North Central
Accountable Community of Health

Rates Workgroup

FIMC Advisory Committee – North Central Accountable Community of Health

MEETING NOTES

8:00 AM – 9:00 AM April 14th, 2017

Attendance: Gail Goodwin, Isabel Jones, Jay Johnson, Torri Canda, Tim Hoekstra, Loc Ohl, Courtney Ward, John Schapman, Christal Eshelman, Senator Parlette. **Via phone**: Thuy Hua-Lu, Christy Vaughn, Jenny Gerstorff, James Matthison, Andrea Tull, Sheila Chilson. **Notes:** Teresa Davis

Goals of Workgroup:

- To ensure rates are adequate to provide services to those in need, and to provide relevant data and information to actuaries.
- Systematic collection of necessary data from all Behavioral Health providers to be submitted to the HCA actuary to produce adequate rates for NCW.

Overview of rate setting process: take behavioral health work that Mercer has done, add in physical health rates, look at any regional differences, adjust data to reflect the region, combine physical & behavioral health, take the savings for integration off of medical services, add admin components and any other non-benefit load items and then you have the rate. What are the regional differences that are driving the rates? They have not looked specifically at North Central but in general…population, prescribing patterns, treatment practices, contracting negotiations, rural versus urban community and network adequacy.

Potential data from related to past/current experience

- Waitlist situations, delays in service/assessments
- Beds not being used to the best capacity
- Are people being turned away (would more people be served with higher rate?)

Concerns:

- Our region still has the lowest rates in the state and rates are being cut again. Confluence Health did a study that showed in North Central the prevalence of mental illness is not lower or higher than other areas. There are no objective facts that support why NCW is still the lowest rate. Is it reasonable that we should be going forward in this mid-adopter program if the rates are still going to be lower? Senator Parlette has drafted a letter to the legislature. It doesn't make sense that we are expected to be a middle adopter if the rates are lower, these providers need to keep their doors open.
- If the HCA is not looking at a blended rate, how do they incorporate the other behavioral health services in the region that are not done through the BHO Network? Rate would be taken from the medical side then combine with the information from Mercer, then on 1/1/19 they will look at the combined data and refresh. They would also take into account forecasted trends ie: new drug coming to the market, new hospital built or facility went out of business.
- There are not any forecasted trends that would create a major change to the median? Is there a way that we can change the conversation to look at how to change the median?
- There is a concern that our area services are not properly represented because they can't code crisis services in behavioral health. They spend hours on crisis services with each patient. These services are expensive and time consuming and are not being recognized. There is also a gap with the substance abuse data collection as well.

Can we change some of the assumptions and re-evaluate the rates? Codes would have to match SERI (Service Encounter Reporting Instructions)

- DSHS will not let providers code crisis services.
- MU1 unit at Central Washington Hospital, how is this cost captured and used for determining the rate? It is coded on the medical side, but the crisis code is not being captured. It can't be reported because it is not a reportable service under SERI. The codes would have to match what is in SERI.

This is the point of this group…We can uncover what is missing as the State is determining the rates. Thuy from HCA said we are definitely going to need some follow up conversations. Linda asked if this can be done immediately before the legislature adjourns. HCA can't promise that rates will be adjusted now, but they could be adjusted later under a supplemental budget. Sheila encouraged everyone to keep the conversation and data with the committee so that we all understand what information is going to the HCA and then as a group we work with the HCA.

Courtney also brought up that we have a crisis stabilization and residential facility coming on board that should be included in the rate setting and it can't be captured. The BHO can provide cost data for that.

Next Steps

-Decide if it would be better for providers to submit salary data rather than using labor statistics?
-Look at in patient bed costs
-Go through more info that providers may have that could be provided to actuaries

- Crisis rate
- MU1
- Things coming on board – Parkside

Action Items:

-Courtney will send out the data dictionary
-HCA will send out rate setting presentation
-Bring data to the next meeting from items 3 & 4 on the agenda (see below) and anything else that you think will be helpful

- *Potential Data Related to Past/Current Experience – Demonstrate unmet need*
  a. *Wait list: how many people are waiting for services; how long?*
     i. *BH provider wait list*
     ii. *Time to receive an intake assessment*
     iii. *Hospital info: patients in beds who should be in outpatient?*
     iv. *Other?*
  b. *How many individuals are seeking treatment and are turned away or not able to obtain treatment?*
  c. *Utilization history – how many people were BH providers previously serving vs. how many are they serving today under lower rate structure?*
  d. *BH Provider Payments: compare provider rates to other regions*

- *Future Experience*
  e. *New programs expected to increase utilization: outreach?*
  f. *Providers increasing capacity?*
  g. *Single case agreement providers: what payment rate would be needed to bring these providers in contract?*
  h. *Expanded MCO networks that demonstrate increased access*
  i. *Parkside – new facility*
  j. *Geographic size with dispersed population*

Next Meeting: April 28th 8:30 AM, Chelan Douglas Health District, East Wenatchee