North Central
Accountable Community of Health

Fully-Integrated Medicaid Contracting Advisory Committee

North Central Accountable Community of Health

MEETING NOTES

10:00 – 11:30 AM January 11th, 2017, Confluence Technology Center, Wenatchee

Attendance: See attached attendance list for full list of participants

Introductions	*Senator Parlette, North Central Accountable Community of Health:* The Fully-Integrated Medicaid Contracting Advisory Committee is an opportunity for us as a region to talk about Medicaid Contracting and give input on the process and changes taking place. The committee will be meeting every 2 weeks for quite some time. As the state moves towards full financial integration for Chelan, Douglas, and Grant counties, the NC ACHs major goal is to help providers be ready for the integration on Jan. 1, 2018. Different groups will be ready at different times. Integration is not being pushed from the ACH, it is coming from the state of WA and the federal government as we move toward value-based purchasing. The ACHs role is to be here to help and to get input at the local level so that we know what is working well and what isn't.
Provider/System Strengths and Gaps	*Isabel Jones, Health Care Authority:* The biggest focus of the transition for the RFP that is going to go out is that the Behavioral Health Organization is going to be dissolving Jan. 1, 2018. The BHO is currently the payer in the region for Substance Use Disorder services and specialty mental health services. These services will be transitioning to the managed care plans that are selected as a result of the RFP. It is important that the strengths of this region are preserved as we make this transition to MCOs. *Barry Kling, North Central Accountable Community of Health:* There is an emphasis on the Behavioral Health transition that makes a lot of sense because those are the organizations that are not used to billing MCOs and carrying managed care contracts. But this change will affect the whole healthcare system (ie. integrating behavioral health with medical care). The contracting change is an important step, but it is meant to lead to a lot of other changes in the way healthcare is organized and delivered. *Small group activity:* Broke into 4 groups of ~8 to discuss what works well, what we want to preserve, what are the gaps in NCW and can this be addressed in the MCO RFP? At the end of small group discussions each group reported out. See attached document for report out notes.
Southwest Washington Integration Lessons Learned	*Isabel Jones, Health Care Authority:* Collaboration: There has been a considerable amount of collaboration in SWWA amongst providers, MCOs, and HCA which has really helped the process.

Consumer Feedback: HCA has sought feedback from clients and families about what is working well and what is not. HCA worked through a county implementation team who was the primary liaison between providers and consumer advocacy groups. The ombudsmen were very active and got a lot of customer voice from them. ACH stood up the consumer behavioral health advisory board (NC BHO has one now) which is 51% consumer led. Ombudsman said she doesn't think that the clients have experienced any negative impact as a result of the transition.

Challenges: HCA is working with providers to understand from their perspective what the biggest challenges have been.

- Fast paced nature of transition – SWWA only had 3 months from selection of plans until integration. NC ACH current timeline is to have 7.5 months and will have no less than 6 months from plan selection to integration.
- Claims submission testing period – providers would have liked 90 days of no fault submission testing after plans are in place either before going live or after. Time to work with the plans to fix submissions that were done improperly. HCA hopes that having a longer time between selecting the plans and going live will give more of an opportunity for that kind of testing.
- Some providers changed EHR programs at the same time as integrations. The MCOs don't require Avatar like the RSN/BHO does which allows providers to choose their EHR. Changing the EHR system at the same time as changing the financial systems was overwhelming. Some historical patient information was lost because of the EHR transition and the RSN disbanding at the same time. All NC ACH providers use Avatar, except Grant Integrated Services which uses a dual record system and does do reporting through Avatar. Out of network providers do paper submissions to the BHO.
    - There was discussion on what reporting MCOs and the state will require. Avatar is being used because it provides the reporting that is required. If the reporting changes it would give providers an opportunity to consider other EHR options other than Avatar.
    - Where the funding comes from and what kind of services are provided determines what reporting is required.
    - The MCOs will coordinate with HCA to get some guidelines on what information will be required for reporting. When it is available (approx. 1 month) it will be distributed to NC ACH providers.
- Billing transition – most difficult for behavioral health providers that had never worked with MCOs before.
    - The plans kept providers in the same payment methodology, mostly cost reimbursement
    - Standard claim forms (1500 and 837 forms) was not something providers had previously done under the RSN

system
- Providers not familiar with submitting encounters through a clearinghouse
- Large spectrum of how ready providers were to integrate – providers that already contract with commercial insurers vs. providers that worked exclusively with the RSN or county – some providers needed more technical assistance than others but HCA and MCOs didn't know where each provider was at on that spectrum
- Providers had not previously used a Practice Management System for scheduling and billing (Office ally or a section of Avatar)
- Workflow training for billing and accounting systems and for doing regular eligibility checks (if client is on Medicare, which MCO, secondary coverage)
- After the go-live date a consultant was provided to the region to help providers figure out why encounters were rejected etc. More Technical Assistance should be provided up front for NC ACH – starting the conversation now.

Early Warning System: – managed by the ACH with broad stakeholders. Used metrics to track and review to identify problems.

Measuring Success: The metrics that were used for success measurement in the beginning were that the providers got paid and the clients got access to services. There are performance measurements that MCOs have to report on to measure longer term outcomes. Isabel will provide report on the Early Warning System that was used to identify problems arising from contract integration.

Investment and Infrastructure: There was discussion on the length of time and investment required to get providers able to submit 1500 forms etc. The BHO commented that Avatar has some other capabilities that aren't currently being used because they weren't necessary. BHO is working to get Netscape directly connected with providers for Technical Assistance for Avatar.

Provider Uncertainty: It was noted from the providers that there is a lot of provider uncertainty. Providers need to contract with all 5 MCOs. Set up a new billing system after plans are selected. What will be the capital investment if there is one for infrastructure or for the billing system.

Hosted EHR System: Okanogan Behavioral Healthcare currently uses Avatar but they are moving to a hosted system. The benefits of the hosted system are that you can build the system and have it hosted, providers can use the internet to access the system, and it is standardized (ie. forms). The region could build a standardized system and have it hosted; new providers could

	be easily added and it could reduce cash outlay for new providers. The region could put out an RFP for a provider to build the system that the region would use. <u>Provider Alliance Charter:</u> A copy of the Charter for Provider Alliance from Southwest Washington was requested. Isabel will provide it to the committee. *Erin Hafer, Community Health Plan of Washington:* Lessons learned from SWWA- • Start provider assessment now and starting to build out IT capabilities now will be beneficial • Having clear ownership and roles around functions and committees (ie. Behavioral health advisory committees) will help • SWWA had a Behavioral Health Planning Council which is tasked with strategic systems planning and identifying gaps in the system. Example: proposal for a crisis triage center as a result of the council.
Qualis Behavioral Health Provider Assessment	*Barry Kling, North Central Accountable Community of Health:* The Practice Transformation Hub is an effort from the state Health Department to assist providers around the state to make the integration changes. The state contracted with Qualis Health (a health consulting firm) for the Practice Transformation Hub by working with ACHs and providers. NC ACH submitted a request to Qualis is to do an assessment for Behavioral Health providers with Behavioral Health providers of the IT issues that will come up in adapting to an MCO billing system and then develop a plan for addressing the needs that it identifies. There may be some funds available to address some of those needs. Qualis will provide the proposal to the NC ACH by Jan. 16th.
Integration Timeline	Medicaid Contracting Integration Timeline • Feb. 15th – RFP is released for MCOs o MCOs will have 2 months to reply • April 15th to May 15th – Scoring of proposals • May 15th – announcement of apparently successful bidders

Upcoming Meetings

Date	Location	Topic
Jan. 25 10:00 - 11:30 AM	Wenatchee Valley College	Crisis system funding flow and overview; Administrative services RFP overview
Feb. 8 10:00 – 11:30 AM	Confluence Technology Center	Rate Setting
Feb. 22 10:00 – 11:30 AM	Confluence Technology Center	Administrative Services RFP comments
Mar. 8 & 22 10:00 – 11:30 AM	TBD	Continuance of committees (FYSPRT, Community BH Board, CLIP committee, others)

Full list of topics to be covered is attached. Please send additional topic ideas that you would like to discuss to Christal.eshelman@cdhd.wa.gov.

Attachments: RSVP Roster
Small Group Report Out – Provider/System Strengths and Gaps
Future Advisory Committee Topics

Fully-Integrated Medicaid Contracting Advisory Committee
Attendance for January 11, 2017

Last Name	First Name	Organization	Title	Jan 11th, 2017
Abel	Kevin	Lake Chelan Community Hospital & Clinics	Chief Executive Officer	X
Allen	Ralph	McKay Healthcare & Rehabilitation Center	Administrator	X
Bastian	Brett	City of Moses Lake Fire Department	Fire Chief	X
Billing	Michael	Mid-Valley Medical Group		X
Boyle	Kathleen	Amerigroup	Director- Behavioral Health	X
Bush	Ruth	Coordinated Care	Dir Behavioral Health Integration	X
Button	Cindy	Aero Methow Rescue Service	Director of Service	X
Cannon	Daniell	Coordinated Care	Manager of Community Education	X
Chilson	Shiela	Moses Lake Community Health Center	Chief Executive Officer	X
Colwell	Kevin	CRH Christopher House	Administrator	X
Crain	Anne	Together for Youth	CVA	X
Cronin	Robin	Catholic Family & Child Services	Compliance Officer	X
Down	Kayla	Coordinated Care	Manager, Health Policy & External Relations	X
Dubuque	Judy	NAMI	consumer advocate	X
Edwards	Blake	Children's Home Society of Washington, North Central Region	Acting Clinical Program Manager	X
Eshelman	Christal	North Central Accountable Community of Health	Project Coordinator	X
Evans Parlett	Linda	North Central Accountable Community of Health	Executive Director	X
Gildred	Tory	Coordinated Care	Sr. Director of Foster Care	X
Goodwin	Gail	Grant Integrated Services	Director of Management Services	X
Hafer	Erin	CHPW	Director	X
Hernandez		Columbia Valley Community Health	Meber Service Rep	X
Hoekstra	Timothy	Columbia Valley Community Health	Behavioral Health Services Director	X
Hourigan	Rick	Confluence Health - Wenatchee		X
Howard	Whitney	Molina Helathcare of WA	Director, FIMC Implementation	X
Johnson	Jay	Confluence Health	Senior Vice President	X
Jones	Isabel	Health Care Authority		X
Kagele	Julie	Chelan-Douglas Community Action Council	Executive Director	X
Kellum	Kyle	Samaritan Healthcare	Clinic Director	X
Kibby	Rosalinda	Columbia Basin Hospital	Administrator/Superintendent	X
Kling	Barry	Chelan-Douglas Health District	Administrator/Superintendent	X
Latet	Kate	Community Health Plan of Washington		X
Lind	Alice	HCA	Manager, Program Development	X
Lutz	Curt	Chelan County Regional Justice Center	Director	X
McRae	Alicia	Chelan Co/Wenatchee Housing Authority	Executive Director	X
Mickelson	Christine	North Central BHO		X
Morris	Molly	Coulee Medical Center	Financial Counselor/CHW	X

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Mott	Craig	Conluence Health - Behavioral Health Services	Practice Manager III	X
Neddo	Melanie	Three Rivers Hospital	COO	X
Neff	Kris	Samaritan Healthcare	Chief Operating Officer	X
Nelson	Clarice	North Valley Hospital	Commissioner	X
Nickel	Mary	McKay Healthcare & Rehabilitation Center	Director of Operations	X
Noyes	Vikki	Confluence Health	COO	X
O'Halloran	Ron	North Valley Hospital, Tonasket	I/CEO	X
Olson	David	Columbia Valley Community Health	Chief Executive Officer	X
Potter	Kelsey	Coordinated Care	Manager, Health Home Program	X
Randall	Lorna	Northwest Justice Project	Attorney	X
Raymond	John	HopeSource Community Action	COO	X
Rosenthal	Skip	Okanogan Behavioral Health	Chief Executive Officer	X
Schanze	Todd	City of Moses Lake Fire	Medical Services Officer	X
Schapman	John	North Central Accountable Community of Health	Program Manager	X
Schimpf	Karen	North Valley Hospital, Tonasket, WA	retired RN/Resident Care Manager/Veteran	X
Stover	Loretta	The Center for Alcohol & Drg Treatment	Executive Director	X
Sullivan	Theresa	Samaritan Healthcare	CEO	X
Switzer	Carmen	CHPW	Provider Relations Administrator	X
Timmons	Tessa	Conluence Health		X
Turner	Laurel	Women's Resource Center Housing and Supportive Services	Executive Director	X
Ward	Courtney	North Central BHO	Fiscal and Contracts Manager	X
Whinston	Melet	UnitedHealthcare	Chief Medical Officer	X

Strengths **What works well and do we want to make sure to preserve?**	Gaps **What are the challenges, gaps, problems?**
• Good working relationships among the service provider community, close network, coordinate well between behavioral health and the medical community • Awareness of local resources as well as state wide resources for services • Awareness locally of where to refer patients when a provider cannot meet a need • Some integrated behavioral health services with medical care • Some treatment providers for Suboxone • Dedicated set of people and organizations that want to improve patient outcomes and population health • Substance abuse provider community likes the PHIP funding model vs. the fee for service • WISE teams, – keeping clients in lower level of service rather than going to a higher level of service • FYSPRT • Diversion team at Catholic Family is being well used • Porch program well used • Medical Unit One at Central Washington has detention beds that can keep people out of Eastern State Hospital • Some behavioral health telemedicine, preserve and expand • People working in the current system are easy to work with and direct about what is needed • Connectedness with the providers – a lot of collaboration that the BHO facilitates with contracted and non-contracted providers, work with the Police Department system, advisory board • BHO provides a lot of technical assistance (IT development and use), quality management oversight, financial oversight	• Need more integrated services • Not enough of certain types of services like psychiatry, crisis beds, mental health beds, acute detox • Need formalized cross-system design through MOUs to work with Law enforcement • Need more Suboxone and Naltrexone prescribers in the area • Need data sharing for complex, high-cost patients • Need system of treatment compliance and review • Inadequate funding for crisis services • Transportation challenges in the area, referring people from rural areas where services aren't offered and getting people to areas where those services are rendered • Monthly provider alliance meetings • Lack of ENT in the region • Lack of neuropsych • Spread use of telepsychiatry, telemedicine, telehealth • Need additional access to Substance Abuse treatment in the region , the center is largely at capacity • More information on substance use disorder in the community, focus on opportunity for preventive services • More of a focus on peer support • Rate setting process • Room for improvement on referral and coordination between Behavioral Health provider community and medical community • Increasing communication between primary care providers, Behavioral Health providers, and social services. • Rural areas don't always have behavioral health providers available, integration may help and physician offices may have more resources to offer • Concern over how well MCOs work together and will there

	be different systems (use common forms, be able to get patients services even if they are in the wrong network) • Potentially gaps with EMRs because services will be less centralized, EMRs need to compatible and accessible for people to work together • Level 1 care and Level 2 care – filtering up of patients, can be a barrier for patients who have to change providers • Need a care coordination hub so patients and providers don't have to navigate on their own • How do we bring physical health and behavioral health together in the community? • Data sharing improvements amongst providers (Behavioral Health and medical) • Clients are already worried about this transition. Communication to clients to let them know that there is a lot of work to make the transition as smooth as possible • Local presence from consumers – community connectedness for local consumers • Housing • No bed reports for inpatient for the population • Rate setting methodology • Crisis services in a large rural region • Further coordination around crisis services – ie. Douglas County utilizes Okanogan jail and Chelan county is home-based • EMPHs, Mental health workforce, and substance use staffing shortages, and it gets worse the further outside of bigger towns you get. Will the funding support adequate salaries?

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Additional Topics:

- Metrics for an Early Warning System
- Knowledge Transfer:
    - Are there topics, presentations, etc. that would be helpful to get, or to give?
- Provider Technical Assistance needs
    - What help do providers need, related to the financial transition?
- Communication Assistance:
    - What strategies should we use to communicate with consumers, patients, community members, etc. about what is happening
    - Are there documents that would be helpful for us to provider to you, to assist you in spreading the message?
    - Are there other avenues/groups we should consider using to spread the word?
- Supportive services (ie. Women's Resource Center); Collaboration between MCOs and housing services
- Regional Variance
    - Are there things we might not have considered, specific to your region we should be made aware of?
- Regional Hosted Electronic Health Record system that includes Billing (Skip Rosenthal)