



# TRIBAL CONSULTATION MEETING DRAFT Summary

April 19, 2018

9:00 a.m. –12:30 p.m. (Arizona Time)

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

## NOTIFICATION TO TRIBES:

### Tribal Consultation Meeting Announcement

Hello,

You are cordially invited to the AHCCCS Tribal Consultation meeting to be held at the beautiful [Twin Arrows Casino and Resort](#) near Flagstaff. We are pleased to announce that the Tséhootsooí Medical Center (Ft. Defiance) is hosting the meeting and will provide a continental breakfast and lunch.

**WHEN:** Thursday, April 19, 2018, 9 a.m. to 12:30 p.m. (Arizona Time), 10:00 a.m. to 1:30 p.m. (Navajo Nation time)

**WHERE:** Twin Arrows Casino & Resort, 22181 Resort Blvd., Flagstaff, AZ 86004 (East of Flagstaff on I-40)

**TO ATTEND BY PHONE:** Call 1-877-820-7831, use **PARTICIPANT CODE:**108903#

**TO ATTEND BY WEBINAR:** [Click here to register](#). Registration is required. Webinar will not be accessible without registration. After your request has been approved, you'll receive instructions on how to join the meeting. Meeting Password: ATC2018

Use the conference call-in number to hear the audio.

**AGENDA:** Click here to [download the agenda \(.pdf\)](#).

**MEETING MATERIALS:** PowerPoint presentations will be available to view or download on 4/18/18. More meeting materials on the [AHCCCS Tribal Consultation Meeting web page](#).

As with all AHCCCS Tribal Consultation teleconference meetings, please **mute** your phones but do not place your phones on hold. If you have to leave the meeting temporarily, please 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.

Sincerely,

Bonnie Talakte  
AHCCCS Tribal Liaison  
[Bonnie.talakte@azahcccs.gov](mailto: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:** April 19, 2018

**Time:** 9:00 a.m. -12:30 p.m. (Phoenix Time)  
10:00 a.m. – 1:30 p.m. (Navajo Nation Time)

**Location:** Twin Arrows Casino Resort, Dine Beh Meeting Room, 22181 Resort Blvd., Flagstaff, AZ 86004

**Tribal Host:** Tse Hootsoi Medical Center (Ft. Defiance)

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

**Webinar:** Click on the link to register: <http://bit.ly/AprilTCwebinar>. Enter Meeting Password: **ATC2018**. Use the conference call-in number to hear the audio.

TIME	TOPIC	PRESENTER
9:00-9:30 a.m.	Welcome.....	Thomas J. Betlach, <i>AHCCCS Director</i>
	Tribal Welcome.....	Oscencio Tom, <i>Tse Hootsoi Medical Center Board President</i>
	Invocation.....	Alex Bill Montoya <i>Tse Hootsoi Medical Center Board Vice-President</i>
	Introductions.....	Director Betlach
9:30-9:45	Overview of Tse Hootsoi Medical Center Health Services	JT Willie, <i>TMC Marketing Director</i>
9:45-11:10	AHCCCS Update	Director Betlach
11:10-11:20	BREAK	
11:20-11:35	Waiver Update	Liz Lorenz, <i>Assistant Director</i> <i>Office of Intergovernmental Relations Waiver</i>
11:35-11:50	State Plan Amendment (SPA) Update	Kyle Sawyer, <i>Intergovernmental Relations Specialist</i> <i>Office of Intergovernmental Relations</i>
11:50-12:30	Health Information Exchange (HIE) Update	Lorie Mayer, <i>AHCCCS</i> <i>Health Information Technology Coordinator</i>
		Keith Parker, <i>Health Current CIO</i>
		Peter Steinken, <i>Health Current Account Executive</i>
12:30 p.m.	Announcements/Wrap-Up/Adjourn	Capt. Peter Vermilyea, <i>Pharmacy Director, Winslow Indian Health Care Center</i> Director Betlach

## ATTENDEES:

Tribes	<p><u>Hopi Tribe:</u> Vernetta Mansfield, Laverne Dallas, Shannon Tewanema</p> <p><u>Navajo Nation:</u> Henrietta Bidtah, Refina Willie, Denella Arra, Peggy Francis, Harrison Begay, Arcenio Charleston, Eukerison Tsinejinie, Jeanetta James, Fermina Joe-Desideno, Berlinda Smith, Vera John, Marie Keyonnie, Ramona Johnson, Miranda Blatch Ford, Thomas Gorman, Merle Charlie, Priscella Jake, Gregg Whitehat, Sidney Brown, Laraine Tsosie, Sharon Yazzie, Candice Yellowhair, Clarissa Thomas, Lisayann Begay, Hope Martinez, Derek Yonnie</p> <p><u>Pascua Yaqui Tribe:</u> Reuben Howard, Rosa Rivera</p> <p><u>San Carlos Apache Tribe:</u> Vickie Began, Ron Ritter, Roger Griggs, David Reede</p> <p><u>White Mountain Apache Tribe:</u> Ryan Johnson, Felix Benally; Lona Hinton, Ginger Myers, Diane Johnson, Reyedel Charley Sr., Velasquez Sneezzy Sr., Isaiah Belkamp, Nella Ben, Sonia George, Lorold Pinal, Ryan Walker, Virgil Pablo</p>
I/T/Us	<p><u>Ft. Defiance Indian Health Care Corporation:</u> Bernie Yazzie, B. Alex Montoya, Sandi Aretino, Oscencio Tom, Christine Becenti, JT Willie, Veronica, Garnenez, Terrilynn Chee</p> <p><u>Navajo Area IHS:</u> Marie Begay, Neva Kayaani, Wanda Begay, Darlene Begay, Vida Khow, Priscilla Whitethorne, Roland Begay</p> <p><u>Native Health:</u> Deanna Sangster, Walter Murillo</p> <p><u>Tuba City Regional Health Care Corporation:</u> Lynette Bonar, Joelle Walters, Selena Simmons, Reasol Chino, Melissa Humetewa, Ronald Chapman</p> <p><u>Winslow Indian Health Care:</u> Carol Chitwood, Cecelia Jackson, Peter Vermilyea, Alutha Yellowhair, Melanie Jensen</p>
Other	<p><u>Arizona Advisory Council on Indian Health Care:</u> Kim Russell</p> <p><u>Arizona Complete Health:</u> Gabe Yaiva</p> <p><u>Care 1<sup>st</sup> Health Plan:</u> Jearlyn Tsosie, Scott Cummings</p> <p><u>Cenpatico:</u> Julia Chavez</p> <p><u>Center for Medicare &amp; Medicaid (CMS):</u> Lane Terwilliger</p> <p><u>Community Bridges:</u> Anderson Phillips,</p> <p><u>Health Current:</u> Keith Parker, Beth Scully, Peter Steinken,</p> <p><u>Inter-Tribal Council of Arizona (ITCA):</u> Alida Montiel, Nicholet Deschine Parkhurst</p> <p><u>Mercy Care:</u> Faron Jack</p> <p><u>Native Resource Development:</u> Jermiah Kanuho, Penny Emerson</p> <p><u>Rainbow Treatment Center:</u> Junandalynn Truax,</p> <p><u>Sage Memorial Hospital:</u> Sharlene Holiday, Gwen White, Rachel Begay, Terrie, Wyaco</p>
AHCCCS Representatives	<p>Tom Betlach, Elizabeth Lorenz, Markay Adams, Lorie Mayer, Heidi Capriotti, Bonnie Talakte, Kyle Sawyer, Leslie Short, Shannon Shiver, Karen Grady, Veronica Valenzuela John Archunde, Lauren Coln, Paige Bartlett, James De Jesus</p>

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.

## MEETING SUMMARY

### OVERVIEW of TSE HOOTSOI HEALTH SERVICES

Presenter: JT Willie, Tse Hootsoi Medical Center Marketing Director

Mission statement for the Fort Defiance Indian Hospital Board, Inc.:

*Our mission is “to provide superior and compassionate healthcare to our community by raising the level of health, Hózhó, and quality of life.” We are committed to providing the utmost quality care, to be compassionate in our interactions with patients and staff, and to extend heartfelt K’e to our patients and staff.*

The Fort Defiance Indian Hospital Board (FDIHB) is a self-determined healthcare organization under the Indian Self-Determination and Education Assistance Act (Public Law 93-638). The FDIHB consists of three (3) medical facilities:

- Tséhootsooí Medical Center located in Fort Defiance, Arizona
  - The facility was constructed in 2002 under the Indian Health Service
  - Is licensed for 56 inpatient beds
  - Multitude of services including a 24/7 emergency department
  - Largest of the 3 health centers
- Nahát’ á Dz’í I Health Center located in Sanders, AZ
  - Facility was opened in 2015
  - Services include but not limited to: primary care, internal medicine, dental, pharmacy, etc.
- Nihi Dine’é Bá Wellness Center located in Navajo New, Mexico
  - Facility opened in 2018
  - Is located on the New Mexico side of the state border
  - Houses the Division of Healthy Living & Outreach
  - Mobile Health Program, Rehab & Physical Therapy services

### AHCCCS UPDATE – Presenter: AHCCCS Director Thomas J. Betlach

#### **Budget and Legislative Update:**

- HB 2228 passed legislature – annual waiver – applicability – exempt tribal members
- Awaiting legislative action on budget
- AHCCCS overall enrollment down about 70,000 members over past 6 months
- K-12 issues important part of budget discussion

#### **AHCCCS Complete Care:**

Tribal Members: Will retain choice of an ACC managed care plan or fee for service 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
- 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:

- Members on ALTCS (EPD and DES/DD);
- Adult members with a serious mental illness (SMI); and

- Most CMDP

RBHA/TRBHA and Crisis Services: The Crisis system responsibilities will remain with the RBHA (in their respective 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 ACC for physical health and behavioral health or AIHP for physical health and behavioral health through a TRBHA if available.

Members who are American Indian with CRS Conditions: will have a choice of receiving physical & behavioral health and children's rehabilitative services through the ACC or 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 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 DES, 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 health services and long term care services through 8 contractors.

#### **Questions, Comments:**

**Q:** Can you explain what the consequences of choice are for an SMI if they choose AIHP. What services are available and will you not get to choose to use a RBHA or TRBHA? In the reverse, if they choose a RBHA or TRBHA what will they not get if they choose the ACC? In regard to behavioral health services, it's my understanding if you are helping someone in the United Health Care Plan and they need transportation to get to a behavioral health provider and the transport is not available and they switch to AIHP, will the transportation be coordinated?

**A:** For an American Indian with SMI, the RBHA is fully integrated. They are responsible for providing behavioral and physical services. For that example, United is still responsible for transport to a behavioral health service as long as the provider is AHCCS registered. The package is still the same. There are a series of letters that will go out to members to explain what their choice options are but the benefits package doesn't vary at all based on the choices.



**Q:** If the options are still the same, how can you help your client make informed decisions about what's appropriate for their needs?

**A:** Part of that is the network. Part of it is looking at a managed care organization and who is in their network, who are they receiving services from today. That's what it really comes down to. The plans will have information on their websites in terms of who their providers are.



**Q:** Is there an opportunity for us to look at the letters that are going to go out to tribal members? It's important to not add to the confusion. Our benefits coordinators will play a key role in this. They will be able to help people to understand their plans better if they understand what's in the letters.

**A:** There are 36 different letters. They are not all related to American Indian tribal members. We have spent a lot of time on those letters. I'm not sure if having a wordsmithing committee would be beneficial and might be difficult to manage in terms of who would sit on the committee and how to get input. I will have to think through how to operationalize that. I do see the value in something like that. As we've gone through other communication efforts we've brought in various stakeholders to give feedback including tribal members. Let me ponder this.



**Q:** When we have a situation where the American Indian that's utilizing a 638 behavioral health system where no transit care or opportunities to access state services is available then that's when we see them register under a RBHA or TRBHA. How does this change that?

**A:** It doesn't change from the perspective of how health care is delivered for an individual in the AIHP that is in a

TRBHA. There is basically not a lot of change at this point of time. It's largely already been integrated in terms of us working with that tribe through the IGA process. When the individual needs more intense services than the tribal 638 facility can offer then it's us working with that TRBHA to look at where we can address those needs. That's not going to change as a result of this contract. Some of the areas that will see potential change is in the urban areas where we tend to have more American Indians. What we're trying to communicate is that certain populations will see no change and some instances like CRS where there will be big change to go from a single statewide contractor to a choice of plan. We're still having an AHIP which will be integrated for the first time to serve that population. Before, if you were a CRS kid you were in United for CRS services. There was a lot of fragmentation that existed for that population that we believe will be better served with this model. I know it is confusing and it seems very complicated but if we back up and understand the system design that we started with where some of these populations we have moved to integration. CRS seems very complicated but if you look back a few years, the CRS individual was enrolled in three organizations for services. They were enrolled in a CRS plan, they were enrolled in a RBHA or TRBHA for behavioral health services and they were in an AHCCCS plan or AIHP for physical health services.



**Q:** I have a question regarding prior authorization. Will this require additional prior authorization if they choose the ACC plan versus the AIHP?

**A:** We are still paying IHS and tribal 638's facilities. All the policies we have in place today will be the policies going forward.

**CRS Members:** CRS members will have choice of 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.

**Questions, Comments:**

**Q:** Do those that are DDD get to choose which RBHA they want for behavioral health services? I misunderstood that because in a previous presentation about a year ago, we talked about the silos process. If someone is DDD the case manager would be responsible for coordinating their group home placement. The way I understand what you're saying is that even though they may be approved from one silo, as a RBHA case manager I'm still responsible. If he's ALTCS eligible?

**A:** If they are ALTCS eligible, the TRBHA is responsible for behavioral health services. You'll have to coordinate with the DDD Support Coordinator around that placement. DDD is responsible for long terms services through the support coordinator.

**Specific Transitions for American Indian Populations:** The following health plan enrollments or assignments will apply to the various tribal populations.

Current Health Plan Enrollment/ Assignment	Assignment on 10/1/2018	
CRS (acute and CRS services), TRBHA	ACC Plan	Approx. 350
AIHP, CRS (CRS services only and TRBHA	AIHP and TRBHA	Approx. 700
AIHP, CRS and RBHA	AIHP	Approx. 300
AIHP and TRBHA	AIHP and TRBHA – No Change	
AIHP and RBHA	AIHP	Approx. 41,000
Acute Plan and TRBHA	ACC Plan	Approx. 200
Acute Plan and RBHA	ACC Plan	Approx. 37,000
CMDP and TRBHA	CMDP and TRBHA – No Change	
DDD and TRBHA	DDD and TRBHA – No Change	

**Complete Care Timeline:** What happens next?

- March 5, 2018 – Seven ACC health plan contracts awarded

- Spring 2018 – AHCCCS hold public forums to explain ACC changes and choices (schedule announced in March)
- June 2018 – AHCCCS send letters to members with assigned health plan information and choices
- July 2018 – AHCCCS members make health plan choices by July 31<sup>st</sup>
- October 1, 2018 – CCCS members begin service with Integrated ACC health plans

**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 aims 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)

Eligible Provider types: 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 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.

Tier 1: PCCM services, 24-hour telephonic access to the care team

Tier 2: Same as Tier 1 plus diabetes education

Tier 3: Same as Tier's 1 & 2 plus participates in State HIE

Tier 4: Same as Tier's 1-3

Reimbursement Per Tier Level: Prospective Per Member Per Month (PMPM) payments based on service tier level provided.

Tier 1: PMPM Rate: \$13.87

Tier 2: PMPM Rate: \$15.96

Tier 3: PMPM Rate: \$21.71

Tier 4: PMPM Rate: \$23.81

Services to Members: Medicaid services are provided to AI/AN through the American Indian Health Program (AIHP) under the Fee for Service Program (FFS). The AIMH program is a voluntary program for AIHP members. Members who choose to participate may dis-enroll or change AIMH sites at any time. AIMH allows for improved coordination of services through the use of a Primary Care Case Manager (PCCM) who is able to assist members in coordinating the health care services they receive.

Member Requirements:

- Title XIX only; not for KidsCare (AZ's Children's Health Insurance Program)
- AIHP enrolled members only
- Tribal ALTCS not included
- Participation is voluntary
- Member may discontinue at any time
- Member may switch AIMHs at any time
- Facility must keep signed AIMH form on file

## WAIVER UPDATE

**Presenter: Liz Lorenz, Assistant Director Office of Intergovernmental Relations**

**Flexibilities Overview:** The March 14, 2017 letter from HHS/CMS encouraged states to seek flexibilities in the administration of their Medicaid programs, including waivers to limit NEMT. On November 17, 2017 a concept paper was submitted to CMS.

**AHCCCS Works Waiver:** On December 19, 2017, AHCCCS submitted a request to CMS to implement AHCCCS Works. To qualify for AHCCCS coverage, certain able-bodied adults 19-49 who do not qualify for an exemption must show community engagement activities for at least 80 hours per month. AHCCCS has requested exemption for American Indians in the waiver request:

- Be employed or actively seek employment;
- Attend school; or
- Participate in employment support and development activities.

### **Proposed Exemptions Part 1:**

- Individuals who are not subject to mandatory managed care
- Individuals determined to have a Serious Mental Illness
- Individuals who are in active treatment with respect to a Substance Use Disorder
- Individuals determined to be medically frail
- Individuals receiving temporary or permanent long-term disability benefits (private or government), including workers compensation

### **Proposed Exemptions Part 2:**

- Designated caretaker of a child
- Caregiver who is responsible for the care of an individual with a disability
- Full time high school students
- Full time trade school, college or graduate students
- Individuals who are homeless
- Victims of domestic violence
- Beneficiaries receiving benefits under SNAP or a Cash Assistance Program
- Beneficiaries receiving Unemployment Insurance
- Designated caretaker of a child
- Caregiver who is responsible for the care of an individual with a disability
- Full time high school students
- Full time trade school, college or graduate students
- Individuals who are homeless
- Victims of domestic violence
- Beneficiaries receiving benefits under SNAP or a Cash Assistance Program
- Beneficiaries receiving Unemployment Insurance

**Prior Quarter Coverage:** Currently, Arizona covers enrollees three months prior to the month of application if the enrollee would have been eligible at any point during those months. An amendment submitted April 6 proposes limiting retroactive coverage to the month of application, consistent with AHCCCS policy prior to 2014. The Waiver will encourage members to obtain and maintain health coverage, even when healthy, and to apply expeditiously.

**Prior Quarter Coverage Costs:** In recent years, total amount paid to I.H.S./638s = approx. \$2.5 million per year with approx. 1400 distinct members per year. Largest service category is outpatient. Community will need to assist those who may be eligible for Medicaid with applying without delay.

**Current Landscape:** CMS issued guidance to states on community engagement waivers in January. CMS has approved Kentucky, Indiana and Arkansas. Kentucky is going live in part of state as of July 1. Litigation is pending in US District Court over the CMS guidance and the Kentucky waiver approval. Approx. 10 other states have



similar waivers in the queue. Currently negotiating waiver approval with CMS and evaluating necessary AHCCCS operational changes

**NEMT Waiver Framework:** Arizona's NEMT waiver flexibility proposal would eliminate NEMT benefits for a very targeted population with incomes over 100% FPL living in urban areas. This waiver proposal will **not** affect people living in rural areas or American Indians.

**NEMT Waiver Flexibility Framework:**

- Restrict NEMT for those who meet all the following criteria:
  - Adults aged 19-49
  - Income above 100% FPL
  - Subject to mandatory managed care
  - Do not have a disability or medical frailty
  - Live in an urban area with adequate public transportation

**NEMT Waiver Exemptions, Part 1, 2 & 3:**

- NEMT benefits would remain unchanged for individuals who meet any of the following conditions:
  - Pregnant or post-partum up to 60 days
  - Individuals determined to have a serious mental illness (SMI)
  - Arizona Long Term Care System (ALTCS) enrollees
  - Acute care members residing in nursing homes or residential facilities when the member's medical condition would otherwise require hospitalization
  - Individuals eligible for Children's Rehabilitative Services (CRS)
  - Individuals eligible as Qualified Medicare Beneficiaries
  - Individuals receiving hospice care
  - Individuals enrolled in the Breast and Cervical Cancer program
  - Individuals receiving Adoption Subsidy or Foster Care Assistance under Title IV-E of the Social Security Act
  - Individuals receiving Title IV-B Child Welfare Services
  - Individuals receiving hospice care
  - Individuals enrolled in the Breast and Cervical Cancer program
  - Individuals receiving Adoption Subsidy or Foster Care Assistance under Title IV-E of the Social Security Act
  - Individuals receiving Title IV-B Child Welfare Services

**Urban Area Definition:** Urban areas in Maricopa and Pima counties that have adequate public transportation. Specifically, the proposed restriction will be limited to zip codes in the Phoenix and Tucson metropolitan areas that have access to local bus services.

**Prescription Drug Flexibilities:** AHCCCS is developing a waiver proposal to obtain more leverage on prescription drugs. The proposal will exclude drugs until market prices are reasonable and cost effectiveness data exists and established formulary with at least 2 drugs per class/category (with exceptions).

**Questions and Comments:**

**Q:** What does active treatment mean?

**A:** It's my understanding that active treatment means any form of treatment for substance use disorder.



**Q:** Have any of these exemptions been approved in other state waivers?

**A:** I think a lot of them been approved. Not the exemption for those who are not subject to mandatory managed care. That is new as far as we know.



**Q:** Has the exemption been pursued in other states? Will Arizona pursue the exemption?

**A:** It has not been pursued in other states as far as we know. Yes, AHCCCS is pursuing the exemption. CMS is

aware of the request. We have not heard back yet.

**C:** I'd like to say thank you to AHCCCS for helping us with everything. And thank you to the tribal leaders here today in helping to push through HB 2228. That was a great win. However, I'd like to remind everyone that this is not over yet. The Trump administration is not in support of exempting American Indians from the work requirement. We need to keep an eye on this. It will affect our programs if nothing gets through. At Tuba City 60% of our members apply for AHCCCS. That means if they (CMS) decide not to approve the exemption our revenue and services will be impacted.

**R:** Thank you for the comment. We encourage our tribal partners to engage CMS and HHS leaders around this topic.



**Q:** About prior quarter coverage, I recall in a previous tribal consultation, that IHS, Tribal 638 health programs and Urban Indian health program's (ITU's) are not exempt from this requirement so there won't be that level of reimbursement that we would have seen in prior quarter coverage that exists now. We didn't have to wait for the waiver to be approved by CMS. Were you able to implement this through a SPA?

**A1:** We have not implemented it. We still have prior quarter coverage right now. We just submitted it 2 weeks ago. If the waiver is approved in its current form then it will go into effect in the future. We not have started negotiating with CMS yet. We will be requesting public comment.

**A2:** We originally requested a waiver for this provision and didn't want to implement it on January 1, 2014 in terms of prior quarter. It is incredibly administratively burdensome for the State to be able to have the infrastructure in place. No other healthcare coverage--Medicare, commercial, individual--offers anything like prior quarter. AHCCCS is very generous in that we offer insurance coverage back to the first of the month of application. A lot of the potential impact can be lessened if people can maintain their coverage and not fall off for either termination or other reasons. Part of this policy initiative is to address the fact that there is a ton of administrative infrastructure to keep prior quarter in place that is burdensome on our program. Medicaid is already very generous as it relates to prior coverage periods compared to any other insurance program. We'd like AHCCCS members to appreciate the fact that insurance is complicated and AHCCCS is a form of insurance. Part of that process means you have to maintain your coverage or sign-up for coverage. That is the policy reasoning behind why we are moving forward with this and CMS has approved this for several states.



**C:** I understand the policy reasoning. But we're feeling the impact of the policy reasons and the change that were to occur as a result of this. It's about being able to communicate the change to our tribal members and facilities so they relay the right information and that people realize they are not going to get back coverage for the 3 month period when they were not on Medicaid yet. It's dealing with the impact of the change and the ramifications of the change.

**R:** Thank you for your comment.

## STATE PLAN AMENDMENT (SPA) UPDATE

**Presenter: Kyle Sawyer, Intergovernmental Relations Specialist**

**Asset Verification SPA:** CMS has required states to acquire an asset verification system which meets certain requirements. AHCCCS will be joining the NESCSO consortium of states to acquire this asset verification system.

**FQHC Alternative Payment Model:** AHCCCS has worked closely with the FQHC and Rural Health Clinic workgroup to develop a new APM which takes into account value. Current Individual FQHC PPS Rate x PSI inflation x (1.000 + Applicable DAP Factor) = Next Year's Individual FQHC PPS Rate. If the PSI is less than 0% the PSI will be 0% if it is greater than 5% it will be 5%. The baseline for new FQHCs will be created based on nearby FQHCs with similar caseloads. There will be no changes to scope of service through September 30, 2020. After 2020, AHCCCS will review scope of service changes. There will be no more than 2 scope changes between October 1, 2020 and September 30, 2023. 638 FQHCs will continue to receive the AIR.

This does not apply to 638 facilities or IHS facilities.

Additional feedback or questions regarding these SPAs can be provided to, [publicinput@azahcccs.gov](mailto:publicinput@azahcccs.gov).

**Questions and Comments:**

**Q:** Is there going to be consultation with tribes to fully understand how this will affect their members? Has this been submitted to CMS?

**A:** We are consulting with tribes today and will continue to consult the tribes. If anyone has any interest, reach out to us. We have not submitted this to CMS. It has not been finalized. We have to get the FQHC's on board with the payment methodology. Once we conclude that process we will start the public comment process then will submit the SPA to CMS.

**C:** Kyle can you lay out the State Plan process.

**R:** Our State Plan Amendment process includes a 45 day tribal consultation and public comment period. During that period we analyze the comments and look to make any changes that are necessary before it's submitted to CMS. After we submit to CMS, there are ongoing discussion and questions with them. If during this period you have unexpected concerns, we are always available to answer any questions. This is negotiated.



**Q:** Is this related to the 4-Walls question?

**A:** That is primarily a 638 FQHC SPA that has already been submitted and is currently being negotiated with CMS.



**C:** I wasn't aware there was a public comment period. I don't think it was clearly communicated that the January meeting that it was submitted and the clock was ticking.

**R:** The 45 day public comment period began on the date of the last tribal consultation. We did post on our website for public comment. We asked for comments to be submitted to the mailbox. The SPA has been submitted to CMS but has not been approved yet. If you have comments, submit to our mailbox and it will be forwarded to CMS and will be part of the negotiations.



**C:** Did you receive comments during the public comment period?

**R:** We received no comments.

**C:** I find it interesting as it is a huge policy that tribes have really worked toward. I've talked to some of my colleagues who were unaware of the public comment period. You would think we would have submitted written comments like we do with other SPA's. Just expressing concern. This is news to me

**R:** To that point, we did open it up. We had a special workgroup and held a series of workgroup meetings for our 638 FQHC's. We created a specific Constant Contact list in which we outreached to our 638 FQHC's contacts that we have and did post to our website.

**C:** Shouldn't there be notification to all tribes of the SPAs? The communication to tribes wasn't clear.

**A:** We'll work with our tribal liaison to improve the process.



**C1:** I served on the tribal workgroup and was on that contact list but there wasn't a 3<sup>rd</sup> workgroup meeting as was communicated to the workgroup. There was to be 3 workgroup meetings but didn't happen.

**C2:** There was a huge communication glitch with this SPA.



**C:** If CMS has not approved the SPA and folks have concerns, let us know. We'll send it out again and if people want to help inform us. We can be flexible.

**HEALTH INFORMATION EXCHANGE (HIE) UPDATE**

**Lorie Mayer, AHCCCS HIT Coordinator, Keith Parker, Health Current CEO,  
Capt. Peter Vermilyea, Pharmacy Director, Winslow Indian Health Care Center**

**AHCCCS HEALTH INFORMATION EXCHANGE UPDATE: Lorie Mayer, Presenter**

**Health Information Exchange (HIE) Opportunity:** IHS and Tribally operated facilities have not been participating in Arizona’s Health Information Exchange to the same extent as other providers. Providers are not benefitting from the ability to incorporate more “real time” patient data into their care delivery. More complete patient health information leads to more opportunities to better care and patient.

**Additional Information:**

As a National Organization, IHS has to develop strategy and solutions that takes into account:

- Costs to building interfaces
- Different state Health Information Exchanges with different operating policies
- Different technologies or exchange platforms
- Different HIE organizations Payment and Governance Models
- Different HIE Participants/ stakeholders state to state

**AHCCCS Has 3 Different Financial Programs to Encourage EHR Adoption and HIE Use:**

**Program 1:** Medicaid EHR Incentive Program encouraging Electronic Health Record (EHR) Adoption for Eligible Hospitals and Eligible Professionals. Seventy-five (75) hospitals in Arizona are participating. Below is a partial list of hospitals that have received at least one Arizona Medicaid EHR Incentive Program Payment.

- Phoenix Indian Medical Center
- Whiteriver Indian Hospital
- Hopi Health Center
- Parker Indian Hospital
- Sells Indian Hospital
- Chinle Comprehensive Health Care Facility
- Gila River – Hu Hu Kam Memorial Hospital
- San Carlos Indian Hospital
- Fort Defiance Indian Hospital (Tse Hootsoi Medical Center)
- Tuba City Indian Medical Center

**HIE Onboarding Program:**

**Program 2:** AHCCCS HIE Onboarding Program with Health Current is pen to any Medicaid Provider who has received an EHR Incentive Payment OR supports a Medicaid MU Participant to reach MU. AHCCCS funds an HIE onboarding infrastructure and team at Health Current to do outreach and educate providers about HIT/HIE and funds the creation of an organizational HIT plan that address needs or resources for problems you want to solve. HIE supports project managers and technical experts to assist you with meeting technical requirements. interface builds *Long Term Goal is Bi-directional Exchange of Clinical Patient Data*. Federal Funds are available until 2021 to support this connectivity

**Descriptions of AHCCCS HIE Onboarding Program Milestones:**

- M1- Organization signs a Health Current Participation Agreement
- M2- or M3- Organization either sends or receives data from or to Health Current
- M4- Organization is sending and receiving health information; achieved Bi-Directional exchange; receives small offset payment ;
  - Hospitals –\$20,000
  - Community Providers/Ambulatory - \$5,000 - \$10,000

**HIE Onboarding Milestone Status of HIS and Tribal Providers:**

Name of Health Current Participant	Milestone 1 Participation Agreement Signed	Milestone 2 One way participant Data to the HIE	Milestone 3 One way interface development from the HIE to the Participant	Milestone 4 Bi-directional Exchange completed; Participant can receive Off set payment
Tuba City Regional Health Care	X			
Chinle Health Care Facility	x			

Gila River Health Care	x			
Pascua Yaqui Tribe Health Service Division	x			
Winslow Community Health	x	x	x	x

**American Indian Medical Home:**

- **Program 3:** AHCCCS State Plan Amendment (SPA) for the AIMH Program was approved by Centers for Medicare and Medicaid Services (CMS) June 2017
- Aims to help address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination
- Program for American Indians/Alaskan Natives (AI/AN) members enrolled in the American Indian Health Program (AIHP)
- American Indian Medical Home (Division of Fee for Service Management)
  - Tier 3 HIE Bi- directional exchange is required
  - Participants can receive \$21.71 PMPM

**AIMH 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.

Tier 1: PCCM services, 24-hour telephonic access to the care team

Tier 2: Same as Tier 1 plus diabetes education

Tier 3: Same as Tier’s 1 & 2 plus participates in State HIE

Tier 4: Same as Tier’s 1-3

**HEALTH CURRENT PRESENTATION: Keith Parker, Presenter**

**Health Information Exchange Enables Providers to:**

- Receive Arizona Hospital Admissions, Discharges and Transfers (ADTs) from over 95% of the Hospitals in Arizona;
  - More real time clinical data like ADTs can assist with care intervention and care coordination
- Track, connect, and intervene with HN/HC members with services in a more timely way
  - AHCCCS DFSM is using HIE to track and coordinate care for 200 HN/HC AI members
  - Allows DFSM to identify if services are being accessed
  - Coordinate information sharing across a range of clinical environments so when member moves across the system, there is information available

**Connecting the Healthcare Community: The State of HIE in Arizona**

Health Information Exchange:

HIE Participants (as of March 29, 2018): An HIE Participant is an organization that has signed a Participation Agreement. These organizations are either already connected to the HIE or are in the process of connecting. Medicaid providers may be eligible to receive financial incentives for HIE participation. Current participants include 475 entities:

- 209 Community Provider Organizations
- 83 Long-Term & Post-Acute Care Organizations
- 76 Behavioral Health Organizations
- 33 Hospitals & Health Systems (95% of inpatient discharges)
- 22 State & Local Government Organizations
- 21 FQHCs & Community Health Centers
- 14 Health Plans
- 14 Accountable Care Organizations (includes Clinically Integrated Networks)
- 3 Reference Labs & Imaging Centers

### Road to Participation:

- Sign Participation Agreement
  - ✓ Beth Scully [beth.scully@healthcurrent.org](mailto:beth.scully@healthcurrent.org)
- Cost / Fees for joining
- Health Current staffing and IT use case support
  - ✓ Client services workflow support
  - ✓ Technical support

### **HIE Stats, Services & Programs**

#### Core HIE Services Currently Operating:

##### Data Exchange

- Push/pull and query/response functionality

##### HIE Portal

- Secure online access to patient data, a summary view

##### Alerts

- ADT alerts and other clinical results notifications in human & machine readable formats
- Batch Reports

##### Direct Secure Email

- Secure email for clinical information exchange; Direct Trust certified and HIPAA compliant

##### Clinical Summary

- The delivery of a continuity of care document (CCD) based on an electronic request

#### New HIE Services & Opportunities:

##### Alerts – Additional Batch Reporting Functionality

- Accumulate ADTs for patient panel & deliver at regular frequency

##### PDMP/HIE Integration

- Access to HIE portal can also show PDMP data to meet prescriber mandate for registered providers

##### Patient Centered Data Home™ (PCDH)

- ADT alerts and follow-up information exchange available in Western Region and soon nationally

##### Behavioral Health Portal & Crisis Summary Tab

- Access to protected substance use treatment information & some behavioral health data
- Emergency access to key pieces of information (currently rolling out)

##### Other Value-Added Services

Medication fill history and electronic image sharing under consideration

### **Health Current's Role in Collaboration**

#### Opportunities to Get Engaged:

##### Councils & Workgroups:

- Council nominations will be open in coming weeks, along with rolling basis applications accepted online
- Workgroup participation is based on volunteers and appropriate stakeholder representation – let our team know if you are interested

##### Share Your Story:

- Share the ways in which HIE is bringing value to your organization

##### Provide Us Feedback:

- Participate in these user group meetings – statewide & regional
- Provide feedback to your account manager
- Meet with our team to discuss new ideas, opportunities, challenges, etc.

#### A Safe Zone Where Ideas May be Brought Forward, Discussed & Developed

- Health Current is an HIE, but it was originally formed on the foundation of serving as a trusted, neutral community convener...
- Where ideas are shared and pursued

- Among a broad scope of organizations and agencies
- Openly, safely, in a trusted and respected space
- Where we are no longer silos, or competitors
- We are partners in pursuit of a better way of serving our communities

**WINSLOW INDIAN HEALTH CARE CENTER PRESENTATION: Peter Vermilyea, Presenter**

**HIE Experience at WIHCC:**

- Tribally managed outpatient clinic (638)
- 45 providers
- Services: cardiology, neurology, surgical, urgent care, wound care, mental health, optometry, dental, pharmacy
- 6 primary care teams with 18 providers
- Using the IHS EHR
  - Implemented 2007

**Need for HIE:**

- Continuity
  - Patient Centered Medical Home (PCMH)
  - Patient empanelment
  - 10,000 patients divided between 18 providers
- Merit Based Incentive Payment System (MIPS)
  - Improvement activities
  - Medical Home gives facility full credit

**3 Phase Implementation**

- Provided access to the HIE, with small, hi-risk patient cohort manually uploaded to monitor
- Work with contractor to have visit data uploaded nightly
- Generate and upload entire empaneled patient population via automated process

**Implementation:**

- Funding - \$ interface for upload
- Training
  - Patient registration forms – opt in vs. opt out
  - RN care coordinator logins
  - Managing multiple Direct mail systems
  - Provider/staff buy-in
  - Need local project manager

**Data Transmitted to Health Current:**

- ADT
- Labs
- Radiology
- Meds
- Immunizations
- Future additions (?)

**Lessons Learned:**

- Recorded webinar
- Fine tuning of notifications
  - how much information is too much?
- End user buy-in
- Staff turnover
- Training is ongoing!

- Health Current team is great 😊

Outcomes:

- RN Care coordinators, case managers
- Neurologist
- Cardiologist
- Discharge medication reconciliation
- Pharmacy monitoring
  - Non formulary meds
  - Anticoag patients

**Meeting Adjourned at 12:30 p.m.**

DRAFT