GCACH Provider Readiness Workgroup
November 1, 2018
2:00 PM – 3:00 PM
Meeting Minutes

1. Attendees: Cheri Snowhite, Caroline Wilson, Joel Chavez, Pat Flores, Juan Valdez, Ali Glasenapp, Gordon Cable, Cody Nesbitt, Marianne Oliver, Dana Oatis, Jamie Carson, Jennifer Flores, Jesse Flores, Chad Anderson, Anthony Gonzalez, Ed Thornbrugh, Troy Wilson, Jenna Shelton, Martin Sanchez, Lauren Johnson, Diane Halo, Matthew Kuempel, Cathy Pipes, Angie Balli, Cicily Zornes, Danika Gwinn, Penny Bell, Michele Key, Dimita Warren, Rachel Flecter, Leslie George, Mary O'Brien, Mel Roy, Courtney Ward, Alicia Egan, Misty Kunstmann, Samantha Zimmerman, Donna Arcieri, Luke Hoisington, Julian Thompson, Steve Ghiglione, Scott Parker, Joey Charlton, Mariana Marquez Sital, Ken Dorais, Corey Cerise, Janis Luvaas, Cathy Neiman, Lindsey Underwood, Brandi, Alice Lind, Jessica Diaz

2. Go over Question Log – MCO/HCA/BHO

   Question: What is the plan for the ASO? Is there an interim director? Who are the staff and what are their roles and responsibilities?
   Answer: The state approved the GCBHO to become the ASO last week and as of November 1, 2018, the Board has approved the budget. The board appointed Troy Wilson to be the Director of the ASO starting January 1, 2019. The GCBHO has been under an intensive review process by the state and the MCOs. It's been a very busy 4 months, but they were the first ASO to get designation. The GCBHO/ASO has a signed contract with the state. There are 4-5 staff who will be offered positions at the ASO. They are still working on the roles and responsibilities for the ASO.

   Question: What expectations does the BHO have for encounter submissions? Will clients need to be enrolled online in order to have a BH-ASO assigned ID or will they be using a Medicaid ID number?
   Answer: The encounter submissions that will be required are for the Block Grant and Non-Medicaid services, and will need to be recorded to the ASO. The crisis claims will be submitted to the MCOs. ASO is responsible for crisis services.

   Question: Will there be an open process for other providers to contract for crisis services?
   Answer: The GCBHO was required to submit their crisis providers 3 months ago when they submitted their plan to the ASO. They have already selected the providers for the crisis services. The crisis system itself is buying capacity. It hard to gauge how many calls you will get in a night. We might get 1 or we might get 20. There isn't a way to put a price on these services. The crisis system has evolved over the years. We have a lot of investment with certain providers and facilities. It is a natural fit, it wouldn't make sense to start contracting with other providers. One of the things the BHO/ASO is being pressured to do is lessen the number of crisis providers. The state tends to view that safety with less is better. This is new to the BHO. Crisis isn't a real easy thing to provide services for.

   Question: If you have an enrolled Medicaid Member that is actively in your care and is in crisis, even if you don't have a DCR team doing investigations, you do crisis care with high intensity. The question that this is addressing is who will employ and certify DCRs?

Answer: There is an RCW that the BHO/ASO and/or the county can appoint someone to issue DCRs. The BHO has appointed a few DCRs recently. The ASO will probably get a list and then ask the counties what they want to do. Some counties prefer not to and some pass that down to who the crisis agency is. This will be left up to the counties to decide at this point.

Comment from Joel Chavez- In addition to what Troy said, the BHO/ASO is going to be the gate keepers of the Non-Medicaid funds and the state only block grant for some counties. Walla Walla has chosen to run it through their court system. The BHO/ASO will be contracting with other non-crisis providers to provide services to the Non-Medicaid SUD clients. We are in the process in getting contracts with some of the residential providers, a secure detox facility, 2 other detox facilities, and ENT within our region. These are for the clients that don't meet Medicaid eligibility.

Question: Will outpatient providers be able to submit an RFP to be part of this contracting?
Answer: Not at this time because the funding has been decreased significantly.

Question: Is there an ASO Board of Directors, if so who's on it?
Answer: Yes, the County Commissioners.

Question: What is the plan for PACT, MHBG, and SABG?
Answer: Right now, the Non-Medicaid portion of PACT is going to flow through the ASO. They have had a PACT contract with Lourdes for 11 years. There is some confusion on PACT team in Yakima. They are still negotiating with the state as to how that will play out. They aren't clear as to how the MCOs are going to manage the Medicaid side. The MHBG and the SABG will stay with the ASO. It's going to be interesting because we are running into some issues already with the residential beds. Some of the providers agree with the rates that the MCOs are offering and the ASO is going to stick with the same rates that they have had for the past couple years. There are some questions we have been getting about rates.
The block grants are going to be used for the detentions. Right now, the rates at a secure detox facility are $525 and addition to that the ASO is responsible for the court costs and the transportation to the facility. It can get very expensive. That is why the ASO is saving the block grants for this because they don't know how much it will be. In addition to that, because of the LRAs, some of the DCRs are detaining clients to long term residential. So, the ASO would be paying the long term residential in those cases. There has been a significant increase in costs since April 2018.
AGP: MCO's are required to have PACT providers in network. PACT services will continue under each MCO.
CCW: agreed
CHPW: Agree with AGP

Comment: The state didn't allow the BHO to use their resources to prepare for the assessment of becoming the ASO. So most of the work they have done has been on weekends or off hours with a small number of staff working on it. The BHO is excited that it has been finalized. They are the first BHO to be approved as the ASO. HCA is much different now. They are much more by the book and will follow the contract to the letter. In the past it wasn't that way. The providers with the BHO had some leeway when it comes to data submission. HCA will be a lot stricter with data and compliance.

Question: Now that the ASO has been approved, will they have the ability to submit a letter of interest to GCACH to participate in round 2 of the Transformation Incentive funding to help facilitate the change.

Answer: I don't know. This will be something that will need to be discussed with GCACH. We haven't discussed how the second funding will be allocated yet.

Question: For the MCO's, when and what is the plan for encounter submission testing?
Answer: AGP: Typically, an executed contract needs to be in place between provider and us in order for testing to start. There is a base level of information, which is obtained through rosters and credentialing, and must be completely processed through our workflow in order for testing to occur.
CCW: Agree with AGP. We are ready to test and that is dependent on Credentialing / Contracting status.
CHPW: We are ready to start testing submissions with you. Please reach out to Donna Arcieri, donna.arcieri@chpw.org, to initiate encounter/claims submission testing.
Molina will send out their Testing Claims and Encounter guide. He will send it to Diane and she can forward it the providers.

Question: Have all providers in GCACH completed contracting, rostering, and if not what is the impact to the region? There are still providers that are re-contracting.
What will happen if all the providers aren't finished with their contracting. They are in the process of completing them. They want to get them all completed so that it doesn't affect the providers.

Question: If that provider doesn't have a contract with a certain MCO and they have clients that have that MCO, what will happen to those clients? Do they need to switch to a different MCO?
Answer: The goal would be to contract with the provider and arrange for the client to continue to have service.

Question: The presentation by the MCOs was nice but the reality is that providing services will not lead to payment for encounters until the system has been tested. We (NCACH Providers) are currently 10-months into services and we are still experiencing failed claims, rejections of claims and errors in payment.
Answer: AGP: This would be better addressed verbally through "lessons learned."
CCW: Agree with AGP
CHPW: We can address this question through "lessons learned" section of the meeting. Additionally, the Early Warning System is built to elevate issues related to payment and lead to a process to address the issue through support with the MCO. Additionally, HCA will be hosting a call with regional providers after 1-1-2019 to discuss any immediate issues.

Question: What is the plan to address value-based care? Is this going to be a GCACH collaborative plan or is this going to be parted out to all the providers and their separate contracts?
Answer: AGP: Is this directed to ACH or MCOs?
CHPW: Value based payment agreements are incorporated into an agency's contract and CHPW will work individually with each agency around value-based payment goals. This is a relationship between the MCO and the individual provider.
The role of GCACH in VBP is to present an opportunity available through the Medicaid Transformation waiver to support/invest in provider capacity to perform in VBP arrangements
GCACH: Value-based care is a form of reimbursement that ties payments for care delivery to the quality of care provided and rewards providers for both efficiency and effectiveness. This form of reimbursement has emerged as an alternative and potential replacement for fee-for-service reimbursement which pays providers retrospectively for services delivered based on bill charges or annual fee schedules.

In more basic terms, value-based care models center on patient outcomes and how well healthcare providers can improve the quality of care based on specific measures, such as reducing hospital readmissions, using certified health IT, and improving preventative care.
VBP arrangements are between providers and MCOs, so GCACH will not play a role except to provide technical assistance to BH providers so that they can maximize reimbursements from MCOs.

Question: After attending the Learning Symposium conference on Wednesday I would like to know when and how we will start to get "Real Time" access to encounter data from the system. Joe's presentation on their data warehouse and the role that data-based decision-making plays in the New York system should push us to have the same level of access. It is silly that we are making contract decisions on data that is two years old. If we are going to be successful development of a data sharing agreement, data warehouse and data analysis should be a top priority.
Answer: AGP: ACH question?
CHPW: It would be great to have a further discussion about what the key takeaways were from the HW Symposium, especially from Joe Conte and the Staten Island PPS. This is a broader conversation that is taking place at the ACH, however there are roles for provider, MCOs, the ACH and the state to play in improving access to data overall.
GCACH: What specific data are you requesting? We have some data available to GCACH, but not patient level data. Can we get further clarification?

Question: How does information on members from each MCO get to the organizations/providers?
Answer: AGP: Need more context here…
CHPW: It would be helpful to understand what "information" you mean? For eligibility information: We suggest that providers utilize Provider One for member eligibility information as the best source of truth, but eligibility information can also be found on member ID cards and within the CHPW Portal.
GCACH: Primary Care Providers receive monthly empanelment reports from the MCOs. Some MCOs provide quality metrics to their providers, (e.g. CHPW provides Arcadia population tool to their providers for free which produces quality data.) GCACH can only get aggregated data and not provider level data.

3. Testing – MCO's will address steps that need to be completed prior to testing taking place. See the question above about testing.

4. Will discuss Rapid Response Calls at next meeting

5. Lessons Learned from Integrated Regions
    - NC – AGP/Molina
    - SW – CHPW/Molina

    AGP: There have been a few hiccups in NC. Amerigroup is working through these so that they don't experience the same hiccups they did in NC. One of the main issues in NC was in regards to contracting. Specifically, for providers that wanted a fee for service contract and a capitated contract for fee for services. Within their system it took a lot of time to configure their internal system to pay those contracts accurately. Which they have troubleshooted over the last 9 months and now it has been corrected. They are fully prepared to pay all types of contracts that have been put in place in the Greater Columbia Region. There are quite a few different types of contracts now. They had to formulate a plan to make sure they could execute

those contracts correctly. This was very important to them. Lesson was doing quality improvement internally to help them to be able to pay all contracts appropriately.
Another issue was setting up automated payments in their system. They have found that some of the contracts have to be done manually. Which means they have to have an FTE that resides within the health plan that calculates and processes those claims. Amerigroup has hired 2 FTEs to set up documentation and how they will be processed per each contract. Amerigroup has tried to be transparent to Greater Columbia. There may be some hiccups in 2019 and they should be able to work through them. Also, with WISe encounter submissions, MCOs have come together collectively to look at how they do the invoicing for WISe encounters. This will be much more streamlined across the MCOs.

Molina – They have been updating and enhancing their claims system. That way payments will be made much smoother going forward. They continually learn about the claims and encounters. Working with HCA on trying to standardize the SERI guide has been very helpful that way it is standardized. Also, the NPI registering process has been streamlined. That way it is all standardized for all the regions transition in 2019.

CHPW – They didn't have a lot of concrete guidance when they started out in SW. So, standardizing the SERI Guide, CPT codes, and other things has been the biggest improvement. This will help going into 2019. The only things we don't know is what we don't know. As long as we keep the communication open with weekly meetings with providers and meetings with the HCA then we should be in good shape.

6. Access to Contingency funds – We need to find out how we are going to access these funds. The leadership team will get back together to decide on how we are going to distribute the contingency funds.

7. Next Meeting is November 29th 2-3pm

8. Future Provider Readiness Workgroup Meetings
   December 13th 2-3pm
   December 27th 2-3pm