

# HCA-DOH Monthly Tribal Meeting

September 4, 2019

9:00 AM – 12:30 PM

Location: Sue Crystal Conference Rm, Cherry Street Plaza, 626 8<sup>th</sup> Avenue SE,  
Olympia, WA

Register for the webinar\* here

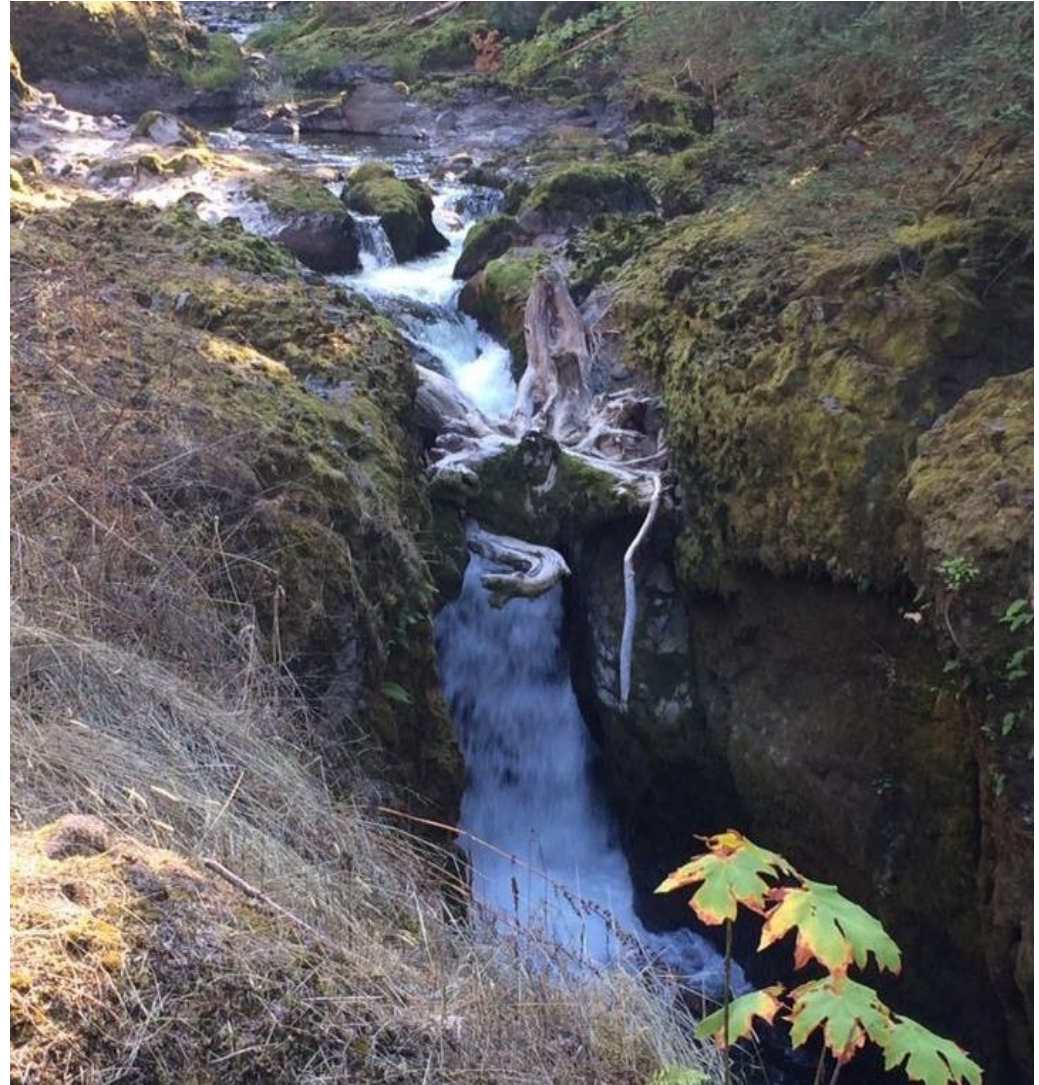
<https://attendee.gotowebinar.com/register/4285851638350652162>

\*If you prefer to just dial in to the webinar – register for the webinar to receive your dial in instructions



# Opening

Webinar Check, Welcome  
and Acknowledgement,  
Blessing, Introductions



# Agenda

---

9:00 AM Welcome, Acknowledgement and Blessing, Introductions

## Department of Health

9:10 AM Updates :

- Collaboration and Consultation
- DOH Dashboards for Data
- Dear Tribal Leader Letters
- Around the DOH

## Health Care Authority

9:45 AM Rural Health Care Transformation

10:15 AM Behavioral Health Updates

- Tribal Evaluation & Treatment Workgroup
- Tribal Designated Crisis Responder (DCR) Training
- AI/AN Opioid Response Workgroup (ORW)
- Indian Nation Agreements

11:00 AM Other Updates

- Medicaid Transformation
- Care Coordination and Tribal FQHC Update: FAQ and Contract Template
- Regional Tribal Liaisons and HCA-Tribal Government-to-Government Planning, including MCOs, ASOs, ACHs and Providers
- Dental Health Aide Therapists (DHATs)
- Integrated Managed Care (IMC)
- Certified Public Expenditures (CPEs)
- Tribal Nursing Facility SPA
- Upcoming Meetings

12:00 PM Open Dialogue/Questions

12:30 PM Closing

# Department of Health



Tamara Fulwyler  
DOH Tribal Relations Director



# Department of Health Updates



# Collaborations/Consultations

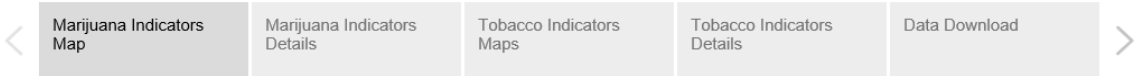
UIHI Interns	Introductions; Epi Knowledge Network
Roundtable on T21: Science & Policy	Follow-Up Handout Provided at 9/4/19 Monthly Tribal Meeting



# DoH Dashboards for Data

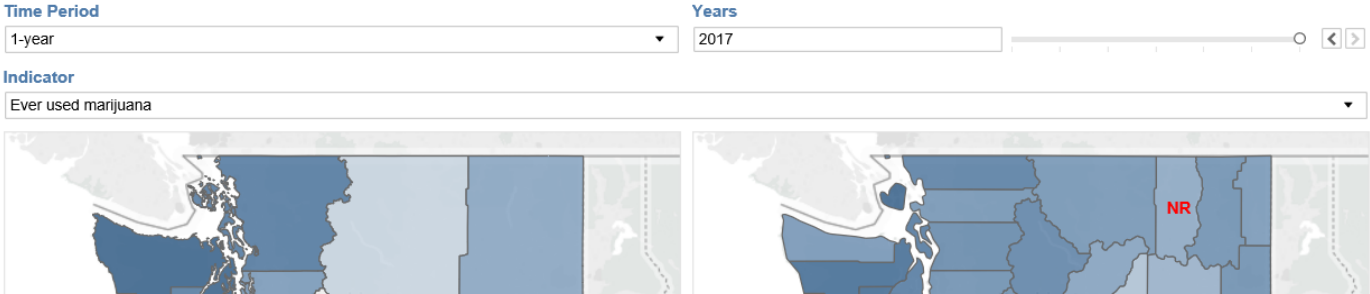
🏠 [Data and Statistical Reports](#) > [Health Data Visualization](#) > [Marijuana and Tobacco Dashboard](#) > [Marijuana and Tobacco Use Dashboards](#)

## Marijuana and Tobacco Use Dashboards



### Marijuana Indicators Comparison Maps

Below are two maps showing marijuana use by Accountable Communities of Health and by County, and a trend for the State level data. Make your selections using the available filters. Some indicators (e.g., e-cigarettes and tobacco smoke ...) do not have multi-year options. Do not select 3-year time for these indicators. If you do, click on Revert to return to 1-year. Hover over the map(s) or trend lines for additional information.



<https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/MarijuanaandTobaccoDashboard/MarijuanaandTobaccoUseDashboards>

# Dear Tribal Leader Letters

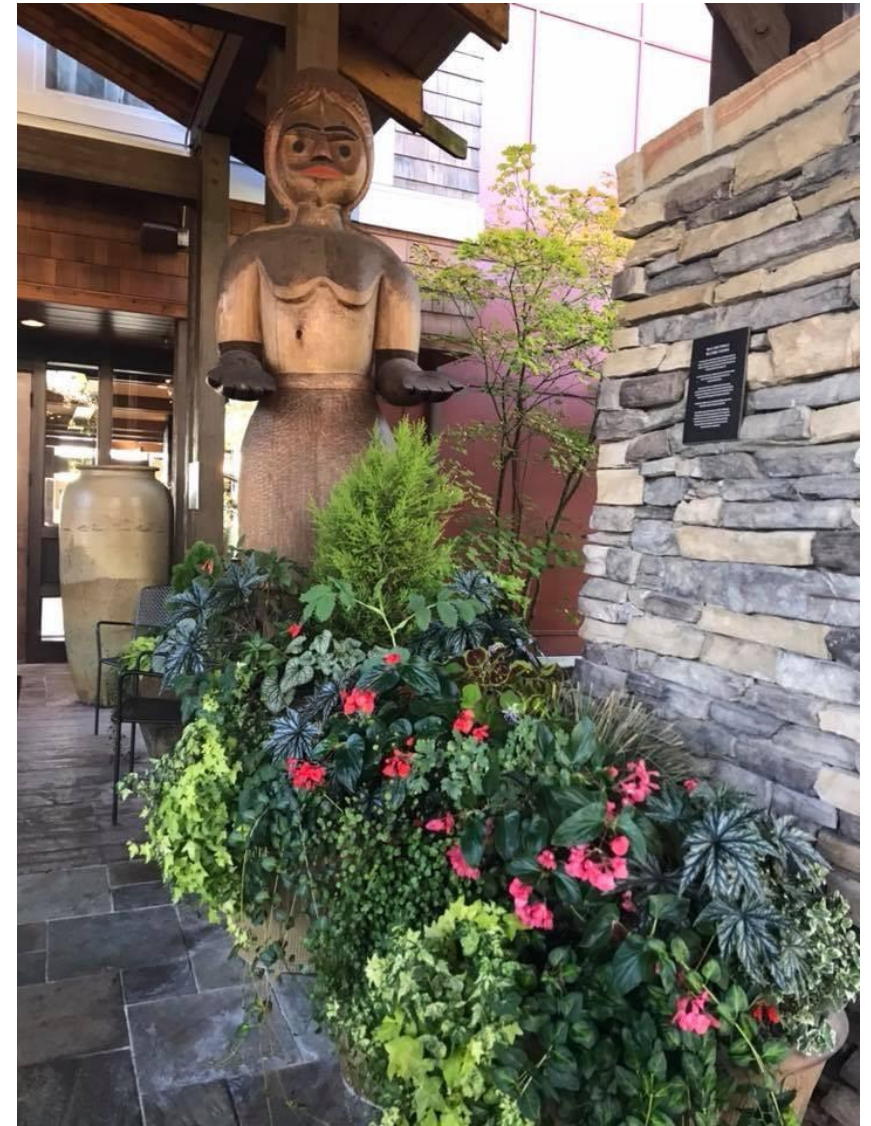


DATE	SUBJECT	CONTACT
8/28/19	Behavioral Health Professions Rule Changes as part of Behavioral Health Integration	James Chaney
8/21/19	DoH 2020 Legislative Policy/Budget Proposed Package	Kelly Cooper



# Around the DOH

- Tribal Marriage Licenses
- Maternal Mortality Review Panel Recruiting “Tribal Representative” (SSB 5425)
- Ongoing Training for DOH Staff, SBOH, and NWCPHP on Tribal Public Health Partnerships



# Health Care Authority



Gary Swan  
Senior Health Policy Advisor  
Policy Department

# Rural Health Care Transformation





# Rural Health System Transformation

September 4, 2019



# Washington's transformation journey



- **State Innovation Model grant** (VBP payments, transformation enablers)  
2014-2019

- **Medicaid Transformation Project**  
(incentivizing community/clinical linkages)  
2017-2021

- **Rural Transformation Engagement** (sustaining access to care in rural communities starting with hospitals and health systems)  
2018 - 2019

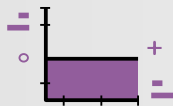
- **CMS Announcement of a Rural Model** (rural community health system transformation)  
September 2019 - 2025?

# A new payment approach and care transformation support are the two main pillars of the model

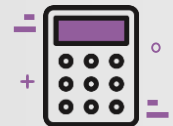
## Fixed annual revenue



Fixed annual payment paid out to hospitals monthly, providing a stable stream of revenue



Stabilize cash flow, so hospitals can invest in care quality and sustainability



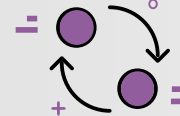
Based on historic data adjusted for transformation-related service changes



## Care transformation support



Tailored assistance at no cost to the hospital



The objective of support is to minimize the burden of making transformation-related changes



Support across all transformation phases: data collection, plan creation, and implementation



# The CMS Rural Model

## Communities redesigning care

### *Primary care, behavioral health, substance-use disorder, and long-term care*

- CMS will be focused on the rural community and intra/inter-local connections, partnerships, and re-orientation of services
- HCA is interested in stabilizing the rural hospital and community health system planning
  - Leveraging the CHNA and other tools for planning service and delivery, not just measurement
  - Rethinking where people get care to encourage care at the right place and the right time
- Rural communities will focus on 2-3 core transformation areas

*NOTE: Based on early discussions with CMS*



## Opportunities to align for Tribal participation

*We are interested in opportunities that strengthen health care and the delivery system for Tribal members.*

- What do we not know? What do we need to know?
- Is there interest or an opportunity to collaborate?
  - Full participation, coordination of care, others opportunities?
  - Are there opportunities to build upon current planned activities?
- Can we create aligned incentives to meet Tribal member needs?





## Potential process to respond to CMS

- Share information as we know it:
  - CMS proposal and expectations
  - Ongoing engagement with Tribal partners
- Build upon the current proposal for consideration and review
  - Care transformation and payment
  - May take the form of an RFP – Details are unknown and will be informed by the CMS request
- Solicit input from interested parties
  - Tribal partners, providers, payers, associations, etc.



## Question and Answer

Gary Swan

Senior Health Policy Analyst

[Gary.swan@hca.wa.gov](mailto:Gary.swan@hca.wa.gov)

o. 360-725-1250

Rachel Quinn

Special Assistant for Health Policy and Programs

[Rachel.Quinn@hca.wa.gov](mailto:Rachel.Quinn@hca.wa.gov)

o. 360-725-0477

# The CMS Rural Model

## Potential elements of a rural model

### Controls for Total Cost of Care



- The model will control for and be accountable to the TCOC
- The model may be based on the region or attributed population

### Potential global budget model



#### Rural hospital

- Payment stability for the rural hospital



#### Hospital-based long term care (LTC)

- Potential inclusion of LTC and home and community based services



#### Hospital-based behavioral health (BH)

- Potential inclusion of hospital-based and non-hospital based facilities

- Stabilize the rural hospital as point of access to care in rural communities
- Hospitals, along with LTC and BH, are a source of the majority of costs and potential savings in total cost of care (TCOC)
- LTC and BH are points of care providing opportunity to extend impact and care coordination across the continuum

### PCP payment model



#### Employed primary care providers (PCPs) and hospital-run RHC / FQHC

- Included within the model



#### Affiliated PCPs and RHC / FQHC

- Potentially included in the model

- Point of care providing an opportunity to extend impact and care coordination across the continuum
- As part of the model, physicians have aligned incentives, but may have a different payment methodology in the model (CPC+, MD Primary Care Program)

NOTE: Based on early discussions with CMS

# Background - Past development on a rural multi-payer model



# Rural Transformation Model

## Proposed Goals & Approach

### Primary Goal: Sustain access to essential care in rural communities

#### Secondary Goals:

- Improve health outcomes and quality of care for rural residents
- Incentivize rural health systems to provide services that meet the needs of their communities (in partnership with the state, federal gov't and payers)
- Improve the financial state of participating rural hospitals by re-aligning incentives and through care coordination
- Reduce the growth of hospital expenditures across payers

#### Proposed Approach – 3 components:

1. Alternative Payment Model (Budget) for all rural hospitals (52 eligible)
2. Delivery system transformation strategy (detailed care transformation plans, annually)
3. Quality metrics

#### Justification for approach:

- Broad accountability for a population as condition of Medicare participation (vs. regional)
- Budget approach brings stability and predictability for rural health systems
- Allows for customized approach for each community (created by each community)
- Opportunity to address state and federal regulatory barriers, e.g., workforce, scope of practice
- Opportunity to synchronize with transformation efforts already underway (e.g., ACHs)

# Sustaining transformation through rural health care transformation

Current system




Value-based system

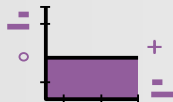
- New payment arrangements to help sustain access to care, stabilize rural hospitals and health systems in all rural communities, incentivize efficiencies, address workforce and support innovative care models and partnerships
- Implementation customizable to meet each hospital and communities needs
- Work with Washington state's other transformation programs and Medicare


Improving Washingtonians' health and preserving access to care by realigning financial incentives for CAHs and rural hospitals

# A new payment approach and care transformation support are the two main pillars of the model

### Fixed annual revenue

- 


Fixed annual payment paid out to hospitals monthly, providing a stable stream of revenue
- 


Stabilize cash flow, so hospitals can invest in care quality and sustainability
- 


Based on historic data adjusted for transformation-related service changes



### Care transformation support

- 

Tailored assistance at no cost to the hospital
- 

The objective of support is to minimize the burden of making transformation-related changes
- 

Support across all transformation phases: data collection, plan creation, and implementation

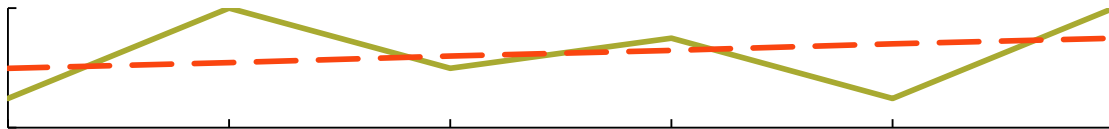
# The global budget provides financial stability lacking under today's system and incentives population health focused transformation

— Revenue in flows — Costs

## Fee for service reimbursement creates hurdles

### Unstable and unpredictable financials

- Decreasing revenues, increasing costs, and decreasing operating margins
- Outstanding payables, and unpredictable receivables



### Healthier populations hurt bottom line

- Incentivized for inpatient admissions volume
- Dis-incentivized from investments without direct, substantial reimbursement (i.e. care management, outpatient/primary care, and healthier populations)



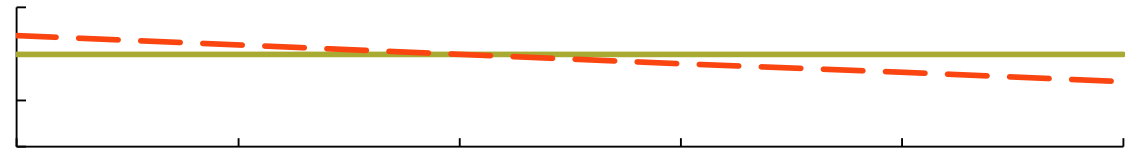
**↓ Unsustainable operating margin**



## Global budget model corrects incentives

### Predictable and stable cash flows

- Predictable, historically based annual revenues without in-year fluctuation
- Stable, dependable cash flows



### Incentives to invest in population health

- Incentivized to transform to meet community needs and keep populations healthy
- Rewarded for identifying lower cost, higher quality delivery options like primary, urgent, and tele care



**↑ Sustainable operating margin**





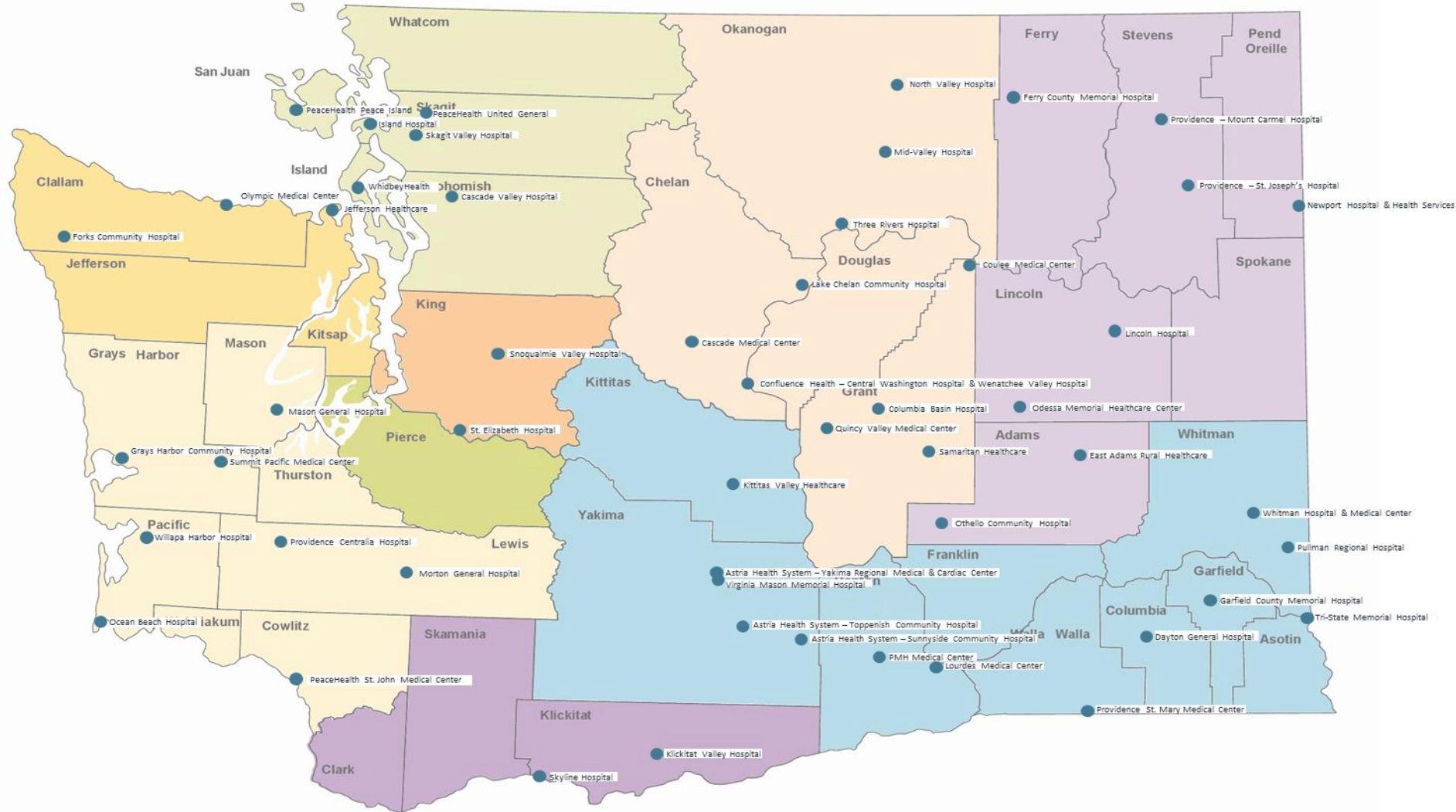
# The rural multi-payer model builds upon Washington State's other transformation efforts

- Build on the foundation of Healthier Washington:
  - Key alignment incentives with the Medicaid Transformation Project and the Accountable Communities of Health
    - Workforce
    - VBP
    - Health systems
  - Opportunities to expand upon foundational community supports and home and community based long-term care services, others....
  - Coordination with, and builds upon Integrated Managed Care
  - Alignment with value-based purchasing goals of HCA
  - Leverage opportunities for Shared Decision Making
  - WA State Common Measure Set
- Department of Health – State Office of Rural Health
  - Washington Rural Palliative Care Initiative
  - Flex Program and SHIP grants


# 52 Eligible Hospitals (CAH or in an OFM rural county)

## ACH Region

- Better Health Together
- Cascade Pacific Action Alliance
- Greater Columbia ACH
- HealthierHere
- North Central ACH
- North Sound ACH
- Olympic Community of Health
- Pierce County ACH
- Southwest ACH (SWACH)



Okanogan and Klickitat are transitional counties based on Medicaid regional service areas.

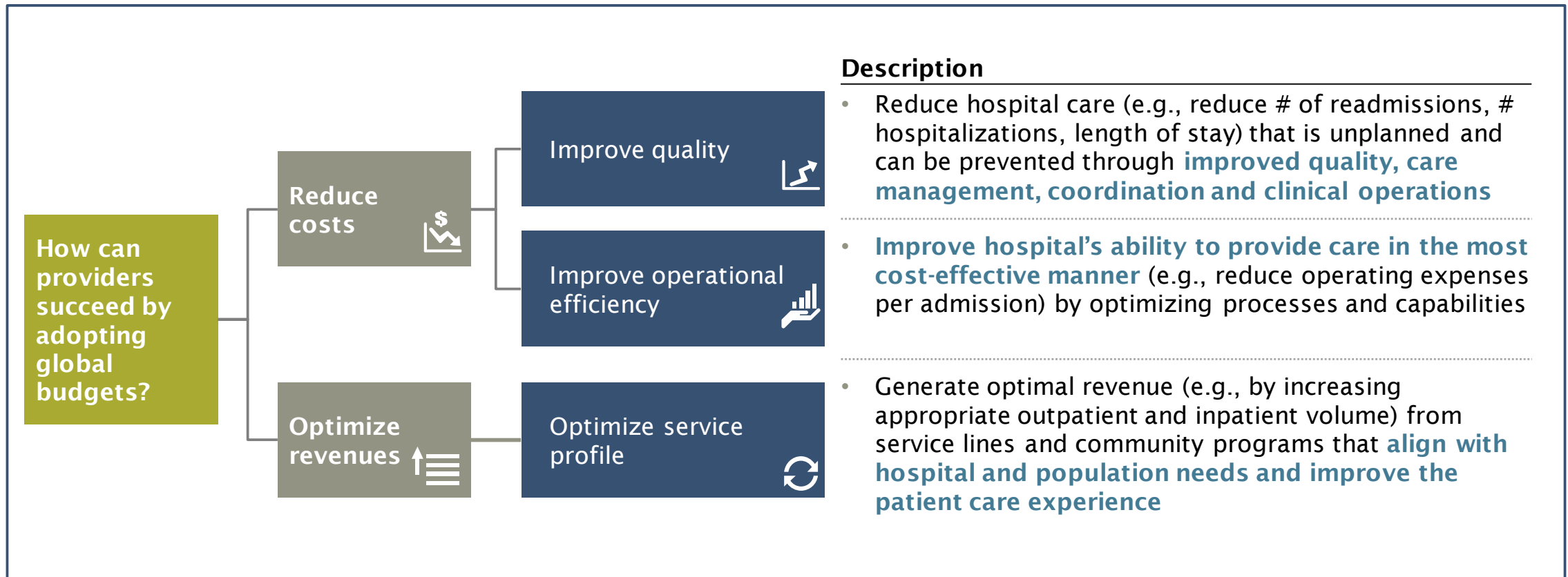


The proposed model will open to 52 rural hospitals and all health plans

## Requirements for model participation

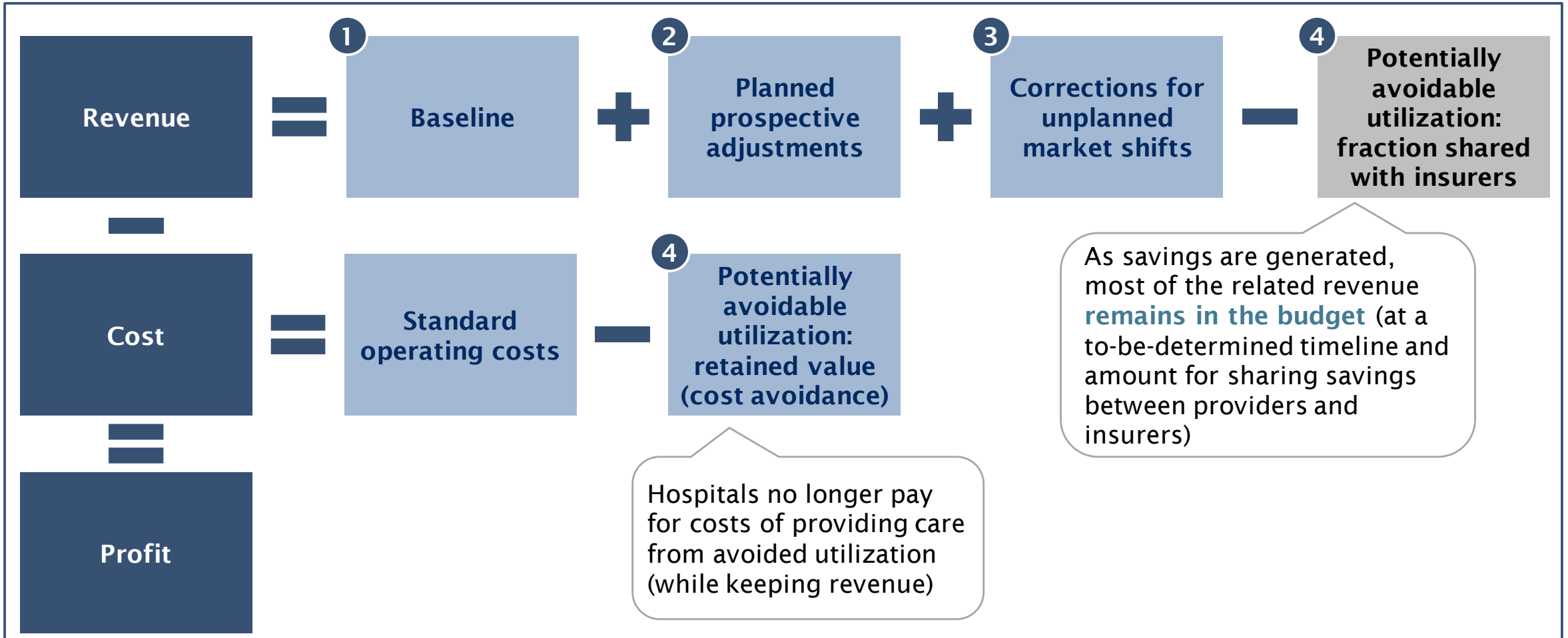
- Defined as a rural hospital by HCA (i.e., hospital is within a OFM-designated rural county or 39 critical access hospitals)
- Have a significant proportion (TBD, although likely greater than ~70%) of the hospital's net patient revenue would be from insurer participants in the model
- Demonstrate interest and commitment to transformation

# Hospitals can transform care, improve quality, and become financially stable under the model



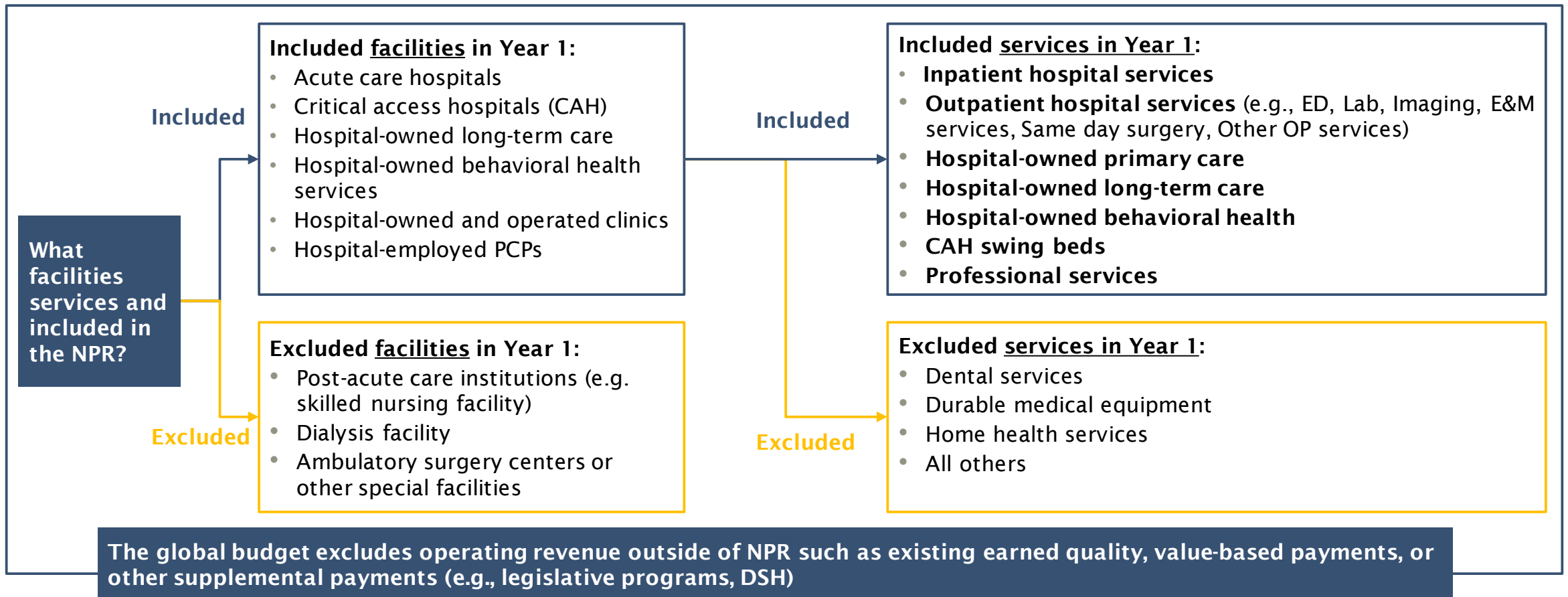
# Profitability under global budget model

X Illustrations available



# 1

## Inclusions in the baseline are based on type of facility and type of service



# Many internal processes will remain unchanged for providers

## Internal processes remaining the same

### Claims processes



Maintained through the same process to later be utilized during reconciliation and future global budget calculations

### Co-pay collection



Continued co-pay collection from patients since co-pays not included within the global budget payments from insurers to hospitals

### Insurer contracts

Currently effective agreements will be maintained except for payment terms – e.g. quality metrics and reporting, negotiated inflation rates, etc. will remain constant as agreed upon in negotiated insurer agreements

Are there internal processes about which you are uncertain – whether they would change or remain the same?

# Participating hospitals would embark on a journey to ensure preparedness and readiness for care design under a new budget

## Community & provider assessment



- Internal or external benchmarking on operational performance, access, and quality
- Understanding community needs by leveraging material (e.g., CHNA) and interviews

## Exploration



- Determine possibility with transformation areas/ levers/ interventions
- Model the impact of provider and insurer participation
- Produce examples of how to identify potential strategic priorities

## Evaluation



- Prioritization of strategic priorities
- Develop initiatives to help define year 1 expectations and interventions
- Consult with experts and communities for best practice sharing

## Plan



- Develop board-level briefing materials
- Develop transformation plan, including:
  - Community needs
  - Capabilities assessment
  - Strategic priorities (w/ targets, financial plan etc.)
  - High-level action plan

## Launch



- Launch global budget model
- Consider change management approach
- Provide guidance on detailed action plan and execution to organization





## Proposed Governance Approach

- A public/private board made up of providers, payers, national rural/payment experts
- Authority to approve and amend budgets within parameters set in state/federal agreement and provider and payer MOUs
- Potential models to emulate/learn from:
  - Maryland Health Services Cost Review Commission
  - Pennsylvania legislation
  - Bree Collaborative

Vicki Lowe  
Executive Director  
American Indian Health Commission

Charlene Abrahamson  
Consultant  
American Indian Health Commission

Lisa Rey Thomas  
Consultant  
American Indian Health Commission

Jessie Dean  
Tribal Affairs Administrator  
Office of Tribal Affairs

# Behavioral Health Updates



# Update on DBHR Work:

---

## Tribal Evaluation & Treatment Facilities Workgroup

Change in structure

New September meeting date

## Tribal Designated Crisis Responder Training Discussion – Key Highlights

## AI/AN Opioid Response Workgroup Update

# Tribal Evaluation and Treatment Facilities Grant

---

- ▶ Funding Cycle for workgroup and report to legislature ended 6/30/19
- ▶ Report to Legislature in editing and approval process with HCA
- ▶ Funding for 2019-20 biennium to create “Hub” for referrals to inpatient facilities and back to Tribal/UIHP communities
- ▶ To move Tribal Evaluation and Treatment /Secure Withdraw Management Facilities forward there needs to be a decision making body in place- “Tribal Centric Behavioral Health Advisory Board”
  - ▶ Needs to be able to take advantage of land or building opportunities across the state
  - ▶ Needs to be able to support activities of individual Tribes and UIHPs, regional activities or statewide activities.

# Statewide Advisory Committee

**North Sound Regional Committee**  
(8 Tribes)

- Lummi Nation
- Nooksack Tribe
- Swinomish Tribe
- Sauk-Suiattle Tribe
- Samish Tribe
- Upper Skagit Indian Tribe
- Tulalip Tribes

**Pierce/King Regional Committee**  
(4 Tribes, 1 UIHP)

- Cowlitz Tribe
- Puyallup Tribe
- Muckleshoot Tribe
- Snoqualmie Tribe
- Seattle Indian Health Board

**Central Wash/Yakama Regional Committee**  
(1 -2 Tribes)

- Yakama Nation
- Cowlitz Tribe

**Olympic Regional Committee**  
(7 Tribes)

- Makah Tribe
- Quinault Tribe
- Quileute Tribe
- Jamestown S’Klallam Tribe
- Port Gamble S’Klallam Tribe
- Lower Elwha Klallam Tribe

**Federal and State Agency Partners**

- Indian Health Services
- Northwest Portland Area Indian Health Board
- The Affiliated Tribes of the Northwest Indians
- HCA, DOH, DSHS

**Eastern Wash Regional Committee**  
(3-4 Tribes, 2 UIHP)

- Colville Tribes
- Kalispel Tribe
- Spokane Tribe
- Yakama Nation
- Native Project
- American Indian Community Center
- Healing Lodge of the 7 Nations

**South Puget Sound Regional Committee**  
(7 Tribes)

- Cowlitz Indian Tribe
- Chehalis Tribe
- Skokomish Tribe
- Squaxin Island Tribe
- Nisqually Tribe
- Quinault Tribe
- Shoalwater Bay Tribes

**Executive Board**

# TCBH Advisory Board Meeting Dates:



Workgroup meetings have been the third Wednesday of each month from 10 am until noon.



September meeting conflicts with AIHC Electronic Health Records Workshop – September 18<sup>th</sup> at Muckleshoot Health and Wellness Center.



Propose Advisory Board continue to meet on the third Wednesday of each month, with a change in the September date to September 25<sup>th</sup> from 10 am to noon.

# Tribal Designated Crisis Responder (DCR) Training Highlights

Training held August 21<sup>st</sup> -23<sup>rd</sup> at Yakama Legends Hotel

The intent of the training was for the Tribal staff to receive the same training as DCRs.

During the training many issues arose that were specific to Tribal staff

Issues grid created for questions that could not be answered by WA DCR staff. Issues were reviewed on final day with recommendation for how to address them.

Affidavit vs Petition- better understanding of how IHCP assessments can be included in the petition of a non-tribal DCR

Up to 29 attendee for the training (# varied by day)

- Up to 29 attendee for the training (# varied by day)
- Plus staff from Washington State DCR Academy, AIHC and HCA

# AI/AN Opioid Response Workgroup Update

AUGUST IN PERSON MEETING CANCELLED  
DUE TO LACK OF REGISTRATION

GRANT PERIOD EXTENDED ONE EXTRA YEAR

SURVEY FOR TRIBAL AND UIHP LEADERS  
AND THEIR STAFF OUT SOON

PLANS FOR COMMUNITY SURVEY IN  
FUTURE

GAPS AND NEEDS IDENTIFIED BY  
SEPTEMBER 20TH



# Indian Nation Agreements

---

- Update from Jessie Dean

Jessie Dean  
Tribal Affairs Administrator  
Office of Tribal Affairs

Lena Nachand  
Tribal Liaison – Medicaid Transformation  
Office of Tribal Affairs

## Other Updates



# Medicaid Transformation

---

- Appreciation of everyone's patience as this is the first time the IHCP-specific Projects are participating in Pay-for-Reporting (P4R)
- Total amount for the semi-annual period 1/1/19-6/30/19 is \$1,862,500
  - Each IHCP to receive \$60,080
- Process:
  1. Commission submits report/deliverable, which is required to pull down the total amount
  2. HCA invoices FE Portal to draw funds into the account from CMS
  3. Lena will individually email you to ask for your specific metrics
  4. You respond
  5. HCA distributes funds
- Funds can be distributed every two weeks
  - Week of: 9/2, 9/16, 9/30, 10/14, etc.

# Care Coordination and Tribal FQHC Update

---

- We are working on an FAQ
  - Currently broken out into Care Coordination FAQ and Tribal FQHC FAQ
  - Current questions:
    - Where did the idea of a Tribal FQHC come from?
    - What authority does HCA have to implement this payment model?
    - What is the purpose of the Tribal FQHC model?
    - What are the benefits of becoming a Tribal FQHC? What are the drawbacks of becoming a Tribal FQHC?
    - How does a Tribal FQHC become a Tribal FQHC?
    - How is a Tribal FQHC related to a non-Tribal FQHC?
    - Can a tribal outpatient behavioral health program be a FQHC without being part of a tribal health clinic?
    - **Other questions?????**
- Additionally, we are getting close to a template contract that would be both a care coordination agreement and FQHC affiliate agreement – more to come

# Regional Tribal Liaisons and HCA-Tribal Gov-to-Gov Planning

---

- Our first Regional Tribal Liaison started yesterday!!
  - Please welcome Raina Peone!
    - She will be working on the east side of the state, partnering with the Confederate Tribes of the Colville, Yakama Nation, The NATIVE Project, Kalispel Tribe of Indians, Spokane Tribe and the border Tribes.
  - Two more have accepted (North Sound region and Olympic region) and will start October 1
- One of the roles the Regional Tribal Liaisons is to work on establishing regional government-to-government planning meetings
  - HCA envisions these meetings to include ASOs, ACHs, MCOs, etc. to work on a single regional plan to address the priorities of the Tribes/IHCPs
  - HCA wants to establish a meeting cadence that would sometimes focus on administrative/operational staff and sometimes on decision makers
  - HCA is attempting to be responsive to meeting burden, clarity of audience and objective, as well as having all parties present to avoid confusion about who is responsible for what
  - HCA does not intend for this type of approach to undermine or take away from each Tribe/IHCP's right to work directly and solely with HCA

# Dental Health Aide Therapists (DHATs)

---

- The Washington State legislature approved general state funds to reimburse for DHATs
  - Fiscal year 2020 = \$3,150,000
  - Fiscal year 2021 = \$3,500,000
- This means you can now get reimbursed, through P1, for DHAT services
  - The billing guide has been updated to reflect this change and provide instructions on how to do it

# Integrated Managed Care (IMC)

---

- The Office of Tribal Affairs (OTA) has been listening to Tribes and IHCPs on some of the challenges being faced with the implementation of integrated managed care.
- OTA is working on IMC managed care contracts with the IMC team internally, MCO tribal liaisons, ASOs, etc.
- OTA is thinking of hosting an event this fall regarding integrated managed care and contracting, which could spur roundtables/consultation on the contracts.

# Certified Public Expenditures (CPEs)

---

- For Tribes that serve non-AI/AN clients for SUD services
  - 16 Tribes
  - The CPE process launched in July
    - For Q3/Q4 2018 attestations (the first round) -- 11 of 16 have submitted the CPE attestation
    - For Q1/Q2 2019 attestations (the current process) – 6 of 16 have submitted the CPE attestation
- Mike plans on being in compliance before CY2019 ends
  - This means HCA would have sanctions set to do their thing beginning on or about 02/15/2020



# Tribal Nursing Facility SPA

---

- Update from Jessie Dean

# Upcoming Meetings

---

- September 9
  - OTA's first attempt at a meeting for Tribes/IHCPs with HCA, MCOs, ASO and the ACH in the North Sound region
- September 23
  - Indian Nations Agreement Consultation

# Open Forum

---

- Topics for discussion?
- Current questions?
- Feedback?
- Topics you would like us to work on in the future?

# Closing / Adjournment



**Jessie Dean**

Tribal Affairs Administrator  
Phone: 360.725.1649  
Email: [jessie.dean@hca.wa.gov](mailto:jessie.dean@hca.wa.gov)

**Lucilla Mendoza**

Tribal Behavioral Health Administrator  
Phone: 360.725.1834  
Email: [lucilla.mendoza@hca.wa.gov](mailto:lucilla.mendoza@hca.wa.gov)

**Mike Longnecker**

Tribal Operations & Compliance Manager  
Phone: 360.725.1315  
Email: [michael.longnecker@hca.wa.gov](mailto:michael.longnecker@hca.wa.gov)

**Lena Nachand**

Tribal Liaison – Medicaid Transformation  
Phone: 360.725.1386  
Email: [lena.nachand@hca.wa.gov](mailto:lena.nachand@hca.wa.gov)

**Melissa Livingston**

Senior Policy Analyst, Tribal Affairs  
Phone: 360.725.9832  
Email: [melissa.livingston@hca.wa.gov](mailto:melissa.livingston@hca.wa.gov)

**Raina Peone**

Regional Tribal Liaison  
Email: [raina.peone@hca.wa.gov](mailto:raina.peone@hca.wa.gov)

**Web:** <http://www.hca.wa.gov/tribal/Pages/index.aspx>

**Tamara Fulwyler**

Tribal Relations Director  
Email: [tamara.fulwyler@doh.wa.gov](mailto:tamara.fulwyler@doh.wa.gov)

**Web:** <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/TribalPublicHealth>