TRIBAL CONSULTATION MEETING

Summary

July 26, 2018
Flagstaff Medical Center, McGee Auditorium, 1200 N. Beaver St., Flagstaff, AZ 86004
9:00 a.m. –12:30 p.m. (Arizona Time)
Call-In, 1-240-454-0879, Participant Passcode: 809 999 868

NOTIFICATION TO TRIBES:

Tribal Consultation Meeting Announcement

Hello,

You are invited to attend the AHCCCS Tribal Consultation meeting at 9:00 a.m., July 26, 2018 at Flagstaff Medical Center in the McGee Auditorium. The auditorium seats 90 people and doors open at 8:30 a.m. Parking is available in the parking structure next to the auditorium. You can also attend by online webinar. Webinar registration information is below.

WHEN: 9 a.m. to 12:30 p.m., Thursday, July 26, 2018
WHERE: Flagstaff Medical Center (Google map), 1200, N. Beaver St., Flagstaff, AZ 86001, McGee Auditorium.
TO ATTEND BY PHONE: Call 1-240-454-0879, use **PARTICIPANT CODE:** 809 999 868
TO ATTEND BY WEBINAR: Registration is required. Click here to register.
You will receive instructions on how to join the meeting. If you already registered for this meeting, you do not need to register again.
AGENDA: Click here to view the agenda (pdf) .
MEETING MATERIALS: PowerPoint presentations will posted on the Tribal Consultation web page on July 25th.

As with all AHCCCS Tribal Consultation teleconference meetings, if joining by phone, please remember to **mute** your phones during the meeting. If you have to leave the meeting temporarily, do NOT place the call on hold. Instead, hang up and call back. This will be less disruptive to others.

We look forward to a productive meeting and thank you in advance for your participation.

Thank you,
Bonnie Talakte
AHCCCS Tribal Liaison
Bonnie.talakte@azahcccs.gov

AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638 and Urban Indian Health Programs

Date: July 26, 2018
Time: 9:00 a.m. -12:30 p.m. (Phoenix Time)
Location: Flagstaff Medical Center, McGee Auditorium, 1200 N. Beaver St., Flagstaff, AZ 86004
Call-In: **1-240-454-0879,** Participant Passcode: **809 999 868**
Webinar: Registration is required. Click here to register: bit/ly/July TC Webinar.

TIME	TOPIC	PRESENTER
9:00-9:15 a.m.	Welcome Invocation Introductions	Thomas J. Betlach, *AHCCCS Director* Jermiah Kanuho, *Native Resource Development NEMT General Manager* Director Betlach
9:15-10:45 a.m.	AHCCCS Update	Director Betlach
10:45-10:55 a.m.	BREAK	
10:55-11:25 a.m.	AHCCCS Best Practice	Karen Grady, *Deputy Assistant Director Clinical Operations Division of –Fee-for-Service Management* Leslie Short, *Integrated Services Administrator Division of –Fee-for-Service Management*
11:25-11:45 a.m.	State Plan Amendment (SPA) Update	Kyle Sawyer, *Intergovernmental Relations Specialist Office of Intergovernmental Relations*
11:45-12:00 p.m.	Direct Care Workers (DCW) Audit	Valerie Van Jones, *Tribal ALTCS Administrator Division of Fee-for-Service Management*
12:00-12:25 p.m.	Navajo Nation Department of Health NEMT Regulations	Dr. Glorinda Segay, *Executive Director*
12:25-12:30 p.m.	Announcements/Wrap-Up/Adjourn	Director Betlach

Next Meeting: October 24, 2018, AHCCCS Administrative Offices

ATTENDEES:

Tribes	Ak-Chin Indian Community: Cecil Peters Gila River Indian Community: Robert Patel Hopi Tribe: Shannon Tewamema Havasupai Tribe: Ophelia Watahomigie Corliss, Kristina Shongo, Laverne Tsosie, Philbert Watahomigie Navajo Nation: Arcenio Charleston, Marie Keyonnie, Tammy Yazzie, Chris Kescoli, Laurine Yazzie, Martin Ashley Pascua Yaqui Tribe: Rosa Rivera San Carlos Apache Tribe: Ursula Wright Tohono O'odham Nation: Joe Clifton, White Mountain Apache Tribe: Debra Sanchez Yavapai-Apache Nation: Chris Little
I/T/Us	Ft. Defiance Indian Health Care Corporation: Christine Becenti, Terrilynn Chee Phoenix Area IHS: John Meeth, Anthony Huma Navajo Area IHS: Priscilla Whitethorne Native Health: Deanna Sangster Tuba City Regional Health Care Corporation: Yolanda Burke, Genevieve Riggs Winslow Indian Health Care: Carol Chitwood, Cecelia Jackson, Julia James, Rosita Paddock, Alutha Yellowhair, Mary Billie
Other	Care 1st Health Plan: Scott Cummings Cenpatico: Sheina Yellowhair Health Current: Ethan Amos, Shawn Now Hopi Assisted Living: Mary Bradley Inter-Tribal Council of Arizona (ITCA): Verna Johnson Ken Whelan & Associates LLC: Ken Whelan NARBA: Merle Charley Native Americans for Community Action: Travis Draper Native Connections: Alyssa Paone Native Resource Development: Jermiah Kanuho Quality Home Care: Yvonne Toledo Rainbow Treatment Center: Sonia George, Tammie, Felicia Suttle,
Other State Agencies	Department of Economic Security: Abel Estrella, Archie Mariano Governor's Office on Youth, Faith & Family: Tonya Hamilton
AHCCCS Representatives	Tom Betlach, Elizabeth Carpio, Markay Adams, Heidi Capriotti, Bonnie Talakte, Kyle Sawyer, Leslie Short, Karen Grady, James De Jesus, Abdurazak Abdurhman, William Buckley, Valerie Jones

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website: **https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html**

Not all questions asked at this tribal consultation meeting were documented due to inaudible reception on the recording device.

PRESENTATION SUMMARIES

AHCCCS UPDATE – Presenter: AHCCCS Director Thomas J. Betlach

AHCCCS Complete Care (ACC): The ACC is AHCCCS' continued effort to integrate care for its members. Tribal members will continue to have choice of an ACC managed care plan or fee for service (FFS) American Indian Health Program (AIHP) option. American Indian (AI) members enrolled in AIHP/FFS can seek services from any AHCCCS registered provider at any time if the provider accepts FFS; services are not limited to IHS/638 providers for AIHP enrolled members. AI members enrolled in a managed care plan can access services from an IHS/638 facility at any time; services are not limited to providers outside of IHS/638 facilities. ACC does not impact: ALTCS members or individuals with SMI.
Who is Affected and When: Starting October 1, 2018, the ACC affects most adults and children on AHCCCS through integration and choice and members enrolled in Children's Rehabilitative Services (CRS). It does not affect: 1) Members on ALTCS (EPD and DES/DD); 2) Adult members with a serious mental illness (SMI); 3) Most CMDP

RBHA/TRBHA and Crisis Services: The Crisis System responsibilities will remain with the RBHA (in their respective Geographic Service Area (GSA) areas). The Crisis System responsibilities will remain with the RBHA (in their respective GSA areas)
Members who are American Indian: Will have a choice to receive services from the 1) ACC for physical health and behavioral heath or 2) AIHP for physical health and behavioral health through a TRBHA if available.
Members who are American Indian with Serious Mental Illness (SMI) Determination: There is no change to this population. American Indian members will have a choice of receiving 1) physical and behavioral health services from a RBHA or 2) physical health from AIHP or ACC or 3) behavioral health services from a RBHA or TRBHA. New ACC plans may provide additional acute care options.
Members who are American Indian with Children's Rehabilitative Services (CRS) Conditions: Will have a choice of receiving 1) physical & behavioral health and children's rehabilitative services though the ACC or 2) through AIHP for physical & behavioral health and children's rehabilitative services.
Members who are American Indian Children in State Foster Care: There is no change for this population. They will receive physical health services from Department of Child Safety (DCS) and behavioral health services from a RBHA or TRBHA.
Members who are American Indian with a Developmental Disability: There is no change for this population. They will continue to receive physical health services from Department of Economic Security (DES) through subcontractors, behavioral health services from a RBHA or TRBHA and long term care services from DES.
Members who are American Indian in Tribal ALTCS (elderly/physical disability program): There is no change for this population. They will continue to receive physical and behavioral heath services and long term care services through 8 contractors. This is already an integrated service program.
CRS Members: CRS members will have choice of an ACC Plan and will continue to be identified and designated by AHCCCS. On October 1, 2018 CRS members in the Division of Developmental Disabilities (DDD) program will have CRS services transitioned to a DDD United contract. The contract requires ACC plans to continue to have Multi-Specialty Interdisciplinary Clinic (MSIC) in network.
Complete Care Timeline: What happens next?

- March 5, 2018 – Seven ACC health plan contracts awarded
- Spring 2018 – AHCCCS holds public forums to explain ACC changes and choices (schedule announced in March)
- June 2018 – AHCCCS sends letters to members with assigned health plan information and choices
- July 2018 – AHCCCS members make health plan choices by July 31st
- October 1, 2018 – CCCS members begin service with Integrated ACC health plans

AHCCCS has been working on a number of communication and education strategies that include; public meetings, forums, MCO meetings, meetings with stakeholders and providers. Over 50 ACC presentations have been held. A frequently asked questions (FAQ) has been developed and is posted to the website. A series of 4

videos have been developed for a variety of populations including for the American Indian Health Program (AIHP) population. The videos can also be found on the AHCCCS website at this link: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/

Questions and Comments:

Q1: Does our tribe need to contract with one of the ACC plans to coordinate behavioral health services or do we continue to provide services and bill AHCCCS like we do now? Does that include case management services as well?

A1: Nothing changes on October 1st for you. As a provider type 77, you can continue to provide services as well as case management services and submit claims.

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Q2: What about non-tribal members who are receiving services from a TRBHA?

A2: If you are serving them as a 638 and you have defined that you serve that population as a 638 then you can continue to serve them and you can continue to submit claims. They would be coming to you for services as the 638 provider. For IHS and 638 facilities, there is no requirement to get a contract.

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Q: For our benefits coordinators, is it possible to get copies of the letters that were sent out to AHCCCS tribal members?

A: Yes, we can provide some samples. Reach out to Bonnie and she will provide that information.

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Q: We're a tribal facility provider type 77. We provide physical and behavioral health services and are billing for behavioral health. Do we need to change anything?

A: As an Urban clinic, you are not an IHS/638 provider. You will be subject to the same requirements as other providers. If you have an American Indian member who is enrolled in AIHP and is receiving services from your facility as of 10/1 you would continue to submit claims to AHCCCS and AIHP will reimburse the claims. If you are providing a behavioral health service to an individual assigned to the Navajo Nation TRBHA you will submit the claims to AHCCCS and we will reimburse those. However, if you have an individual who is enrolled in Care 1st, as an example, assigned to their ACC plan, you will need to have a contract with Care 1st and be in their network in order to be reimbursed for providing services to that individual.

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C: I want to recognize and thank AHCCCS for working through tribal consultation and public comment period with the Waiver. We appreciate that. You sat down with us to work through the legislative process. I want to thank you for that.

R: Thank you. We appreciate all the discussion and thoughtful comments and the collaboration around that issue.

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Q1: We had a meeting with Care 1st and they made it clear they would need to authorize our outpatient services after the 6 month grace period. If there are no changes on how we're doing business now why would Care 1st have to authorize services of our members enrolled in the ACC and with our TRBHA?

A1: If you're providing services as a 638 then you are not subject to Care 1st prior authorization requirements and you would not be subject to their 6 month grace period. You can continue to provide those services.

R1: Care 1st: We were referring to those services you would refer out of your facility into the community for services you would perform, not services done by you.

Q2: So when we do have to refer out of our 636 facility, then we're subject to Care 1st or whatever plan they are enrolled in?

A2: Yes you are. There's no change, it the same as today. If you serve individuals who are enrolled with an MCO and you refer them out of the 638 facility, then you are subject to that plans' prior authorization requirements and their network.

Q3: So do we need to have a contract?

A3: The provider who you are referring the member to will have to have a contract with that heath plan. Example: If you are referring the member to Dr. Smith in Tucson because he provides specialty care, Dr. Smith will need to have a contract with Care 1st to be reimbursed for the services he provides to the member that you

referred. You don't have to have a contract to refer that member out. However, you are responsible for coordinating care with Care 1st just as Care 1st is responsible for coordinating care with you for that member. It might be helpful to have additional conversations and meetings in terms of some of the details as part of TRBHA meeting through DFSM and AIHP. We can set that up.

Q4: Is this for behavioral health as well as physical health services?

A4: Yes

Q5: I have another question. We have a specialty clinic that we contract with different providers that come out to the reservation to provide services. Will that change? We have our own providers that we contract with and the services are provided on the reservation.

R5: For the specialty providers, do you submit the claim or do the providers?

R5: We submit the claim as a 638 facility.

A5: Then nothing changes

Q6: Do we have to do care coordination with the plan if they are coming on the reservation?

A6: if you are sharing a member with any plan, just as it is today, you should always be coordinating care. That is the purpose of integration. We really try to ensure that our members have the best quality of care. It's also part of the contract you have through the IGA you have with AHCCCS in terms of the TRBHA administrative care coordination requirement as well.

Q7: Is there a cap on how much services the plan can provide?

R7: As the provider you have to follow AHCCCS billing requirements and submit the claim to AHCCCS. In terms of care coordination, if you are referring a member to a different provider, that provider has to be enrolled with the plan. You need prior authorization where it's applicable.

Waiver Update:

AHCCCS Works - AHCCCS Works was submitted December 2017. The Waiver included exemption for all American Indian members (approx. 44,000 members). The Arizona Legislature enacted HB 2228 and passed legislature that provided an exemption for tribal members. CMS issued guidance stating they would not approve exemption for tribal members. AHCCCS is still discussing the issue with CMS. AHCCCS is not comfortable accepting a waiver that does not have an exemption for Tribal members.

Questions and Comments:

Q: About the decision that is not being made by CMS, is there a timeline when the decision will be made?

A: There is no timeline. We're asking the federal government to revisit their decision.

SMI Determination:

Eligibility - Individuals (aged 17.5+) who have a severe behavioral health disorder may be referred to an AHCCCS designated contractor to evaluate an individual's eligibility for SMI services.

Contractor - In 2013, Crisis Response Network (CRN) became the SMI Eligibility Contractor in GSA-6 (Central) and expanded Statewide in 2015. TRBHAs and Tribal ALTCS may utilize the SMI Eligibility Contractor to render SMI Determinations.

Eligibility Contract Award - CRN's current award expires 12/31/18. SMI Eligibility RFP was issued by AHCCCS March 15, 2018. SMI Eligibility Contract awarded to incumbent Contractor, CRN = no changes. Initial Term of Contract: January 1, 2019 - September 30, 2021.

Tribes and CRN - TRBHAs/Tribal ALTCS continue to have the option to use CRN to render SMI determinations. The following Tribes have utilized CRN to render SMI Determinations: Gila River, Navajo Nation, and White Mountain Apache.

American Indian Medical Home (AIMH): The AHCCCS State Plan Amendment (SPA) for the AIMH Program was approved by Centers for Medicare and Medicaid Services (CMS) June 2017. The AIMH goal is to help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. This is a program for American Indians/Alaskan Natives (AI/AN) members enrolled in the American Indian Health Program (AIHP). As of October 1, 2017 IHS and Tribal 638 Facilities serving AHCCCS members enrolled with the American Indian Health Program (AIHP) are able to submit the AIMH application. Phoenix Indian Medical Center (PIMC) and Chinle Hospital recently established as AHCCCS' first two American

Indian Medical Homes.

Provider Requirements:

- Be an IHS or Tribal 638 facility
- Enter into an AIMH Inter Governmental Agreement (IGA)
- Primary Care Case Management (PCCM) accreditation:
    - National Committee for Quality Assurance (NCQA) or another appropriate accreditation body, OR
    - National IHS Improving Patient Care (IPC) program annual attestation
- Provide 24-hour telephonic access to the care team
- Dependent on selected tier level, provide diabetes education and/or participate in the State Health Information Exchange (HIE)

Service Tier Levels: There will be an annual renewal process every October at which time the medical home can select a new tier level. The medical home provider will be required to include the appropriate supporting documents with their application. The prospective Per Member Per Month (PMPM) payments are based on service tier level is provided.

Tier 1: PCCM services, 24-hour telephonic access to the care team/PMPM reimbursement rate=$13.87

Tier 2: Same as Tier 1 plus diabetes education/PMPM reimbursement rate=$15.96

Tier 3: Same as Tier's 1 & 2 plus participates in State HIE/PMPM reimbursement rate=$21.71

Tier 4: Same as Tier's 1-3/PMPM reimbursement rate=$23.81

Three organizations have gone through the process:

- Phoenix Indian Medical Center (PIMC) is at service level Tier 2, has 639 members and has completed their 2018-2019 renewal.
- Chinle Comprehensive Health Care Facility (CCHCF) is at service level Tier 2, has 4,870 members and would like to renew at Tier 4. Payment to them to date, $33,000 next month.

One organization has applied and is awaiting approval:

- Winslow Indian Health Care Center (WIHCC) has applied at service level Tier 3, is on hold per ISD.

Fee for Service Ambulance Rate: The Inter Tribal Association of Arizona (ITAA) expressed concerns regarding tribal EMS provider reimbursement. There were things that needed to be addressed so as a result, in January 2018 a tribal consultation meeting was held with AHCCCS, DHS, ITAA, Tribal leaders and Tribal EMS providers. AHCCCS has spent the past few months working on what a methodology would look like to address the concerns and will draft a state plan to increase the payments by about 30%. ITAA adopted a resolution on June 22, 2018 to support the proposal put forward by the State to provide payment parity for Tribal EMS providers. AHCCCS appreciates the partnership and collaboration by tribes and tribal EMS providers in resolving this issue.

Dental Health Aide: HB 2235 formally recognizes and establishes scope of practice for Dental Health Aide Therapists (DHAT). The Bill limits DHATs to practice settings or locations, including mobile units that are operated or served by FQHCs/FQHC look-alikes, community health centers, a nonprofit dental practice or organization that provides dental care to low-income and underserved individuals. IHS/638 and Urbans are exempt from state licensure requirements. January 1, 2019 is the targeted implementation date.

NEMT Update: AHCCCS reconvened the tribal NEMT workgroup to look at a variety of issues. One of the issues is the evolving/shifting market being driven by Lyft and Uber. We're looking at what our policy looks like with this mass change within that industry. There is a lot less infrastructure around NEMT that existed a few years ago because of this new industry. Uber and Lyft have concerns about meeting all the requirements within the AHCCCS Provider Registration. AHCCCS will continue to work with Tribal NEMT programs on supporting local requirements and will continue to update policies.

AHCCCS BEST PRACTICE: CARE MANAGEMENT SYSTEM

Presenters: Karen Grady, Deputy Assistant Director Division of Fee-for-Service Management & Leslie Short, Integrated Services Administrator, DFSM

DFSM Care Management Systems: Over the past several years there have been significant changes in DFSM from claims processing to include care management and care coordination to improve better health outcomes

of AHCCCS AIHP members. The goal of care management is to reduce the fragmentation of health care services and increase the coordination between the providers serving our members. Care Management systems include; TRBHAs, Tribal ALTCS and the American Indian Health Program (AIHP). Provider contracts are not required to provide services to AIHP members, only a signed Provider Participation Agreement.

Integrated Services Priorities: One of the top priorities for integrated services is to, 1) Identify, create and support care coordination opportunities within the Indian Health Services and Tribal 638 health care delivery system to improve member health outcomes. 2) Care Coordination Strategies: High Needs High Cost (HNHC) Care Coordination, and the American Indian Medical Home (AIMH) Program.

Four Strategic Area of Focus: For High Needs High Costs

- Internal Staff – consists of a team of 7 that focuses on care coordination
- Relationship with Partners - develop partnerships with those who are involved in the care of shared members
- Data Utilization – Utilize data from claims and encounters with HNHC members that is shared with partners
- Improving Patient Care Model - adopted IHS model of care

HNHC Care Coordination: Ensures that regional partnerships are convened with the appropriate hospital system, IHS/638 facility and/or TRBHA or RBHA. Improve information sharing capabilities thru partnerships by facilitating monthly staffing's with approximately 15 different stakeholders.

HNHC Care Coordination Activities: 1) Health Information Exchange notifications that inform patient ED visits, inpatient stays and hospital discharges, 2) Coordinate with TRBHA/RBHA to identify, select, and monitor members for HNHC inclusion, 3) Internally automate regularly used claims and encounter data reports, 4) Update member's care plan with claims and encounter data, and member demographics, 5) Identify members to include in the preferred pharmacy.

American Indian Medical Home (AIMH) Program: The AIMH initiative aligns with state-wide focus on integrated care, health information exchange, and care coordination, national IHS efforts to advance Patient Centered Medical Homes through the IHS Improving Patient Care (IPC) program and coordinating care with IHS/Tribal 638 facilities. The concept of Primary Care Case Management (PCCM) and the Per Member Per Month (PMPM) strategy as an AIMH was brought to fruition thru efforts of a Tribal Workgroup.

Integrated Services and AIMHs: Integrated Services (IS) provides oversight of the AIMHs. IS supports AIMHs efforts of care coordination for its members, produce and share reports on utilization for enrolled members and provide technical assistance as needed. As of July 2, 2018, two AIMHs- Phoenix Indian Medical Center (PIMC) and Chinle Comprehensive Health Care have attained Tier Level 2, IPC Attestation. Eight (8) AIMHs is the goal in 2019.

DFSM Care Management Systems Care Coordination Summary: Over the past several years, DFSM has increased capacity in the following areas:

- TRBHA Care Management coordination/oversight
- Tribal ALTCS Care Management coordination/oversight
- AIHP Clinical coordination/oversight
    - HN/HC
    - AIMHs
    - GMHSA and CRS Integration 10/1/18

Questions and Comments:

Q: A lot of our members seeing providers are being turned away because they are being told that they don't accept AIHP members. These providers don't seem to understand the billing part of AIHP. When we run into these scenarios do we contact you for assistance with these providers?
A: Yes, please reach out to DFSM and we will contact the provider.

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Q: I'm from Native Health an urban health program in Phoenix. I have a question about our FQHC quarterly

payments. We'd like to get that increased because we noticed that our quarterly payments are being based on member months again. Our member months rely on MCO data and not AIHP patients. Some of our American Indian/Alaska Natives were automatically enrolled in MCOs but visit us which further reduces our member months.
A: As an FQHC, DFSM is not the appropriate place for that. If you have future questions, you can coordinate with the Division of Health Care Management (DHCM). You can speak to Victoria Burns or Matthew Isiogu. They will be able to assist you with your questions.
C. We've been trying to contact Victoria Burns but have not been successful.
R: We will make that connection for you. Bonnie will ask Matthew Isiogu to contact you.

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Q: Can you reach out to Native Americans for Community Action (NACA) as well? We are exempt from the alterative payment model. We did discuss the issue with Jami Snyder.
A: You are referencing the FQHC waiver. Yes, you are exempt from that. We will make sure Matthew and Victoria have that information as well.

STATE PLAN AMENDMENT (SPA) UPDATE
Presenter: Kyle Sawyer, Intergovernmental Relations Specialist

Emergency Medical Service Rate (EMS): AHCCCS is establishing a new methodology for Tribal EMS rates beginning October 1, 2018. The methodology was developed in collaboration with the Inter Tribal Association of Arizona (ITAA) and other Tribal organizations. The proposed change is estimated to result in a 30.2% aggregate increase in reimbursement. The SPA language, Public Comment and ITAA Resolution can be found at: https://www.azahcccs.gov/AHCCCS/PublicNotices/Tribal-EMS-Rate-SPA.html.
Calculated Rates - Using the provider-specific ambulance rates established by ADHS as of July 1, 2018, AHCCCS will apply provider-specific AHCCCS claims and encounter data for federal fiscal year 2017, using the number of units billed of each procedure code to determine, for each procedure code, a weighted average rate. This will be calculated in two ways: (1) using all paid Fee-For-Service (FFS) claims and MCO adjudicated encounters, and (2) using only paid FFS claims. For each procedure, AHCCCS will select the greater of the two results, and multiply that result by 68.59% to establish the Tribal EMS ambulance rate for the procedure. The rate associated with a rural ambulance trip will continue to be set at +10% relative to the base rate for each procedure code.

Questions & Comments:
Q: Are these rates for non-CON providers or CON providers?
A1: These rates are only for non-CON providers. If you applied for a CON from ADHS you would have a rate set by ADHS. You would then take the 68.59% apply it to the rate and you'd have your own custom rate from ADHS through AHCCCS.
A2: As a point of clarification, it's only for non-CON IHS 638 providers. There is a 3rd rate for non-CON providers such as national park service, out-of-state providers, etc.

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Q: Can you further clarify the EMS resolution statement – 2C? Is this for CON holders?
A: No, this is for non-CON tribal IHS/638 EMS providers. Essentially, there are different rates for CON providers based on their costs and utilization for the previous year. We take a weighted average. We take 2 of them. In the first we take their fee-for-service plan and MCO encounters and in the second one we take only the fee-for-service plan. Then we take the greater of the two. Based on the previous years we take the average of all the CON providers then we weight them, whichever is higher and we give you the higher rate. That solves the issue of not having the CON rate from ADHS by taking the weighted average.

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Q: Are you going to require any data from tribal EMS providers or are you going to take that out of the claims submitted?
A: There will be no data required from the non-CON IHS/638 providers.

Federally Qualified Healthcare Centers (FQHC) Alternative Payment Model: AHCCCS has negotiated an alternative payment model (APM) with FQHCs.

The payment model does not include Rural Health Clinics, Urban Indian Health Programs or 638 FQHCs. All those payments will continue to be paid according to the current methodology. We have already done a 638 FQHC SPA. The timeframe for the APM is 10/1/18 – 9/30/23. AHCCCS will establish a baseline Prospective Payment System (PPS) rate for each FQHC equal to the greater of the FQHC's FFY 2018 or FFY 2016 rate. Annually, the rate will be multiplied by the inflation statistic for the Physicians' Services Index (PSI) subcomponent of the Medical Care Services component of the Consumer Price Index: (1) If the PSI is less than 0%, the adjustment will be 0%, (2) If the PSI is greater than 5%, the adjustment will be 5%.

FQHCs will be eligible for an annual additional incentive payment of up 1.5% based on performance on three quality metrics (.5% per metric):

Metric	Minimum Performance Standard
Patients with Colorectal Cancer Screening	Greater than 65%
Patients with diabetes Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c>9%) or No Test During Year	Less than 41%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Greater than 55%

Incentive for FQHCs with patient population with >20% homeless/transient or >50% uninsured based on year-over-year improvement:

Metric	Minimum Performance Standard
Patients with Colorectal Cancer Screening	Increase over prior year greater than 5%
Patients with diabetes Hemoglobin A1c Poor control (Diabetic Patients with HbA1c>9%) or No Test during Year	Decrease from prior year greater than 5%
Weight Assessment and counseling for Nutrition and Physical Activity for Children and Adolescents	Increase over prior year greater than 5%

For new FQHCs: AHCCCS will calculate the initial PPS rate using baseline PPS rate for an established FQHC in the same or an adjacent area with a similar caseload. Apply the annual PSI adjustments which have occurred since the establishment of that baseline PPS rate.
Scope of Service: There will be no changes to scope of service through September 30, 2020. Between 10/1/20 – 9/30/23, AHCCCS will review scope of service changes and adjust the FQHC PPS rate, if appropriate and is limited to no more than 2 scopes of service changes during that period.
Reconciliation: At the end of each FFY, AHCCCS will calculate each FQHC's costs using paid claim and adjudicated encounter data. If the total calculated cost (based on multiplying number of visits by FQHC's PPS rate) is greater than the total payments, the FQHC will be paid the difference. If the calculated cost is less than the total payments, the FQHC will refund the difference.

Questions and Comments:
Q1: Will the data used by AHCCCS include AIHP claims as well as MCO claims?
A2: Yes
A2: AHCCCS is still doing research on reconciliation and whether or not it will include denied claims. We're in the midst of doing targeted reviews of why there are denied claims and what types of denied buckets exist. Our biggest challenge in all of this is understanding why we are still making sizable reconciliation payments, even though the plans and AHCCCS are paying the PPS rates, we are seeing in some instances, services being delivered without a claim and is showing up in the reconciliation process. That gives us a lot of pause for concern that we can see things show up from FQHCs that have never gone through the claims and encounter process but that clinic is identifying as a service delivered. We're starting with this for discussion purposes but we're trying to learn more as to what sits in that denial bucket and why we would be seeing instances of services being rendered with no claim or encounter tied to it.

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Q: Will the current process be used this year?
A: Yes, for IHS programs

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Q: In regard to case management and behavioral health, it was mandated early this year that any case

management services provided by either a Native health technician or Native professional would not be eligible for the PPS encounter rate meaning that the AIR could be not attained. Is that still in place?
A: Yes

Outpatient Drug Rule: The Outpatient Drug Rule requires states to outline the methodology underlying outpatient drug rates in the State Plan. IHS/638 pharmacy methodologies are not outlined in this SPA and remain unchanged including the recently passed Specialty Drug SPA**.** IHS/638's will not be impacted by this SPA. This SPA primarily provides further explanation of currently established reimbursement methodologies.

This is the methodology for most retail pharmacies which are not 340b entities, including Urban Indian Health Centers if they are not 340b entities. For prescribed drugs, including specific AHCCCS covered non-legend drugs that are prescribed by an authorized prescriber and legend drugs prescribed by an authorized prescriber, AHCCCS will reimburse at the lesser of:
- The usual and customary charge to the public, or
- AHCCCS Fee-For-Service's established Maximum Allowable Cost (MAC) for the drug plus a professional fee, or
- The current National Average Drug Acquisition Cost (NADAC) for the drug plus a professional fee, or
- The contracted rates between AHCCCS and the FFS Pharmacy Benefit Manager plus a professional fee.

340B Entities that are not licensed hospitals or outpatient facilities that are owned or operated by a licensed hospital:
- Must submit 340B claims at their Actual Acquisition Cost (AAC).
- The 340B entity shall be reimbursed at the lesser of AAC or the 340B Ceiling Price plus a professional fee.
- 340B Entity Contract Pharmacies are not allowed to use drugs purchased under any type of 340B arrangement when providing services to AHCCCS members. The only exception is when the AHCCCS Administration has a contractual arrangement or there is a demonstrated need approved by AHCCCS that requires participation by a 340B Entity Contracted Pharmacy.

For the Federal Supply Schedule purchased drugs, the provider shall be reimbursed at no more than their actual acquisition cost plus a professional fee. For Nominal Pricing, the provider shall be reimbursed at the actual acquisition cost plus a professional fee. Hemophilia Factor and Other Blood Disorders Products are reimbursed using a discounted Wholesale Acquisition Cost (WAC) methodology. Ancillary supplies, mailing, and other services are paid as defined in the contract between AHCCCS and the pharmacy supplying the hemophilia factor and blood disorder products. Investigational/experimental drugs are not reimbursed by AHCCCS.

Physician Administered Drugs:
Physician:
- For non-chemotherapy drugs that are priced on the Medicare Part B Drug Schedule, AHCCCS sets its FFS rates as 95% of the Medicare Part B rate.
- For chemotherapy drugs and drugs that are not priced on the Medicare Part B Drug Schedule, AHCCCS sets its rates as 80.75% of the Average Wholesale Price.

Outpatient Hospital:
- Drugs priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates as 80% of the Medicare OPPS rate.
- For drugs that are not priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates equal to the FFS rates for physician billing.

Ambulatory Surgery Center:
- For all drugs that are priced on the Medicare Ambulatory Surgery Center Fee Schedule, AHCCCS sets its FFS rates as 95% of the Medicare ASC Fee Schedule rate.

Additional feedback or questions regarding these SPAs can be provided to publicinput@azahcccs.gov

DIRECT CARE WORKER (DCW) AUDIT

Presenter: Valerie Van Jones, Tribal ALTCS Administrator

Direct Care Worker Agencies: Direct Care Worker (DCW) Agencies employ direct care workers. A DCW is a person who assists an elderly person or individual with a disability with activities necessary to allow them to reside in their home in order to provide services (attendant care, personal care, homemaker, respite, or habilitation services) to ALTCS members. In 2019, DFSM plans to conduct annual monitoring of Direct Care Service Agencies serving Tribal ALTCS members who live in their own homes. The goal of the audit is to ensure the provision of: 1) service delivery in accordance with authorizations and member needs, 2) quality of care for members; 3) training and supervision of direct care workers. There are a total of 96 agencies currently serving Tribal ALTCS members in members' homes. Approximately 52 of these agencies are affiliated with a managed care organization (MCO) and receive monitoring. Forty-four (44) agencies are fee-for-service only and do not receive monitoring.

Educational Campaign: DFSM will conduct training for agencies to 1) explain the process, 2) explain the standards and the monitoring tool and 3) provide assistance on how to meet the requirements, 4) provide follow up training to review overall findings and common areas for improvement, and 5) provide training sessions at the AHCCCS office and by webinar.

Process: The monitoring will be an annual desk audit. The desk audit will be consistent with AMPM Policies, Chapters 900 and 1200. Monitoring will be conducted by DFSM & DHCM (Division of Health Care Management) staff from; DFSM Tribal ALTCS, DFSM Policy, Audit, Education Team and possibly DHCM Clinical Quality Management.

Audit Elements: The Administration Review will review service utilization, employee screening and policies and procedures. The Member File Review will review customer satisfaction, service provision, quarterly supervisory visitations and contingency plans.

Timeline DCW Agencies:

- June 2018 - DFSM to create audit tools
- July 2018-September 2018 - Notification to Tribes, DCW Agencies
- October 2018-July 2019 - Provide technical assistance & guidance to DCW Agencies
- August 2019 - Begin Audits

The audit tool will be provided to supervisors.

Questions and Comments:

No questions were asked.

NAVAJO NATION DEPARTMENT OF HEALTH: NEMT REGULATIONS

Presenter: Dr. Glorinda Begay, Executive Director

Dr. Glorinda Segay, Executive Director of the Navajo Nation Department of Health, provided an overview of the recently approved NEMT Regulations. Dr. Segay provided information on the various sections of the regulations that include Authorities, Permit Applications, NEMT Requirements, Violations to Client Safety, and Complaints and Fines.

Questions and Comments:

No questions were asked.

Meeting Adjourned at 1:00 p.m.