



TRIBAL CONSULTATION MEETING

April 20, 2017

9:00 a.m. – 12:30 p.m. (Arizona Time)

San Carlos Apache Tribe, San Carlos Apache Healthcare Corporation, 103 E. Medicine Way,
Peridot, AZ 85542

Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:

Good Afternoon,

I'm pleased to announce the second 2017 AHCCCS Tribal Consultation meeting scheduled for **April 20, 2017 from 9:00 a.m. – 12:30 p.m., at the San Carlos Apache Healthcare Corporation (SCAHC) on the San Carlos Apache Nation.** The meeting will be held on the beautiful grounds of the new health facility in the **Administrative Building, Triplett Conference Room, 103 Medicine Way Road, Peridot, AZ 85542.** The SCAHC will generously provide continental breakfast and lunch. When you enter the campus, hospital staff will direct you to visitor parking. The draft agenda is attached as well a map to the health facility and a list of lodging/dining options. Be aware that Route 60 from Phoenix to Superior is under road construction so allow time for reduced speeds through the construction area.

If you plan to participate by phone, please dial-1-877-820-7831 and enter participant code, **108903#**. **Please mute your phones and do not place phones on hold as this will disrupt the meeting with music.** Meeting materials will be posted to the AHCCCS website to download the day before the meeting. Click on the following link to access the Tribal Consultation page:

<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>.

Please inform me if leaders from your tribe will attend the meeting as it is AHCCCS practice to recognize tribal dignitaries.

Don't hesitate to contact me if you have questions. Thank you for participating in this important meeting.

Bonnie Talakte

Tribal Relations Liaison
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AGENDA

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: April 20, 2017

Time: 9:00 a.m. – 12:30 p.m. (Arizona Time)

Location: San Carlos Apache Healthcare Corporation, 103 E. Medicine Way, Peridot, AZ 85542

Conference Call-In: **1-877-820-7831** Participant Passcode: **108903#**

TIME	TOPIC	Presenter
9:00 – 9:30 a.m.	Welcome..... Tribal Leader Welcome..... Opening Prayer..... Introductions.....	Elizabeth Carpio, <i>AHCCCS Assistant Deputy Director Business Operations</i> The Honorable Terry Rambler, <i>Chairman San Carlos Apache Tribe</i> Johnathan Kitcheyan, <i>Tribal Council Member San Carlos Apache Tribe</i> Elizabeth Carpio
9:30 – 9:50 a.m.	Overview of San Carlos Apache Health Services	Victoria Began, <i>Chief Executive Officer San Carlos Apache Health Care Corp.</i>
9:50 – 10:30 a.m.	AHCCCS Update	Elizabeth Carpio & Elizabeth Lorenz, Assistant Director, Office of Intergovernmental Relations
10:30 - 10:45 a.m.	1. Home and Community Based Services (HCBS) Rules 2. Electronic Visit Verification (EVV)	Valerie Jones, <i>Tribal ALTCS Administrator</i>
10:45 - 11:00 a.m.	Tribal Court Involuntary Treatment Legislative Proposal (HB-2084)	Elizabeth Lorenz
11:10 - 11:30 a.m.	2018 Integrated Contractor Request for Information (RFI)	Paul Galdys, <i>Assistant Director Division of Health Care Advocacy & Advancement</i>
11:30 - 11:50 a.m.	1. Tribal 638 Federally Qualified Healthcare Centers (FQHCs) 2. Pharmacy Update	Elizabeth Carpio
11:50 - 12:05 a.m.	1. Value Based Purchasing Differential Payments 2. Inpatient Hospital APR-DRG Rebase	Victoria Burns, <i>Reimbursement Administrator</i>

12:05 – 12:20	Traditional Healing Workgroup Update	Terrilynn Nez, <i>Workgroup Chair</i>
12:20-12:30 p.m.	Announcements/Wrap-Up/Adjourn	Elizabeth Carpio

Next Meeting: July 27, 2017, Navajo Nation

ATTENDEES:

Tribes	<p><u>Colorado River Indian Tribes:</u> Kelly Baldenegro</p> <p><u>Hopi Tribe:</u> Ruth Kewanimptewa, Anthony Huma, Al Siquah</p> <p><u>Navajo Nation:</u> Gen Holona, Theresa Galvan, Marie Keyonnie</p> <p><u>Pascua Yaqui Tribe:</u> Reuben Howard, Rosa Rivera, Raquel Avelas</p> <p><u>San Carlos Apache Tribe:</u> Thea Wilshire, Melinda ?, The Honorable Chairman Terry Rambler, Ernestine Cruzado, Brenda Harvey, Julia James, Jim Smith, Jonathan Kitcheyan, Jasmyn Kindel, Vickie Began, Isaiah Belknap, Brenda Schildt, Yvonne Lees, Valerie Chee, Bridget Austin, David Reede, Raynelle Brown, Krystie Dia, Ron Ritter</p> <p><u>Tonto Apache Tribe:</u> Michelle Johnson, The Honorable Vice-Chairman Calvin Johnson</p> <p><u>White Mountain Apache Tribe:</u> Ryan Johnson, Jessica Rudolfo, Jessie Johnson, Billie Fall, Tiffany Hinton, Blaine Goklish, Abilene Burnette, Marion Declay, Ginger Myers, Cheyanne Burnette, Felicia Suttle, Shanna Antonio-Edwards</p> <p><u>Yavapai Apache Nation:</u> Trudy Clark</p>
I/T/Us	<p><u>Fort Defiance Indian Health Board:</u> Terrilynn Nez-Chee, Alicia Shields, Sharmaine Benally</p> <p><u>Tohono O’odham Nation Medical Center:</u> Ron Speakman</p> <p><u>Tucson Area Indian Health Services:</u> Dan Marino</p> <p><u>Tuba City Regional Health Care Corporation:</u> Selma Simmons, Melissa Humetewa,</p> <p><u>Winslow Indian Health Care Corp.:</u> Cecelia Jackson, Carol Chitwood, Victoria Chee, Nemora Lee, Kelly Sagan</p>
Other	<p><u>Arizona Advisory Council on Indian Health Care:</u> Kim Russell</p> <p><u>Cenpatico:</u> Sheina Yellowhair</p> <p><u>Community Bridges:</u> Anderson Phillips</p> <p><u>Health Choice Integrated Care:</u> Gabriel Yaiva</p> <p><u>InterTribal Council of Arizona:</u> Alida Montiel, Verna Johnson</p> <p><u>Native American Connections:</u> Alyssa Paone</p> <p><u>Native Resource Development:</u> Jermiah Kanuho</p> <p><u>NRDCI:</u> Yvonne Toledo</p>
AHCCCS Representatives	Elizabeth Carpio, Elizabeth Lorenz, Bonnie Talakte, Valerie Jones, Paul Galdys, Markay Adams, Albert Escobedo, Karen Grady, Patricia Garcia, Patricia Krotenberg

MEETING SUMMARY

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website:

<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>

TOPICS	SUMMARY
<p><u>Overview of San Carlos Apache Health Services</u></p> <p><u>Presenter:</u> Victoria Began, CEO San Carlos Apache Health Care (SCAHC)</p>	<p>San Carlos Apache Health Care (SCAHC) is a tribally operated 638 health facility. Prior to SCAHC, health services for the San Carlos Apache Tribe were provided at the Indian Health Services Hospital established in the early 1960’s. Currently, there are two 638 programs in San Carlos under Title 1.</p> <ul style="list-style-type: none"> • The Division of Health and Human Services (DHHS) was established in 2003 and includes a tribally run out-patient mental health and substance abuse program. Other health programs include CHR, Public Heath, Tribal EMS, WIC and Food Distribution. • The SCAHC Corporation was established in 2015 and provides oversight of the new Hospital. <p>Other information provided by Ms. Began included the 2016-2019 SCAHC strategic plan, partnering strategies with SCAT tribal council and DHHS, and a list of services offered at the hospital.</p>
<p><u>AHCCCS Update</u></p> <p><u>Co-Presenters:</u> Elizabeth Lorenz, Assistant Director, Office of Intergovernmental Relations</p> <p>Elizabeth Carpio, Assistant Deputy Director, Business Operations</p>	<p>Federal Health Care Reform: Congress continues the debate over repeal and replace of the Affordable Care Act (ACA). A new bill called the American Health Care Act (AHCA) has been proposed by House of Representative Speaker Ryan. To date the bill has not been voted on and approved. Even if approved by the House the health package will go to the Senate where there will be modifications and continued debate.</p> <p><u>Question:</u> Q: What is Senator Flake’s position on health care reform? A: Senator Flake is in favor of repealing the ACA. Senator Flake seems to think the bill will pass if the Democrats come on board. Engagement with your Senators on this topic is extremely important.</p> <p>Current Status of Medicaid Expansion Decisions: There are 16 states with Republican governor’s that have expanded the ACA including Arizona. These states appear to have quite a bit of say in how to move forward in repealing the ACA. AHCCCS Director Betlach and Governor Ducey have been very involved in the dialogue occurring in Washington, DC, to ensure Arizona’s interests are represented.</p> <p>AHCCCS by the Numbers: 400,000 represent the number of adults in the expansion population. Of that number 82,000 receive mental health services and 47,000 receive substance abuse disorder services. Two age brackets most affected by the expansion are ages 20-29 at 31% and ages 50 and older at 31%. Between 2013 and 2015, the uninsured rate declined from 17.3% to 11.1% as a result of Medicaid expansion.</p> <p>AHCA Impact Snapshot: The AHCA is the only bill proposed by the House of Representatives that will repeal and replace the ACA. If the bill is approved, Medicaid enrollment will be frozen. Impacts are as follows; starting FY 2020, 134,000 of the adult population will no longer receive Medicaid coverage. Carried forward to FY 2023, 383,000 will no longer have Medicaid coverage which is close to the number of adults now able to receive coverage as a result of Medicaid expansion to uninsured adults in AZ.</p>

Questions/Answers/Comments/Responses:

Q: If Medicaid dollars go to the states in the form of block grants what will the numbers look like and how will tribes be impacted?

A: Starting in 2018, if Arizona decides to keep enrolling the expansion population, the new costs will be \$30M. By 2023, it will cost Arizona nearly \$500M over and above what AZ spends to keep enrolling the Prop 204 population. AZ will have to take on additional costs. There would be no enhanced federal share if the government freezes enrollment. American Indians (AI's) represent about 10% of the 383,000 who would lose coverage if Medicaid enrollment is frozen. In Repeal and Replace discussions it is implied that there would be no change to AI service delivery. However the government is not clear on the intent of that statement. Would states still receive the 100% FMAP for services delivered to AI's and will AI's be subject to the same freezes, benefit reductions, etc.? An unlikely intent would be to have 2 programs; Medicaid Program A for AI's that offered all the services and no freezes and Medicaid Program B for everyone else. That was never made clear as part of the Repeal and Replace discussions.

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Q: In reading the AHCA for every section that dealt with AI/AN's, the only exemption I saw was the exemption from the enrollment cap. What does that mean in terms of dollars? It wasn't clearly stated.

A: They were saying that it doesn't make sense for a program that covers 100% of the expenses to be part of the block grant or the per capita payments to the states. If there is an enrollment freeze, it affects everyone including AI's. Payments will flow outside of the system but is still not part of the formula.

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C: The issue that tribes have with block grants is that tribes have not done well with block grants to address behavioral health, substance abuse, etc. The percentage of dollars that go to tribes is less than 5%. That is what is concerning to tribes in the state of Arizona.

R: AHCCCS has concerns with block grants as well. Block grants don't reflect population growth. But the per capita system is different. The state would get a payment per person as the population increases. However, it doesn't take into account rising health care cost or epidemics, etc.

State Flexibility Letter to Governor's: The general CMS flexibility discussion encourages states to add more flexibility to their programs. CMS Administrator Seema Verma and Health Secretary Tom Price indicate they will support these types of ideas. States are responding by writing letters to Ms. Verma telling her what would be most useful to their state in terms of additional flexibilities. In a letter that Director Betlach and Governor Ducey co-wrote to House Majority leader Senator McCarthy, they outlined flexibilities that AZ would benefit from. Some examples include interest in re-structuring how FQHCs get reimbursed, changes to the NEMT requirement in urban areas, eliminating the essential health benefit requirements, grandfather what is requested in the 5 year Waiver - path to permanency.

Question:

Q: The Navajo Nation is hoping to move forward in becoming their own Medicaid agency. Is that something the Governor might consider telling Congress to allow the Navajo Nation to be their own Medicaid agency?

A: I would urge you to let the Governor's office know of any and all flexibilities you are interested in. We are working with the Governor's office to help them identify what would best assist AZ and our unique populations. Everything should be brought to the table and vetted.

Percentage of Change in Federal Funding: Over time federal spending on Medicaid has increased by 35% while federal spending on other sectors has decreased. This is relevant because if the healthcare reform went into effect it would transfer risk to states through things such as block grants and the per capita system. This means we would have to deal with rising

costs to health care and how to manage that. We need additional flexibilities to figure out how to contain cost while still providing quality health care.

Medicaid Portion of General Fund: In the last couple of years the amount of state general funds spent on Medicaid has remained very stable. This will be a challenge if AZ has to deal with healthcare reform.

Integration – System Design Matters: In the current AHCCCS system, some AHCCCS members and their families have to navigate very complex systems to obtain care. This can include navigating 3 to 4 different health plans to get services. If multiple health conditions are added, it becomes even more complicated. In considering whole person centered care (integration), AHCCCS is proposing to streamline the system, one plan and their payer, so members don't have to navigate with several different entities.

Conditions of Members: individuals who have complicated health conditions also have co-occurring conditions and co-morbidities. For example, a person with diabetes can also have a mental health condition, can have a substance use disorder, can have a physical illness such as asthma, etc. As chronic illnesses and complications are added, how do you coordinate their care, how do you get them the proper care in the right place, at the right time, and at the right level? It all becomes very complicated.

American Indian Medical Home: The American Indian Medical Home (AIMH) Waiver has been revised to be a 1932-A State Plan Amendment (SPA). AHCCCS is limiting AIMH to AI members enrolled in the American Indian Health Program (AIHP) and IHS/638 facilities. When services go into a state plan, AHCCCS cannot limit them to a particular population and providers. AHCCCS wanted this to be specific to AI members who go to IHS/638 facilities. The SPA was sent to CMS on April 12th. The submission starts the clock for CMS to review and ask questions. The SPA was posted for public comment for 45 days and tribal stakeholders were informed at multiple consultations most recently at the February 9, 2017 meeting. The SPA is currently posted on the AHCCCS website. As AHCCCS gets closer to approval from CMS, stakeholder meetings will be scheduled specific to this topic to go over details so entities understand the requirements to become an AIMH, how to apply, all the operational details that are necessary to get it up and running. Elizabeth Carpio thanked the workgroup for their hard work in bringing the AMIH to this point.

Targeted Investment: Formerly called DSRIP. Focus areas include:

- Adults with behavioral health needs
- Adults transitioning from the justice system
- Children with behavioral health needs, including care for children with ASD and care for children in the child welfare system

Projects include:

- Integrated care at the ambulatory care site for adults and children with behavioral health needs
- Care coordination during and after hospital stay for mental health diagnosis
- Integrated care delivered in settings co-located at select county probation and DIOC parole offices.

Targeted Investment is parallel to AMIH. *Targeted Investment* does not include IHS or 638 facilities but it does include AI members who may be enrolled in managed care for their service delivery. Currently, there is 50,000 AI's enrolled in managed care for their physical or behavioral health needs.

Questions/Answers/Comments/Responses:

Q: Moving forward, can we have discussion on creating something specific to IHS/638 facilities?

We have the same issues, probably more dire, with tribal systems. Jails on tribal reservations don't get reimbursed for any of their care. We have the same problems with children with behavioral health needs in the tribal welfare systems. How can we get a piece of the *Targeted Investment* pie to improve our systems? How can we start that discussion?

	<p>A: One of the challenges we have when DSRIP became <i>Targeted Investment</i> is that funding was dramatically reduced. The funding over the entire 5 years is \$300M. While that is a great amount of money, when you look at the system of 1.9M Arizonan's on Medicaid and the projects to get providers interested and actually participating, the funding by year becomes very small. <i>Targeted Investment</i> contemplates the funds actually flowing to our managed care organizations and to the provider community. On the justice system projects, 3-6 sites are targeted across the state. Unfortunately AHCCCS was in a position of take it or leave with the federal government. These funds do not roll over. AHCCCS is in the first year of funding. AHCCCS is prohibited by federal law in reimbursing jails and prisons for services once a member becomes a resident or inmate of an institution.</p> <p style="text-align: center;">∞</p> <p>Q: On slide 14, where did the data come from?</p> <p>A: From the Government Accountability Office (GAO) report. We will get the citation and send that out to the tribal listserv.</p> <p style="text-align: center;">∞</p> <p>C: Could the Targeted Investment result in policy recommendations for however Medicaid is going to be transformed? It is time limited and we don't know if the current Administration is going to consider anything beyond 5 years. That could keep something in place and could potentially include the tribes and IHS. That's my recommendation.</p> <p style="text-align: center;">∞</p> <p>Q: Yesterday, Health and Human Services (HHS) sent out information on opioid addiction. Arizona is going to receive \$12m. Who will be putting plans together? Will AHCCCS take the lead on that?</p> <p>A: AHCCCS has an opioid administrator who is actively engaged in that work. Shana Malone and Dr. Salek are actively engaged.</p>
<p><u>HCBS Rules and Electronic Visit Verification</u></p> <p><u>Presenter:</u> Valerie Jones, Tribal ALTCS Administrator</p>	<p>Intent of HCBS Rules: In 2014 CMS released the final rule requirements for HCBS. CMS is requiring compliance with regulations for all long term care HCBS settings. The intent of the rule is to enhance the quality of HCBS, provide protections to participants, and to assure full access to benefits of community living. The requirements impact licensed residential and non-residential settings. All settings must come into compliance by end of the 5 year transition period from October 2016 to September 2021.</p> <p>Person Centered Planning (PCP): Ensures that the member receives all the services necessary, are engaged in their service plan, safeguards member rights and ensures that members have supports to help them make informed decisions.</p> <p>Timeline for New PCP Process: An advisory committee provides feedback on policies, procedures forms and develops case manager training. This will roll out March 2019.</p> <p>System Assessment: AHCCCS conducted a preliminary assessment of AZ HCBS settings to determine levels of compliance provide recommendations for variances and develop a system for continuous monitoring. AHCCCS finalized the assessment and transition plan in 2015 and submitted it to CMS. The process included review and evaluation of statutes, policies and contract language.</p> <p>Assessment Process: A statistically significant number of settings were randomly selected in greater AZ for the assessment process. Settings on tribal lands were not assessed. On-site assessments were not intended as a licensing or monitoring review. A process was created to gather and submit evidence for settings to CMS to make a determination. CMS determines whether or not the evidence supports the setting or can become compliant by the end of the transition period. If CMS determines the setting does not or cannot meet the compliance standards, Medicaid funds cannot be used for those settings.</p>

Questions/Answers/Comments/Responses:

Q: In regard to on-site assessments, is notification provided by AHCCCS to tribes to come onto tribal lands?

A: The assessments have already been conducted. These assessments were conducted in the Phoenix metro area. Assessments were not conducted on tribal lands.

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Q: If there are Navajo providers in the Phoenix/Tucson metro area, in the agreement we have with providers, our concern is that they are not advising us but are being assessed on-site. We're trying to move toward the streamlined system. How do we have that interaction?

A: If there was anything to happen in the facility and there are AHCCCS tribal members in that facility the Tribal ALTCS Program would be notified.

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C: That needs to be a bullet point in the slide. You're using the slide as documentation at tribal consultation that needs to be reiterated to tribes to explain that piece, when contact is made to tribal facilities by ALTCS.

R: That's great feedback. We'll add that to the slide and will re-post the PowerPoint to the website.

Heightened Scrutiny: As a result of the assessment process several facilities were found to have the characteristics of institutions. States use the heightened scrutiny process to preserve settings that are presumed to have institutional qualities and presumed not to be compliant with HCBS rules.

Assessment Findings: Of 45 residential settings, 15 were compliant and 1 not compliant and of 36 non-residential settings, 12 were compliant and 7 not compliant.

Preliminary Findings – Themes: Findings for residential settings that were assessed include; service plans that are clinical in nature, did not incorporate support/services related to interests and personal goals, had generalized restrictions versus individualized restrictions and Individuals are not getting access to the outside community

What will be Different for Assisted Living Facilities? There will be employment services and supports, external engagement in community life, maximizing independence and choices, updates to facility service plan and customer satisfaction practices.

What will be Different for Assistant Living Facilities - Compliance with Rules: Lockable doors to bedrooms and units, freedom to furnish rooms, choice of roommates, freedom to come and go at any time, access to meals and snacks at any time and options to have visitors at any time.

Next Steps: There will be a formation of multi-stakeholder and multi-disciplinary workgroups, development of outreach materials for members and families and development of training for providers and case managers.

Questions/Answers/Comments/Responses:

C: We are thinking of opening our own assisted living facility on the Tonto Apache Reservation. Would you recommend adopting the rules as stated?

R: If you intend to bill AHCCCS or Medicaid for services, then you would need to be in compliance with the rules. Yes, you would be ahead of the game if you started now.

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Q: In slide 6, is this the tribal ALTCS population?

A: The number is the total managed care members and tribal ALTCS members.

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Q: Where would we get the tribal ALTCS numbers? Would they qualify for both Medicare and Medicaid?

A: The numbers for tribal ALTCS members look very similar. They are not necessarily both

	<p>Medicare and Medicaid. The ALTCS Program is our long term care program. We have a number of members who have both because they met the financial criteria and met the medical criteria.</p> <p>Electronic Visit Verification – What is EVV? An electronic system that verifies in-home service delivery. This is federal mandate released in December 2016 that impacts personal care service and has to be compliant by 2019. It affects attendant care, respite, habilitation, and homemaker services. It impacts home health services with a role out on January 1, 2023 and is eligible for funding from CMS. There is no cost to members and no cost to direct care workers. The goals of EVV are; timely delivery of services, reduced administrative burden generates cost savings from preventions of fraud, waste and abuse.</p> <p>System Design: The system should electronically verify:</p> <ul style="list-style-type: none"> • Type of service performed • Individual receiving the service • Date of the service • Location of service delivery • Individual providing the service • Time the service begins and ends <p>Next Steps:</p> <ul style="list-style-type: none"> • Research other state models/plans by May 2017 • Select vendors for presentations by May 2017 • Decide on system design and management model by June 2017 • Secure project manager by June 2017 • Public comment period August 2017 <p>Questions:</p> <p>Q: Is the goal to create one system, to streamline or quality safety?</p> <p>A: To have one vendor established for the electronic system. This would not apply to members in skilled nursing facilities. This is for members receiving in-home services. There would be an electronic system in the home with a device that would ensure the direct care provider scanned in, provided on-time services and scanned out when finished. It would be like an electronic timecard. This is only for ALTCS members.</p>
<p>AHCCCS Legislation: HB-2084</p> <p>Presenter: Elizabeth Lorenz</p>	<p>Tribal Court Order Recognition: Pursuant to A.R.S. 12-136, in order for a mental health treatment facility to admit a tribal member for involuntary treatment, the tribal court order must first be recognized in Superior Court. If a tribal court order for involuntary commitment includes inpatient treatment, and options are not available to the member within the tribal jurisdiction, the member must receive inpatient treatment off tribal land.</p> <p>Current Issue: Due to current statutory language AHCCCS tribal members needing Court Ordered Treatment (COT) services outside of tribal land are waiting extended periods of time. AHCCCS tribal members not receiving any form of definitive behavioral health treatment when placed in an alternative setting can be a danger to self and others, gravely and/or persistently/ acutely disabled and require immediate action.</p> <p>AHCCCS Legislation – HB 2084: Seeks to take a positive first step in addressing this important issue.</p> <ul style="list-style-type: none"> • Amends A.R.S. 12-136 to allow a mental health treatment facility to admit a tribal member pending recognition of the tribal court order. • Requires the mental health treatment facility to discharge and provide transportation for the member back to the jurisdiction of the tribal court if the order is not filed with the clerk of the superior court by the close of business on the next day the court is open, unless That day is a tribal holiday in which case the tribal court order must be filed with the clerk of the superior court by the close of business on the following day. • Updates statute to reference AHCCCS, rather than DHS, in regard to intergovernmental agreements.

- This clean up is a result of Administrative Simplification, which was effectuated July 1, 2016.
- Removes references to “state” mental health treatment facility in order to align with current delivery model.
- HB 2084 does **not** affect Court Ordered Evaluation (COE), and is **not** a mandate on any Tribe, Provider, or the Court System.
- Due to the varying dynamics and timeframes with getting tribal court orders recognized in superior court, the AHCCCS proposal seeks to accomplish three things:
 - Improve processes and efficiencies within state government;
 - Reduce unnecessary incarceration for our tribal members; and
 - Ensure timely delivery of behavioral health services.
- Passed unanimously through the House (60-0) and Senate (30-0).
- Governor signed on March 29, 2017.
- Effective 90 days following the end of the legislative session.

Questions/Answers/Comments/Responses

C: Thank you for bringing up this bill. It will take time with case managers, hospital staff and all tribal health departments. The other issue is with cultural belief and understanding what medical intervention is all about and educating the family. Unfortunately we don’t have the capability on the reservation. I hope in the future we will. My staff and I really advocate for Power of Attorney. Our clients don’t have that. In order to go into long term care they have to have that.

R: Thank you for the comment.

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Q: How many tribal comments were received on the House bill?

A: We had lots of positive feedback. It was the tribes that brought this issue to our attention and state legislators. It became obvious that something needed to be done. We can have Chris Vinyard, Legislative Liaison, quantify the number of comments that were posted on line.

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C: We worked really hard with Chris Vinyard and the tribes to seek consultation on this bill and Chris followed up. There were several consultation meetings and a forum to discuss this. Unfortunately, we weren’t able to proceed with translating comments into amendments. We were never able to get amendments submitted to Representative Farnsworth because he wasn’t amenable to that at any time. I know you are aware of our concerns. We did present ITCA comments to the Senate side. I’m counting on intergovernmental agreements to improve the process. There were many things we could have done to improve the bill. The law was originally passed in 1992 and this is the first time it’s been substantially amended. Now were looking forward to what the intergovernmental agreement process will be with respect to tribes, rule making and maybe future amendments.

R: I appreciate that you brought up the fact that we’ve been talking about this through many venues. This is a first step in the right direction and it’s not mandated. If you continue to have concerns, this is a judiciary statute and it’s their process so it’s really important to engage them in that process to continue to have your voice heard. We know there is more to be done but we’re excited that the Judiciary is open to working with us on their statute and are willing to take this first step.

C: I appreciate that too but at the same time I don’t know why AHCCCS couldn’t have weighed upon Mr. Farnsworth to get these amendments by January 18th when you start hearing these concerns. We weren’t aware in advance that it was on the (legislative) agenda that afternoon so people could go down to the legislature. For future reference, we tried to have this on the consultation agenda before the legislative session starts so we start having some bills on these kinds of topics.

R: Just to point out that Chairman Farnsworth is the Chairman of the Judiciary Committee so it did involve a lot of extra work on Chris’ part to engage with him so he was very excited to have Chairman Farnsworth sponsor this AHCCCS bill. Since he’s Chairman of the Judiciary it had to go through that committee. We are happy that it worked out and that it passed unanimously. You

make a good point about the court system and e-filing. Those are valid points and there are many steps to be taken after this. We'll move forward from here. Thank you for your comment.

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C: Notwithstanding Alida comments, I'd like to extend my appreciation to AHCCCS for working with us and listening to us. Something had to be fixed. It's not perfect but it's a start. To get someone into treatment right away is a big step. It's a big step for the programs.

A: Thank you so much. I'll pass that on to Chris. That will mean a lot to him.

Q: This is going into effect in 90 days how are the receiving facilities be educated to operationalize this so patients get received and don't get sent back. How is that education happening?

A: That's a good point. I'll have to check with the court system and with Chris and get back to you. We will definitely have to know what's being done. Now we have to implement it.

Integrated Contractor Request for Proposals

Presenter:
Paul Galdys, Assistant Director, Division of Health Care Advocacy and Advancement

A Request for Information (RFI) was posted in late January 2017. Notification was sent to the tribal listserv by the tribal relations office in February 2017. In February 2017, five (5) community forums were held and twenty-one (21) formal responses to the RFI were received. There have been no decisions made. Community engagement and communication will continue throughout implementation.

Integrated Contractor RFI: Puts forth for consideration integration of physical and behavioral health for individuals enrolled in an "acute care plan" (other than Comprehensive Medical and Dental Program-CMDP) or Children's Rehabilitative Services (CRS) who are not currently integrated. Also examines, crisis services currently provided by RBHAs and grant funded services – TBD.

Integrated Contractor Anticipated Procurement Timeline:

Activity	Target Date
Issue Request for Proposal	November 1, 2017
Prospective Offerors' Conference and Technical Interface Meeting	November 8, 2017
Proposals Due	January 25, 2018
Contracts Awarded	By March 8, 2018
Transition Activities Begin	March 9, 2018
Contract Start	October 1, 2018

Note: *Dates are subject to change*

Potential Impact on American Indian Members: Integrated choices for fee-for-service (AIHP) and managed care. What we propose with CRS is that we no longer have a single statewide plan serving that population but instead integrated contractors would be responsible for serving these children. The Autism Spectrum Disorder (ASD) Services workgroup recommend that we integrate into an acute care plan.

Request Feedback on:

- Crisis System
 - Statewide crisis vendor for system coordination;
 - Single statewide crisis line vendor; *and/or*
 - Single statewide crisis phone number.
- CRS
 - Designation
 - Multi-Specialty Interdisciplinary Clinics (MSICs)

Next Steps:

- Post updates to the AHCCCS website
- Do you want AHCCCS to offer RFP presentations to tribal members?
- Should we produce an FAQ for American Indians?

- Other thoughts?

Questions/Answers/Comments/Responses:

Q: Do you have plans to meet with other tribes that may be affected by county lines that may cross different regions. There may be other tribes that may not be aware they can make that request.

A: We would welcome anyone that wants to have that conversation. We can coordinate through Bonnie or however you want to do it. It's important that we start doing those as quickly as possible.

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Q: This particular map, ALTCS-EPD, is what you're thinking about going forward with the new GSAs?

A: That's what we proposed. That was our preferred approach when we published the RFI. There will be three regions - 2 options in the managed care world available in the north and potentially a separate RBHA depending on who wins the bids in the north. We'd have 2 in the south. We asked should we have a 3rd in Pima county considering the population size there and we suggest there should be four more in the central region. So we asked for comments on what the right number of awardees are to do integrated contractor work and the RBHAs being an option. In addition, fee-for-service for American Indians is an option in that contract.

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Q: Is there a thought about growing the number of TRBHAs?

A: Those thoughts come from your tribal nations as to what you want to do.

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C: This means aligning ourselves with contractors for these regions. If we had our own TRBHA's, we'd be our own regions. Just a thought.

R: The TRBHAs wouldn't change from what they are today. They are not their own regions today. They would not be an integrated contractor. When AHCCCS merged with DBHS, 81,000 American Indian members, who were in AIHP and assigned to a TRBHA for their behavioral health, became integrated from a payer perspective. We are always open to tribes who are interested in becoming their own TRBHAs to manage their own behavioral health services within their communities. But whether it's with this contract or just in general we are open to that conversation but tribes' becoming a TRBHA doesn't mean they become their own region.

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Q: Is it mandatory for the MCOs to apply for the RFP?

A: Yes, for integrated care. We wouldn't have a physical health only plan.

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Q: So what have you learned from this process?

A: First, when it comes to Children's Rehabilitative Services (CRS) the multi-specialty interdisciplinary clinics are valuable to families who want those to stay in-network. Most people like the idea of integrating care as opposed to navigating 2 systems. There are concerns around network change.

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Q: You mentioned the Cenpatico plan for patients with SMI. They are bound to that plan. We are having difficulty switching members with SMI to AIHP unlike some of the other AHCCCS plans. A lot of our patients who have been getting their primary care through us are now under the Cenpatico plan. We are having difficulty referring those patients while we are still trying to manage their medical care and patients don't want to go to a Cenpatico provider to get their primary care. That's the feedback I'm getting from some of these patients.

A: So, they are not happy with the network with that contractor? Its good feedback. I would encourage you to communicate with us when you see network challenges so we can follow-up with our contractors. That is one of the challenges with MCO vs FFS.

FQHC and Pharmacy Update

Presenter:
Elizabeth Carpio

CMS Guidance-Tribal Federally Qualified Health Centers: On February 26, 2016, CMS issued a state health official (SHO) letter that was specific to care coordination agreements for the “received through services” of an IHS/638 facility. It was through an engagement process that CMS identified an issue that was systemic. It was around the “four walls” limitations. CMS issued additional guidance called FAQ’s on January 18, 2017 around the SHO letter for the received through services from an IHS/638 facility. The FAQ focused only on pages 5 & 6 of the initial letter and it addressed the four walls issue. If you are a facility that is registered as a clinic, the AIR is only reimbursable when the clinic services happen within the four walls of the clinic. If the services happen outside the four walls of a clinic those are not reimbursable at the AIR but are subject to the fee schedule that any other provider is subject to. CMS indicated that this is not being applied equally across most programs in most states and will begin auditing with dates of service after January 30, 2021. This will give states time to come into compliance with the four walls limitation. The relief they propose, as part of the FAQ’s, was specific to tribal 638 facilities and indicate that if 638’s are registered as clinics, and the four walls limitation is of concern, they have the option to register with the state Medicaid agency as an Federally Qualified Health Center (FQHC) and the four walls limitation would not apply. The AIR could potentially be used as an alternate method for reimbursement. At this time, AHCCCS is proposing to form a workgroup for 638’s who would be interested in changing their registration to FQHC. AHCCCS will convene the workgroup in the May/June time frame. This is not available for IHS facilities but only for 638 facilities.

Questions/Answers/Comments/Responses:

Q: If we have services being done in buildings all over the West does that constitute four walls? I have team members in 12 different buildings because we don’t have space for them.

A: It depends on how you are registered with the Medicaid agency specific to those who are registered as clinics. The guidance does speak to that and indicates that those out-stations are included as part of the clinic.

IHS/638 Pharmacy Services: As of April 1, 2017, reimbursement for IHS/638 pharmacy is no longer AIR for consultation but for dates of service. Additional updates and changes to the language in the billing manual specific to pharmacy services were presented at tribal consultation on a couple of occasions this year. The AHCCCS pharmacy workgroup requested that AHCCCS look at an opportunity to reimburse specialty drugs outside of AIR because AIR doesn’t cover the cost of the expensive drugs. AHCCCS said they would look into it and recently provided an update which stated that at this point, as part of the workgroup, it would take quite a bit of work on both the IHS/638 pharmacy side as well as our PDM because those specialty drugs would not be adjudicated as claims are adjudicated today. They would be sent to our pharmacy benefit manager, Optum, to be adjudicated. It takes quite a bit of work from a systems perspective to have the systems talk to each other properly so claims can be submitted. AHCCCS has to re-procure our pharmacy benefit manager for the effective date of 10/1/2018. What we are looking at doing is including that particular scope-of-work provision for the pharmacy benefit manager as part of the new RFP to go live for 10/1/2018. The specialty drugs will be included in that procurement. Phoenix Area IHS proposed to AHCCCS that IHS/638 pharmacies go through the pharmacy benefit manager for all drugs including specialty drugs and be adjudicated by the pharmacy manager so they would know if the drugs are covered benefits and are reimbursable in real time. The proposal will need to be taken to tribal consultation for feedback. The pharmacy workgroup will be reconvened to explore the proposal in more depth and detail.

Questions/Answers/Comments/Response:

Q: I’m reviewing the billing manual on page 9-11 item #4. It states that a 3 month supply of medication shall be billed. In previous meetings we have requested the option of billing on a 30 day supply versus 90 days. I don’t see that here.

	<p>A: I apologize but I don't have the manual in front of me so I'll have Albert Escobedo from DFSM follow-up on your question.</p> <p style="text-align: center;">∞</p> <p>Q: In talking with pharmacy services we are looking at new comers to our facility specifically oncology. They do fall into high cost medication. It would be beneficial for us to go through the managed care program with Optum RX and getting the authorization completed through them. We also bill on the AIR rate. With the proposal from Phoenix Area IHS, if 638 facilities chose to do all our medication through the managed care program, would we be able to opt out of that and continue on the AIR and only designate high cost medication on those that require prior authorization?</p> <p>A: Optum is not a managed care program it is AHCCCS' fee for service pharmacy benefits manager. We will still maintain all AIR reimbursements as it exists today except for the specialty drugs.</p>
<p><u>Rates Update</u></p> <p><u>Presenter:</u> Victoria Burns, Reimbursement Administrator</p>	<p>Value-Based Purchasing FFS Rate Differential: AHCCCS will be implementing value based purchasing (VBP) differential adjusted fee schedules for selected provider types resulting in enhanced reimbursement for providers who meet the established criteria and qualify for the VBP. The provider types covered under the program are;</p> <ul style="list-style-type: none"> • Hospitals subject to APR-DRG reimbursement • Psychiatric hospitals • Long-term acute care hospitals • Rehab hospitals • Behavioral health sub-acute facilities with 1-16 beds • Nursing facilities • Physicians, Physician Assistants, Registered Nurse Practitioners • Integrated clinics <p>Qualifying criteria and important dates:</p> <ul style="list-style-type: none"> • Hospitals subject to APR-DRG reimbursement – effective 10/1/17 <ul style="list-style-type: none"> ○ VBP adjustment +0.5% on inpatient and outpatient ○ Must participate in state health information exchange by 03/15/2017 • Psychiatric Hosp., Long-Term Acute Care Hosp., Rehabilitation Hosp., Subacute Facilities (1-16 Beds) – effective 1/1/18 <ul style="list-style-type: none"> ○ VBP adjustment of +0.5% on inpatient and outpatient ○ Must participate in state health information exchange by 10/01/2017 • Nursing Facilities – effective 10/1/17 <ul style="list-style-type: none"> ○ VBP adjustment +1% for pneumococcal vaccine measure ○ VBP adjustment +1% for influenza vaccine measure ○ Based on Medicare Nursing Home Compare Arizona Average • Physicians, Physician Assistants, and Registered NPs – eff. 10/1/17 <ul style="list-style-type: none"> ○ VBP adjustment +1% on all reimbursable services ○ At least 100 AHCCCS prescriptions, at least 50% e-prescribe • Integrated Clinics – eff. 10/1/17 <ul style="list-style-type: none"> ○ VBP adjustment of +10% on selected physical health procedures ○ IC provider must have had at least 40% BH claims in FFY 2016 <p><u>Questions/Answers/Comments/Responses:</u></p> <p>Q: My question is on pharmacy. When you look at 100 AHCCCS prescriptions to be 50% e-prescribed, is that for all AHCCCS to e-prescribe to pharmacies because we have our pharmacy here in the 638 facility. How would that apply?</p> <p>A: We will be looking at AHCCCS claims and encounter data for prescriptions written. We'll be able to determine that they have been e-prescribed and associate them with a prescribing provider. This will be based on a percentage of filled prescriptions that are e-prescribed.</p>

	<p>All Patient Refined (APR) Hospital Diagnostic Related Group (DRG) Rebase: AHCCCS has begun its analysis for rebasing the APR diagnosis related group reimbursement system for in-patient hospitals. APR-DRG was first implemented on 10/01/14 and was phased in over 3 years and completed this year. The targeted date for implementing the rebase system is 1/1/18. The rebase at a minimum will update the ARP-DRG grouper to 3M version 34 where the version 31 has been in use throughout the 3 year phase -in. It will realign all reimbursement values to the most recent year utilization which is federal fiscal year 2016. The ways and labor indices that have been used to calculate the reimbursement rate will be updated and the most recent year for that will be calendar year 2017 as published by Medicare. AHCCCS will take the opportunity to make some slight operational changes to address some issues that arose during the first couple of years of APR-DRG. The rebase analysis is still in the early stages. A workgroup will be studying a more robust system of identifying potentially preventable events and readmissions with a goal of excluding payment where the claim was found to represent preventable health events or readmission. IHS and Tribal 638 facilities remain exempt from DRG methodology.</p> <p>Questions/Answers/Comments/Responses: No rebase questions were asked.</p>
<p><u>Traditional Healing Workgroup Update</u></p> <p>Presenter: Terrilynn Nez, Workgroup Chair</p>	<p>Traditional Healing Services in Section 1115 Waiver: AHCCCS is seeking waiver authority from CMS for Traditional Healers to be reimbursed for certain traditional healing services through FMAP. AHCCCS does not currently reimburse for Traditional Healing Services. The Waiver language developed by the Traditional Healing Workgroup include:</p> <ol style="list-style-type: none"> a. What kind of qualified providers will provide the service b. What services will be included c. What services will be covered and not covered <p>Traditional Healing Workgroup: The workgroup has been in existence for about 2 years, starting in 2015 and is working on behalf of the 638 tribes and hospitals in regard to traditional healing services.</p> <p>Traditional Healers with IHS and tribal 638 Facilities: Traditional healing services are currently being provided in IHS/tribal 638 and urban healthcare clinics and hospitals and traditional healers are considered part of the staff. These services are currently not a covered service benefit under AHCCCS so therefore are not reimbursable.</p> <p>Service Parameters: Traditional practitioners can be endorsed by a qualifying entity through an endorsement letter. The qualifying entity can be a health facility governing body, hospital board, medical executive committee, traditional healers program director or can be endorsed through tribal acknowledgement by tribal leader, tribal traditional healer or through a traditional healer association.</p> <p>Payment Methodology: The workgroup is requesting reimbursement for traditional healing services through the All Inclusive Rate (AIR) or Fee For Service (FFS) or through a member benefit allowance in which AHCCCS tribal members are paid and choose how to utilize the money in obtaining traditional healer service</p> <p>Workgroup Timeline: The workgroup continues to work on drafting the SPA language and hope to submit to AHCCCS by June who in turn will to submit to CMS.</p> <p>Questions/Answers/Comments/Responses: Q: When is the next workgroup meeting? A: May 1st in Flagstaff.</p>
<p>Meeting Adjourned 12:45 p.m.</p>	