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 February 22nd, 2017, Confluence Technology Center, Wenatchee

Attendance: See attached attendance list for full list of participants

Report from Behavioral Providers Visit with Southwest WA Providers

Tim Hoekstra, Loretta Stover, Skip Rosenthal, and Gail Goodwin

Behavioral health providers from North Central ACH travelled to Southwest Washington (SWWA) on February 7th in order to talk with the providers there about their experiences with Medicaid contracting integration (strengths, challenges, and the current state). Appointments were set up with providers from Clark and Skamania Counties throughout the day. The people that attended from NC ACH included: Skip Rosenthal (Okanogan Behavioral Healthcare), Loretta Stover (The Center for Alcohol & Drug Treatment), Tim Hoekstra (Columbia Valley Community Health), Gail Goodwin (Grant Integrated Services), John Schapman (North Central ACH), Tenzin Denison (Okanogan Behavioral Healthcare), and Robin Cronin (Catholic Family & Child Services). **The full report is attached.** Below are the highlights discussed at the Advisory Committee meeting:

- NC ACH is ahead of the game in terms of having medical partners already at the table.
- The substance abuse disorder providers did not have the infrastructure in place to be able to bill MCOs. Both NC ACH providers know how to bill insurance and MCOs.
- SWWA is still on fee for service. NC ACH already moved to managed care with the BHO. Sounds like the managed care plans will want to go back to the fee for service model which is something that NC ACH providers will need to look at.
- Not a lot of changes in SWWA as far as actual service delivery.
- National Alliance for the Mentally Ill seemed to think that things are going worse than before integration. There is a need for NC ACH to be getting consumer/family/advocate voice to make sure that that doesn't happen here.
- The role of the ACH in SWWA was and is underdeveloped. Intentional approach to bring behavioral health and physical health care together at the table is something that the NC ACH is already doing. SWWA Behavioral Health providers do not have a lot of interface with physical health providers. In SWWA common problems around behavioral and physical health integrated care is not something the system is able to tackle very well right now.
    - IN SWWA, behavioral health providers are trying to co-locate and integrate physical health into behavioral health setting but having difficulty getting it funded.
    - There was no financial incentive for the medical providers to join at the table.
- New contracts in SWWA matched existing contracts: behavioral health = cost reimbursement contracts and substance use disorder = fee for service.
- SWWA wished they would have addressed their IT issues earlier. They really struggled with IT issues. Most were part of the consortium and when the BHO dissolved the consortium dissolved. When the BHO and Avatar went way, they lost their EHR history. They don't have clinical history on any patients prior to April 1, 2016. Would have liked to have had more technical assistance early on.
- SWWA providers like their relationships with the MCOs. ~80% Molina, ~20% Community Health Plan of Washington. They have a good relationship with the ASO (BEACON). But prior to integration, providers had a very poor relationship with their RSN.

- Even in spite of getting contracts in place there were delays in getting funding. Some of the providers had up to a 90 day delay in getting funding. They talked about establishing a line of credit early. Some had to establish a line of credit to cover costs such as payroll.
- Interpreters – billing for interpretive services and limiting it to only the providers of interpretive services that the MCOs approved. There was a change in approved interpreters. The new ones were not available after hours, unreliable, etc. HCA pays for interpretive services differently than DSHS. HCA uses a contractor, CTS. HCA is revising the policy on how to get to interpreter services during off hours etc and will share draft with Advisory Committee.
- Crisis Services – in SWWA the counties kept the crisis services so they separate (Clark and Skamania) which is different than how NC ACH will be.
- Not all of Clark County is integrated yet. This is an example of how will it work for NC ACH patients in Okanogan (which isn't integrating until 2020) and other border counties where patients cross county lines to access care.
- The SWWA RSN audited them almost continually. Now, the administrative workload has gone down significantly. SWWA providers like that the MCOs aren't asking for a whole lot of paperwork or auditing them but will still need to maintain licensure with the state so they will be audited, eventually. NC ACH provider comment: It could be easy to get lulled into a situation where you are not as tight as you used to be and then you get audited by the state and get in a bind.
- NAMI representative felt like there was no ultimate responsible party, where in the past it was the RSN. (Note from Alice Lind, HCA: The Health Care Authority is the ultimate responsible party and if providers or advocates are unhappy, the HCA is/should be contacted and able to help).
- A system development around transportation – police, EMS, Medicaid funded drivers – getting patients to various types of services in the region. A regional approach to getting patients to services, getting connected by transportation, and how the referrals get made?
- Regional approach to compatible EMRs – disparate EHRs being able to communicate up so that providers have access to information on patients for example who go into crisis and the provider needs to know background on that patient (who is there PCP, who are they established with) in order to provide informed care and stabilize the patient and returned to the community. Regional approach to this and who are the partners needed (Law Enforcement, ERs, public health, crisis services, behavioral health providers, etc).
- SWWA: Providers feel that the system has stabilized and forcing the BH providers to come together, partnering with the MCOs, and talk about what is working and to move the system along. They have 1/10th of 1 percent so they can think about the use of the dollars more from a regional perspective.
- MCOs have hands on care coordinators which has been an improvement.
- Complication in care coordination when behavioral health is covered by one MCO and physical health is provided by a different MCO – needs follow up. (example: People who had private insurance could also be enrolled in Medicaid.)
- Problem around insurance shifting: a provider may have an inclination toward one of the MCOs or another so there is physical health on one side and behavioral health on another so you have a patient that is switching back and forth.
- Even though it is pretty much status quo in SWWA, they felt they have better coordination around law enforcement in Clark County, the crisis services, and looking at beds in a more consolidated regional area; felt they had partners in the MCOs to talk about and address

gaps in services; had a voice in the ACH; felt empowered and a sense of bringing more stakeholders to the table to coordinate services (ie. law enforcement).
- Providers in SWWA felt they could accomplish more with the MCOs because there was the physical and behavioral health connectivity (for example if a behavioral health provider identifies a physical health need, they could work with the MCO and care coordinator to get it addressed).
- What NC ACH needs to do going forward to be successful:
    - Close relationship with the ASO
    - Crisis services
    - Bed capacity
    - Communication through the EHR systems so that we have a cross provider look at services
    - Stabilizing patients at the lowest level of care

Qualis Behavioral Health Provider IT Assessment

Senator Parlette and John Schapman

The NC ACH has asked Qualis to visit behavioral health providers to do an assessment to know their IT status in terms of Medicaid contracting integration. This will help to know where technical assistance and IT help is needed to make sure the behavioral health providers will be ready and able to bill the MCOs starting Jan. 1, 2018. The NC ACH will be sending a letter to the behavioral providers to let them to know why this is happening and who the contact at Qualis will be.

Timeline:

- Connect with the BHO in the next week to get initial information
- March – connecting with behavioral health providers and scheduling onsite assessment
- 1st week of April – onsite assessment of behavioral health providers
- Mid May – final report submitted to each facility (corresponds to timing of MCO selection announcement)

Final report for each behavioral health provider will include an assessment of their IT infrastructure and recommendations on next steps of moving into fully integrated care.

Managed Care Organization RFP Released

The MCO RFP was released on Feb. 16th. The link is: http://www.hca.wa.gov/about-hca/bids-and-contracts Scroll to the bottom of the page and click on "Request for Proposal (RFP)" and scroll to the bottom to request #K1812 –Integrated Managed Care Mid-Adopter.

Timeline:

- Question period: There is an official way to submit questions about the RFP (the RFP explains how to do this) – questions must be submitted to HCA by March 13th.
- HCA will provide publicly posted answers to those questions by March 23rd (posted at the same link).
- Proposals from bidders are due on April 5th.
- Evaluation period will go through May 5th.
- Apparently successful bidders will be released on or around May 11th.

The intentions of how many health plans will be contracted is outlined in the RFP. HCA is required to have at least 2, but gives itself permission to contract with a 3rd plan if necessary.

Page 20 of the RFP addresses the requirement for proposals to include signed contracts with providers.

Comments Received on the Administrative Service Organization RFP

- Coordination between the various pieces of the crisis system; making sure that HCA is asking how the hotline will coordinate all the way through to the DMHPs and coordination within the crisis system with both behavioral health and primary care providers.
- Linking community organizations and resources to serve high needs populations.
- Request for targeted questions regarding the experience that the responding ASO has on operating crisis systems.
- Requested targeted questions on E&T services and capacity.
- Questions about thinking ahead to value-based purchasing and paying for performance.
- Assistance with TA to providers around help with multiple funding sources and eliminating provider payment delay that was seen in SWWA.
- Make sure that the questions are reflective of the population of NC region (ie. rural nature, language considerations, high needs/targeted populations).
- **Comment from Advisory Committee:** Concern from providers that they wouldn't be able to provide "crisis services" if they weren't contracted with the ASO. NC ACH providers like the model in SWWA where the MCOs pay for crisis services provided by that provider if it is an established patient and then if it escalates beyond the provider's capacity or scope of services, or there is a higher need then it moves into the crisis services from there.

From the Advisory Committee

- SWWA doesn't have info on how modified service delivery model with managed care and the ASO is driving cost. Lack of clarity on outcomes and cost containment. What are we going to build; what is missing in order to gather that type of information?
- How does this look and what are the impacts to the social service providers and their clients/patients? Data sharing with social service organizations (ie. homeless agency). Functional relationships between multiple providers in talking about the realities of the work.
- More elected officials working side by side with us on this.
- Goal: to be able to tell someone clearly and simply what we are about and how to access services.
- Have some scenarios that the advisory committee or CHIs work through the questions that we know we have and the questions that we haven't even thought of yet. How would we ultimately want to work together as an ACH to manage a certain situation?
- What can the Advisory Committee do to help identify the risks (BHO transition, Funding, IT) and work to develop a plan to avoid them?
- Courtney Ward – the BHO is working a transition plan for continuing all the responsibilities of the BHO. The BHO will also have a knowledge transfer with the awarded MCOs.
- How many players are out there doing certain things that could be coordinated better (ei. housing)?
- Address:
    - Access to information and communication.
    - Crisis system.

- Resources, especially beds (include better diversion). Different levels of care; crisis stabilization units, outreach diversion programs.
- Take a snapshot and look at data on where we are now to be able to compare next year.

Upcoming Meetings

Date	Location	Topic
Mar. 8 10:00 – 11:30 AM	Okanogan Behavioral Healthcare, 1007 Koala Drive, Omak, WA 98841	Continuance of committees (FYSPRT, Community BH Board, CLIP committee, others)
Mar. 22 10:00 – 11:30 AM	Confluence Technology Center, 285 Technology Center Way, Wenatchee, WA 98801	Early Warning System
Apr. 5 10:00 – 11:30 AM	Quincy Community Health Center, 1450 1st Ave SW, Quincy, WA 98848	TBD
Apr. 19 10:00 – 11:30 AM	Confluence Technology Center, 285 Technology Center Way, Wenatchee, WA 98801	TBD

Please send additional topic ideas that you would like to discuss to christal.eshelman@cdhd.wa.gov.

Announcements:

HCA Medicaid Transformation Demonstration Public Forum

Wednesday March 15th: 6 – 7:30 PM
Douglas County Public Services Building Hearing Room
140 19th St NW, East Wenatchee, WA 98802

North Central ACH Medicaid Demonstration Project Update Meetings

Wenatchee **Monday March 6th**
Confluence Technology Center
285 Technology Center Way #102 Wenatchee, WA
3:00 PM – 4:30 PM

Twisp, WA **Wednesday March 8th**
Aero Methow Rescue Services
1005 Hwy 20 East Twisp, WA
1:30 PM – 3:00 PM

Omak, WA **Friday March 24th**
Okanogan Behavioral Healthcare
1007 Koala Ave Omak, WA
1:00 PM – 3:00 PM

Grant Co. **Meeting to come in April [Date and location TBD]**

Attachments:

RSVP Attendance Roster
Full notes from Behavioral Health provider visit to SWWA

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Attendance February 22nd, 2017

Last Name	First Name	Organization	Title	Feb 22
Abel	Kevin	Lake Chelan Community Hospital & Clinics	Chief Executive Officer	X
Adams	Winnie	North Central Educational Service District	School Nurse Corps Director	X
Boothman	Darla	Grant Integrated Services	Director Administrative Services	X
Boyle	Kathleen	Amerigroup	Director- Behavioral Health	X
Bucknum	Patrick	CCCN	CEO	X
Bush	Ruth	Coordinated Care	Dir Behavioral Health Integration	X
Chilson	Shiela	Moses Lake Community Health Center	Chief Executive Officer	X
Colwell	Kevin	CRH Christopher House	Administrator	X
Cox	Gwen	Qualis Health	Coach/Connector Practice Transformation	X
Crain	Anne	Together for Youth	CVA	X
Cronin	Robin	Catholic Family & Child Services	Compliance Officer	X
Diaz	Jessica	Health Care Authority		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
Emery-Morelli	Jennifer	UnitedHealthcare Community and State	Director of Behavioral Health Network Services	X
Eshelman	Christal	North Central Accountable Community of Health	Project Coordinator	X
Evans Parlette	Linda	North Central Accountable Community of Health	Executive Director	X
Fall	Tami	Family Health Centers	Grants Accountant/Internal Auditor	X
Gillis	Megan	Molina Healthcare of Washington, Inc.	Provider Contract Manager	X
Goodwin	Gail	Grant Integrated Services	Director of Management Services	X
Hafer	Erin	CHPW	Director	X
Hightower	Christine	Optum	Network Manager, Behavioral Health	X
Hoekstra	Timothy	Columbia Valley Community Health	Behavioral Health Services Director	X
Hogue	Kristy	UnitedHealthcare	Director, Network Management	X
Hourigan	Rick	Confluence Health - Wenatchee		X
Howard	Whitney	Molina Helathcare of WA	Director, FIMC Implementation	X
Ishizuka	Paul	Samaritan Healthcare	Chief Financial Officer	X
Jacobsen	Karen	Family Health Center	BH Director	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
Latet	Kat	Community Health Plan of Washington		X
Lind	Alice	HCA	Manager, Program Development	X
Lutz	Curt	Chelan County Regional Justice Center	Director	X
Lynch	Karen	Catholic Family		X
Mickelson	Christine	North Central BHO		X

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Last Name	First Name	Organization	Title	Feb 22
Miller	Deb	Community Choice	Executive Director	X
Nelson	Kathleen	Grant County Health District	Manager	X
Nelson	Clarice	North Valley Hospital	Commissioner	X
Politte	Danielle	Optum	Network Manager	X
Potter	Karin	Ch	Program Manager	X
Rose	Rick	USDA Rural Development	Loan Specialist	X
Rosenthal	Skip	Okanogan Behavioral Health	Chief Executive Officer	X
Ryan	Eric	LifeShare USA		X
Schapman	John	North Central Accountable Community of Health	Program Manager	X
Stover	Loretta	The Center for Alcohol & Drug Treatment	Executive Director	X
Switzer	Carmen	CHPW	Provider Relations Administrator	X
Thompson	Tawn	DOH	Practice Facilitator	X
Tippett	Chris	The Center for Alcohol & Drug Treatment		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
Wilson	Karianna	Wilson Strategic	CEO	X
Young	Jessica	LifeShare USA	Director Operations	X