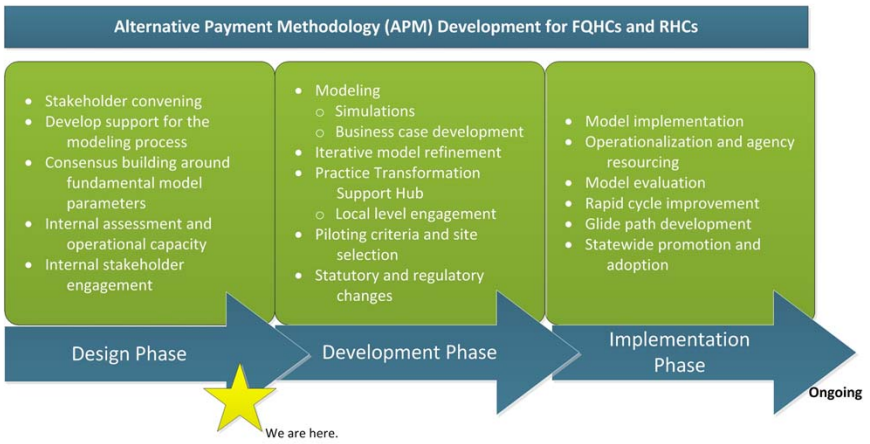
Principles and Shared Values:

- Predictable payments that comply with federal standards
- Simple, fair, transparent model that is inexpensive to administer
- Align with primary care practice transformation
- Reward for outcomes, encourage the use of alternative patient/provider connections, and incent movement away from volume-based, face-to-face visits

An APM 4

- *Opting into an APM 4 will be voluntary during the pilot phase*

FQHC/RHC APM – Development Status



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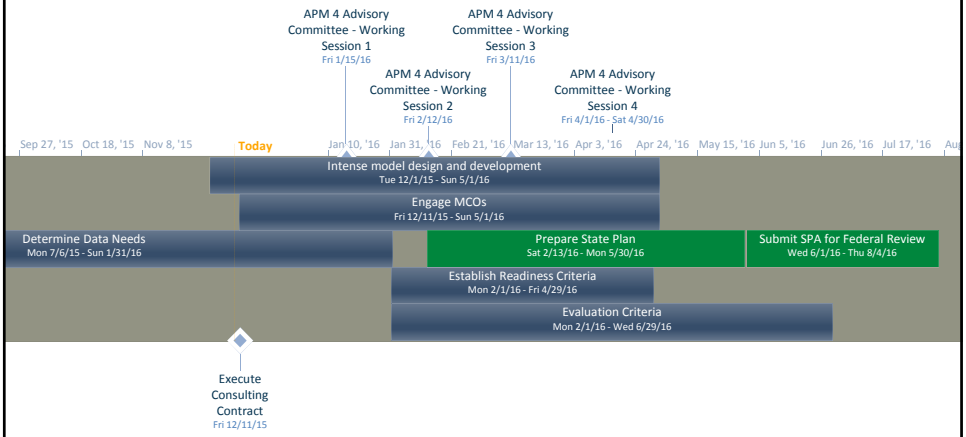
FQHC/RHC APM – Timeline



APM 4 Advisory Committee is not a decision making body

- *First meeting January 15, 2016*
- *Expecting open and transparent process*
- *Not only venue for discussion*
  - *View this as an iterative process*

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SIM Grant Objectives: Payment Model 2

- Simplified FQHC/RHC Reconciliation Process
- Paying for Value
  - Quality/Performance Incentives with Shared Savings
  - Bend cost trend over time
  - Shift from Encounter-based to Value-based
  - Increased Financial Flexibility/Practice Transformation
    - Group Visits
    - Telemedicine
    - Non-traditional workforce

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Desired Elements of an APM 4

- Simplified FQHC/RHC Reconciliation Process to reduce administrative burden
- Payment of Full PPS Encounter at Time of Service
- Budget Neutrality to APM 3
- Incentives Tied to Quality
  - Based on FQHC/RHC Specific Reporting and Baseline
- Potential for Upside and Downside Risk in a Phased Approach

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Open Discussion and Questions?

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Payment Redesign Model 2:
Encounter-based to Value-based

Contact:

Gary Swan
Payment Redesign Model Analyst
gary.swan@hca.wa.gov

- Job Opening: Healthier Washington Tribal Liaison

HEALTHIER WASHINGTON & MEDICAID TRANSFORMATION WAIVER

Washington State Health Care Authority

Job Opening: Healthier Washington Tribal Liaison

Job Opening: Healthier Washington Tribal Liaison

Primary responsibilities:

- Represent the Healthier Washington project in various settings involving Indian health organizations and relevant State agencies;
- Develop written materials, where appropriate, to describe or explain how the various initiatives of the Healthier Washington project may affect Indian health organizations or American Indian/Alaska Native health; and
- Track the status of, and follow-up on, Indian health organization requests and action items and various implementation milestones related to the various initiatives of the Healthier Washington project.

Time Period: 3 years position, ending January 2019

Reports to: Administrator of Tribal Affairs and Analysis

Annual Pay Range: $53,424 - $70,056

Washington State Health Care Authority

Job Opening: Healthier Washington Tribal Liaison

Minimum Qualifications:

- Either
  - Bachelor's degree + one year of experience in health care related field, or
  - Seven years of experience in health care related field; and
- One year of experience working with Tribes or American Indians/Alaska Natives; and
- Ability to travel extensively in-state.

Preferred/Desired Qualifications:

- Experience facilitating meetings.
- Experience analyzing laws and regulations.
- Experience working in or with an Indian Health Service (IHS)-funded program, including Direct Service IHS, Title I Tribal health programs, Title V Tribal health programs, and/or urban Indian health programs.

Job Opening: Healthier Washington Tribal Liaison

URL: https://www.governmentjobs.com/careers/washington/jobs/1310121/tribal-liaison-maps3-71045641

Closes: February 1, 2016

Interviews: Mid-February

Hire Date: As soon as possible, likely March timeframe

- Medicaid Transformation Waiver – Update

HEALTHIER WASHINGTON & MEDICAID TRANSFORMATION WAIVER

Washington State Health Care Authority

Medicaid Transformation Waiver

Development of Transformation Project List

January 22, 2016

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Agenda

- CMS Updates
- Updates on the project submissions
  - Available on the web site
    http://www.hca.wa.gov/hw/Pages/mt_initiative1.aspx
  - Public comment period
  - Confirm need for placeholder in STCs that allows for the AIHC process

Next webinar update – February 4, 2016

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Medicaid Transformation Website

http://www.hca.wa.gov/hw/Pages/mt_initiative1.aspx

HCA Home | Health Benefits | Agency Programs | Employment

Projects and Initiatives
- Home
- Accountable Communities of Health
- Community Health Worker Task Force
- Integrated Physical and Behavioral Health Care
- Medicaid Transformation
- Paying for Value
- Performance Measures
- Plan for Improving Population Health
- Practice Transformation Hub

Resources
- About the Plan
- Contact Us
- Feedback Network Announcements
- Governance
- Health Innovation Leadership Network
- How to Participate
- Resources and Documents

MEDICAID TRANSFORMATION

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Initiative 1: Transformation Projects

Transformation through Accountable Communities of Health

Each region, through its Accountable Community of Health, will be able to pursue transformation projects aimed at:

- **Health systems capacity building**—workforce development; system infrastructure technology and tools; and system supports to assist providers in adopting value-based purchasing and payment
- **Care delivery redesign**—bi-directional integrated delivery of physical and behavioral health services; transitional care focused on specific populations; alignment of care coordination and case management to serve the whole person; and outreach, engagement, and recovery supports
- **Population health improvements**—prevention activities for targeted populations and regions

Update—January 19, 2016

Thank you to everyone who submitted transformation project suggestions.

We are in the process of posting your transformation project suggestions and will have a complete list later this week. Project proposals are posted "as is" and have not been reviewed by the State.

We will provide an update on next steps at the February 4 Medicaid Transformation webinar (details and a registration link will be posted soon).

In the meantime, we are interested in your comments regarding the proposals we've received. Please send comments to medicaidtransformation@hca.wa.gov.

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
1	ACH*	As part of notice and consultation requirement, State needs to invest in competent analysis, planning, and technical assistance to: 1. Ensure AI/AN and ITU needs are adequately addressed 2. Help ITUs determine whether they want to work with a TCE or an ACH 3. Help ITUs determine how they will work with ACHs Reasons for TCE: • Statewide Medicaid Transformation projects for ITUs and AI/ANs, across multiple ACH regions. • Conflicts between Tribes and counties. • Reflects the government-to-government relationship. Any Tribal Coordinating Entity (TCE) will need funding to develop capacity, potentially through the 1115 waiver	1. This Log contains the work on (1). 2. HCA: Work with AIHC on "AIHC Project" for (2) and (3): • Educational meetings on ACHs and ITUs • Individual meetings with ITUs to understand what type of engagement is appropriate for each ITU: (a) engage with regional ACH (including what is needed and appropriate for ITU to engage the ACH), (b) engage with one or more Tribal Coordinating Entities (TCEs), or (c) both options. • Report on findings due January 31, 2017. 3. HCA: Work with CMS to keep placeholder in 1115 waiver for ITUs, pending AIHC Report. 4. HCA: Work with consulting team to: • Identify essential functions of "coordinating entity" (e.g., fiscal management of waiver dollars); • Develop options for having "coordinating entities"; • Work with ITUs on TCE

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
2	ACH*	ACHs need to be educated about ITU system in order to engage effectively with ITUs and Tribes	See "AIHC Project" above.
3	ACH*	Ensure ACHs are designed and implemented in a parallel, complementary and coordinated manner with the ITU system	See "AIHC Project" above.
4	Gen-eral	Inconsistent confidentiality rules for HIPAA and SUD services	
5	Other Waiver *	Uncompensated care waiver for optional services provided by ITUs	AIHC/ITUs: Describe the services that are being discussed in connection with the comment on uncompensated care. HCA: Create list of uncompensated care services to confirm with ITUs.
6	State Plan*	Require MCOs to contract with every ITU on request and to use the Indian addendum	HCA: Amend HCA-MCO contracts, starting April 1, 2016 – after Tribal consultation.
7	State Plan*	Improve Medicaid reimbursement system to reduce administrative burden on ITUs	HCA: Work with MCOs on MCO payment of full IHS encounter rate, with back-end reimbursement process between MCOs and HCA.
8	State Plan*	Require MCOs to participate in training on ITU system and to participate in tribal roundtables	HCA: Amend HCA-MCO contracts, starting April 1, 2016 – after Tribal consultation.

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
9	State Plan*	Expand tribal assister program to apply to Classic and MAGI Medicaid	HCA/BHA: Work with AIHC to expand capabilities of Tribal assisters to include eligibility for both Classic Medicaid and MAGI Medicaid, including: • Access to Washington Connection as well as Healthplanfinder (this will likely require agreement with DSHS); • DSHS training added to OIC trainings with Tribal assisters—quarterly by region.
10	State Plan*	No auto-assignment for AI/ANs into managed care. State Response: No AI/ANs are being auto-assigned into managed care.	
11	Waiver/ State Plan*	Increase access to primary and specialty care in FFS • Rent a network/MCO acceptance of ITU referrals for FFS clients • Work through ACHs? • Medicaid System Transformation Project?	HCA/DSHS: Work on how to increase access to specialty care in FFS under the State Plan. Also see "Medicaid System Transformation Project" in "Waiver" category below.

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
12	State Plan/ BHO*	Ensure compliance with federal protections • No cost-sharing • AI/AN MCO-enrollee may choose ITU as PCP • Sufficient ITUs in MCO network • Payments to ITUs notwithstanding network restrictions • Prompt payments to ITUs by MCOs	HCA/BHA: Develop process to monitor compliance and address issues.
13	Waiver/ State Plan/ BHO*	State will work with ITUs to analyze complications for ITU behavioral health programs and AI/AN health care needs due to (a) the integration of SUD services with mental health managed care (BHOs), and (b) the coordination of the BHO system with physical health care	HCA/BHA: Work with ITUs to monitor and analyze issues.
14	State Plan/ LTSS	Request for in-patient IHS encounter rate for long-term care services	HCA/ALTSA: Work with CMS to determine whether and how to authorize this in the State Plan.
15	TCBH*	Continue to use IHS encounter rate to reimburse Tribal mental health and chemical dependency programs (Medicaid funded).	
16	TCBH*	Continue to allow Tribal and urban Indian health programs mental health services to clinical family members of Tribal members (Medicaid funded).	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
17	TCBH*	DSHS/HCA should contract with adult and child consulting psychiatrists to provide medication consultation services to Tribal and urban Indian health programs (State funded).	
18	TCBH*	DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop and reimburse for culturally appropriate evidence-based and promising AI/AN practice treatments (State funded).	
19	TCBH*	DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions (Medicaid funded through separate encounter rates).	
20	TCBH*	DSHS should seek state funds to pay Tribal programs for chemical dependency services provided to non-AI/ANs (State funded; Medicaid funded with Medicaid expansion).	
21	TCBH*	Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA commitments for Tribal members.	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
22	TCBH*	DSHS should assist Tribal programs to train and have DMHPs who can detain AI/AN for ITA commitments (State funded).	
23	TCBH*	DBHR dedicated FTE to provide technical assistance to Tribes and monitor Tribal relations in BHO contracts (State funded).	
24	TCBH*	DBHR use 2SSB 5732 appropriations to contract or employ a dedicated FTE to assist with implementation of the report's recommendations (State and Medicaid funded).	
25	TCBH*	Obtain state funding to conduct a feasibility study for one or more E&T facilities to service AI/AN people needing inpatient psychiatric care (State funded).	
26	TCBH-BHOs*	Require each BHO to identify BHO staff member as Tribal liaison.	
27	TCBH-BHOs*	Include historical trauma and its resultant disorders, in all their complexity for AI/AN people, in BHO Access to Care Standards and list of covered diagnoses.	
28	TCBH-BHOs*	Require BHOs to contract with Tribal DMHPs to serve AI/AN people on Tribal Land (if Tribal DMHPs are available and willing to contract with the BHO).	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
29	TCBH-BHOs*	Require BHOs to provide timely and equitable access to crisis services for AI/AN. This would include BHOs to contract with Tribal and urban Indian health programs that are willing and able to provide crisis services. • BHOs to develop protocols, in conjunction with each Tribe with CHSDA in BHO's RSA, for accessing Tribal land and providing crisis and ITA commitment services (including protocols for coordinating outreach and debriefing the crisis/ITA review outcome with the ITU mental health provider within 24 hours)	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
30	TCBH-BHOs*	Define and clarify role and scope of governing boards. Require BHOs to include Tribal representatives in their decision and policy making boards. • BHO boards are excluding Tribes and instead inviting Tribes to have a representative on the BHO advisory committee; this is not government-to-government relations. • BHOs have said their existing funding is not sufficient for them to give full faith and credit to Tribal court orders. • RCW 71.24.300: 1) Upon the request of a tribal authority within a BHO, 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 BHO. 2) The roles and responsibilities of the county and tribal authorities shall be determined by the terms of that agreement, including a determination of membership on the governing board and advisory committees, the number of tribal representatives to be party to the agreement, and the provisions of law, and shall assure the provision of culturally competent services to the tribes served.	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
31	TCBH-BHOs*	Require BHO-contracted and DBHR-credentialed licensed psychiatric care hospitals, including state psychiatric hospitals, and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.	
32	TCBH-BHOs*	As part of 2SSB 5732, Tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments that the BHOs will be required to provide.	
33	TCBH-BHOs*	Require that BHOs and their provider networks who provide Medicaid encounters to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and departmental Workgroup.	

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
34	Waiver	ITUs should have the same opportunity as other providers and ACHs to receive incentive payments for transformation activities	
35	Waiver	Need to develop separate measures methodology to determine supplemental payments to ITUs	
36	Waiver	Need to ensure that State will not require ITUs to participate in the value-based payment system	
37	Waiver1*	Need full Tribal consultation in design and implementation of the 1115 waiver	1. HCA/BHA: Create workgroup (or use MTM?) to advise on formal consultation needs 2. HCA/BHA: Email to ITUs/Harbage the minutes of Medicaid Transformation Tribal workgroup meetings, with running list of highlighted issues 3. HCA/BHA: Email to each ITU with their own specific issues and status updates

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Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
38	Waiver1*	Exclude AI/ANs from 1115 waiver projects unless they opt in (under managed care exemption in Section 1932 of SSA), with notices explaining this to AI/ANs State Response: AI/AN managed care exemption under Section 1932 will continue; 1115 waiver will complement –not override – State Plan	
39	Waiver1*	Require coordination of care and prior authorization MCO requirements to be consistent with ITU requirements for coordination of care and referrals	HCA/BHA: Work with ITUs on "Medicaid System Transformation Project" (and supportive rule changes) to support: • Better coordination of care with ITUs; • Alignment of MCO prior authorization/IHS referral requirements between ITUs and MCOs; • Better cultural competence at MCOs through training on ITU system and tribal roundtables with MCOs; • [OTHER COMPONENTS TO BE DETERMINED]

Statewide Tribal Health Care Delivery Issues Log

#	Category	Issue Description/Analysis	Next Steps Timeframe/Target Dates
40	Waiver1*	Use GPRA measures or other IHS clinical data to reduce duplication and over-reporting by ITUs	HCA: Work with ITUs to use existing ITU measures for any Medicaid transformation project.
41	Waiver1*	Need to reinvest savings to prevent federal and state recoupment of savings and to support non-project/community reinvestment	HCA: Work with CMS to ensure that savings can be reinvested to sustain transformations.
42	Waiver3	Need to ensure that the payment methodology for Initiative 3 (foundational community supports) services is compatible with ITUs	
43	Waiver3	Need to ensure AI/AN and ITU exception to the integration into MCO and BHO rates of the cost of the benefit and delivery of foundational community supports	

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Statewide Tribal Health Care Deliver Issues Log

Key:

- *AIHC requested inclusion in Special Terms and Conditions to the 1115 Waiver
- ACH – Accountable Community of Health issue
- AIHC – American Indian Health Commission for Washington State
- BHO – Behavioral Health Organization
- CHSDA – Contract Health Service Delivery Area
- FFS – Fee-for-service client issue
- General – General issue
- Harbage – HCA-contracted Communications Consulting Firm for Healthier Washington
- ITA – Involuntary Treatment Act
- MCO – Managed care organization-enrolled client issue
- Payments – Incentive payment and/or performance measure issue
- RSA – Regional Service Area
- TCBH – Recommendations in Tribal Centric Behavioral Health (2SSB 5732) Report to the Legislature
- Waiver – Applicable to 1115 Waiver
- Waiver1 – Initiative 1 to 1115 Waiver: Medicaid Transformation
- Waiver2 – Initiative 2 to 1115 Waiver: Long-Term Service and Supports Redesign
- Waiver3 – Initiative 3 to 1115 Waiver: Foundational Community Supports

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Questions?

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For more information, contact:

Website:
www.hca.wa.gov/hw

Join the Healthier Washington Feedback Network:
healthierwa@hca.wa.gov

For questions about Medicaid Transformation:
medicaidtransformation@hca.wa.gov

Thank you

MISCELLANEOUS

HCA and BHA Meetings Q1 2016

Date	Meeting
January 25 (Mon) √	MTM (HCA+BHA)
February 10 (Wed)	TBWG
February 16 (Tues)	BHA TCBH
February 22 (Mon)	MTM (HCA+BHA)
February 24 (Wed)	MCO-Tribal Meeting
March 9 (Wed)	TBWG
March 28 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
BHA TCBH	BHA Tribal Centric Behavioral Health Workgroup – Third Tuesday of January and February (webinar and OB-2 SL-04)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)

HCA and BHA Meetings Q2 2016

Date	Meeting
April 13 (Wed)	TBWG
April 25 (Mon)	MTM (HCA+BHA)
May 11 (Wed)	TBWG
May 23 (Mon)	MTM (HCA+BHA)
May [TBA]	MCO-Tribal Meeting
June 8 (Wed)	TBWG
June 27 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

HCA and BHA Meetings Q3 2016

Date	Meeting
July 13 (Wed)	TBWG
July 25 (Mon)	MTM (HCA+BHA)
August 10 (Wed)	TBWG
August 22 (Mon)	MTM (HCA+BHA)
August [TBA]	MCO-Tribal Meeting
September 14 (Wed)	TBWG
September 26 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

HCA and BHA Meetings Q4 2016

Date	Meeting
October 12 (Wed)	TBWG
October 24 (Mon)	MTM (HCA+BHA)
November 9 (Wed)	TBWG
November 28 (Mon)	MTM (HCA+BHA)
November [TBA]	MCO-Tribal Meeting
December 14 (Wed)	TBWG
December 19 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

Status Updates Since December 23, 2015

Project	Status
AI/AN Health Care Issues Grid	In process of being drafted
Tribal Consultation Minutes	Completed – Distributed on December 8
Medicaid Transformation Waiver	HCA in preliminary discussions with CMS; meeting held on December 15; next meeting in January • Coordinating with AIHC project • Upcoming process on submitting project ideas
Joint Agency-Tribal Summit	Meetings held on December 4, 14, and 21 • No longer looking at February 5 or January 29 Seeking feedback on alternative options: • April DSHS Tribal Leader Summit • AIHC Biennial Tribal Leader Health Summit in: ➢ Week of June 13 ➢ Week of June 20 ➢ Combined/coordinated with July 14 IPAC meeting

Status Updates Since December 23, 2015

Project	Status
MCO Payment of Wraparound Encounter Rate	No update - Scoping changes that would need to be made to ProviderOne to enable MCO payment
Forms for HCA Contracts with Tribes	No update - Preparing form Indian Addendum for Core Provider Agreements
AI/AN Maternity Support Services (MSS) and First Steps	No update - Working to increase awareness of reduced team requirements and Medicaid reimbursement for CHR case management
ACH-Tribal Engagement Technical Assistance (including resources on Tribal representation on ACH governance bodies) and Tribal Meeting Facilitation	No update - Contract with AIHC in final approval stages

Status Updates Since December 23, 2015

Project	Status
Tribal-State Data Workgroup	No update
HCA Training: Gov't-to-Gov't and Indian Health Care Delivery	No update
Quarterly MCO-Tribal Meetings	Next meeting on February 24, 2016; HCA working on notes from November 18 and May 8 meetings
Pilot of Mental Health Technical Assistance Review at Tribe	Re-evaluating
Federal Ownership Disclosure Requirements for I/T/Us	Still waiting for guidance from CMS
Tribal Consultation on April 17, 2015	No update - HCA working on minutes

Status Updates Since December 23, 2015

Project	Status
Foster Care Medical and Tribal Foster Care	No update - HCA will work with the IPAC subcommittee for Children's Administration
Tribal Health Homes	No update - DSHS has determined that it can extend the funding of the Health Homes program through June 30, 2016; legislature will determine whether to extend program after June 30, 2016

Status Updates Since December 23, 2015

Open Item	Status
CMS-Required Inter-Governmental Transfer Process	No update
Replies to AIHC briefing papers/questions	No update
Expansion of AI/AN exemptions from Medicaid estate recovery	No update
Amendment to HCA Tribal Consultation Policy	No update
Review of AIHC Medicaid eligibility materials	No update
Expansion of HCA resources on AI/AN eligibility	No update
IHS Services and Medicaid spenddown	No update

Status Updates Since December 23, 2015

Open Item	Status
Domestic Violence Perpetrator treatment and Medicaid coverage under Brief Intervention Treatment procedure	No update

Medicaid State Plan Amendments (SPAs) and Waivers: Notices Since November 25, 2015

SPA#/Waiver# (Date of Letter)	Brief Description
None	None

[UPDATE]HCA WAC Change Requests: CR-102 Filings Since December 23, 2015

WSR # (Date of Filing)	Rule Title and Brief Description
WSR 15-24-110 (12/1/2015)	Certification Periods and Change of Circumstance: Housekeeping changes to make rules consistent with each other and to clarify that reinstated or continued coverage continues until an order is issued by HCA's Office of Administrative Hearings (WAC 182-504-0130, 182-504-0135). *Hearing on January 5, 2016.*
WSR 15-23-060 (12/1/2015)	Medical Assistance Units: Various amendments to improve clarity (WAC 182-506-0010). *Hearing on January 5, 2015.*
WSR 15-24-112 (12/1/2015)	Medical Definitions - A: Various technical amendments (WAC 182-500-0010). *Hearing on January 5, 2015.*
WSR 16-01-068 (12/14/2015)	Long Term Care: Clarifying rules to comply with federal guidance (Chapter 182-514 WAC). *Hearing on January 26, 2016.*
WSR 16-01-104 (11/20/2015)	Estate Recovery: Amend WAC 182-527-2742 to clarify that Individual and Family Services and Community First Choice are subject to estate recovery and to remove Washington Medicaid integration partnership since it is discontinued. In addition, amend Chapter 182-527 WAC to more clearly distinguish rules that apply to TEFRA liens and rules that apply to estate recovery. *Hearing on January 26, 2016.*

BHA WAC Change Requests: CR-102 Filings Since December 2015

WSR # (Date of Filing)	Rule Title and Brief Description
WSR 16-01-124 (12/18/2015)	Competency evaluation and restoration services: to implement 2ESSSB 5177 and the court decision in *Trueblood v. DSHS* by providing notice of the required minimum standards to gain and maintain certification to provide competency evaluation and restoration services. DSHS will develop alternative locations and increase access to competency evaluation and restoration treatment services under chapter 10.77 RCW (WAC 388-865-0900 through 0970). ***Hearing on January 26, 2016.***
WSR 16-01-026 (12/08/2015	Behavioral Health Organizations: to comply with SSSB 6312; repeal WAC sections that pertain to RSNs, and to add new sections that pertain specifically to RSNs becoming BHOs, updating language regarding BHOs, the BHO managed care plan, behavioral health services, and other related changes (WAC 388-865, 388-875, 388-877, 388-877A, 388-877B, 388-877C). ***Hearing on February 9, 2016.***

Thank you!

Health Care Authority
Office of Tribal Affairs & Analysis

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DSHS – Behavioral Health Administration
Division of Behavioral Health & Recovery

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- **Website:** https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery