

Partnership Access Line

Recommendations for an Alternative Funding Model and Non-Duplication

Substitute Senate Bill 6452; Section 1(4); Chapter 288; Laws of 2018
December 1, 2018



Partnership Access Line

Acknowledgments

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Clinical Quality and Care Transformation
P.O. Box 45502
Olympia, WA 98504
Phone: (360) 725-0473
Fax: (360) 586-9551
www.hca.wa.gov



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Executive Summary

Substitute Senate Bill (SSB) 6452 (2018) states that the Health Care Authority (HCA):

... shall convene the University of Washington, Seattle children's hospital, medicaid managed care organizations, organizations connecting families to children's mental health services and providers, health insurance carriers as defined in RCW 48.44.010, and the office of the insurance commissioner to recommend:

- (a) An alternative funding model for the partnership access line; and
- (b) A strategy to ensure that expanded services for the partnership access line...do not duplicate existing requirements for medicaid managed care organizations as required by RCW 74.09.492...

By December 1, 2018, the authority must recommend a plan to the appropriate committees of the legislature, and the children's mental health work group created in chapter . . ., Laws of 2018 (Engrossed Second Substitute House Bill No. 2779), if chapter . . ., Laws of 2018 (Engrossed Second Substitute House Bill No. 2779) is enacted by the effective date of this section.

The current Partnership Access Line (PAL) at Seattle Children's Hospital provides children's mental health consultation services for primary care providers to benefit their pediatric patients. Beginning January 1, 2019, expanded "PAL for Moms and Kids" services will include:

- PAL for Moms — a telephone psychiatric consultation service at the University of Washington available to health care providers caring for "pregnant women and new mothers" with behavioral health needs; and
- PAL for Kids — an assistance line that parents and guardians, as well as health care practitioners, can call to receive help connecting with "children's mental health services and other resources" for their children or pediatric patients.¹

In this report we:

- Provide background on the current and expanded PAL services, the requirements of the Medicaid Managed Care Organizations (MCOs), and explain the process by which we convened the work groups, per SSB 6542, to develop recommendations for an alternative funding model and a non-duplication strategy;
- Present alternative approaches for funding the PAL services, and discuss the core requirements to implement the alternative funding approaches;
- Recommend an alternative funding model; and

¹ See SSB 6452, Section 2(3)(b), <<http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6452-S.SL.pdf>>, accessed on September 4, 2018.



- Present the care coordination interface designed by representatives from Seattle Children’s Hospital and the MCOs to assure non-duplication of responsibilities, but achieve the intent of the legislation and the plan to implement the process.

We considered two alternative funding models to pay for the portion of the current and expanded PAL services benefitting patients who are not enrolled in Apple Health:

- Using funding from an existing revenue source combined with standard Medicaid funding; and
- Using a per-covered-child assessment on private fully insured health plans and third-party administrators (TPAs).

We also considered whether to implement either of these alternative funding models by including a governing board to advise HCA about PAL services, promote PAL services to health care providers, and review PAL services data.

Recommendation: HCA recommends that the Legislature use an existing revenue source to pay for the proportion of PAL services that benefit clients not enrolled in Washington Apple Health (Medicaid). Examples of existing revenue sources from health care-related entities are the health insurance premium tax, the business and occupation (B&O) tax on hospitals, and the Washington State Health Insurance Pool (WSHIP) assessment (see the “Sources of Alternative Funds” section for details). This recommendation assumes HCA would receive both funding from an existing revenue source and the standard Medicaid funding for the PAL program in its operating budget appropriation. HCA does not recommend including a governing board. Depending on funding authorization, we could implement this funding model, beginning January 1, 2021.

We further recommend that the HCA:

- Evaluate the effectiveness of the funding model after each year; and
- Share our findings and recommendations to the Legislature after implementing the funding model for one year.

We recognize the following benefits to using funding from an existing revenue source as the alternative funding model instead of a per-covered-child assessment and/or including a governing board:

- It is a simpler, more cost-effective method to administer the funds for the current and expanded PAL services;
- While the expanded PAL services become more established and demand for those services potentially grows, we will have time to explore the need to build additional infrastructure (such as a per-covered-child assessment and/or involving a governing board) to support the program; and
- It avoids creating potentially unnecessary administrative infrastructure before the Legislature decides whether to continue funding the expanded PAL services beyond the program pilot period.



In addition to recommending an alternative funding model, HCA will proceed with implementing the care coordination process developed by Seattle Children’s Hospital and the MCOs on January 1, 2019. This process supports the “no wrong door” approach to serving Apple Health clients who need to access behavioral health services and achieves the requirement to not duplicate the contracted MCO services.

Background

The health of Washington State’s children is a priority. Recent events and published reports highlight the increasing prevalence of mental health challenges in children.²

In 2018, the Legislature unanimously passed SSB 6452, which directs HCA to expand current PAL services and supports clinicians’ efforts to provide evidence-based behavioral health services. The Legislature also directs the HCA to ensure the expanded PAL services do not duplicate MCOs’ coordinated care requirements.

Current PAL Services

Seattle Children’s Hospital launched its PAL program in 2008. The PAL is an evidence-based program that provides child psychiatry consultation to primary care practitioners caring for children with behavioral health needs during business hours.³ The PAL program also:

- Provides training to primary care providers;
- Maintains a guidebook related to children’s mental health; and
- Performs interrater reliability activities on its consultations to ensure consistent, quality telephone consultation services.

HCA administers the PAL program through a contract with Seattle Children’s Hospital.

Current PAL services increase access to care by supporting primary care practitioners diagnose children with mental health disorders and refer them to the correct treatment. These services remove barriers to treatment by reducing the time children need to wait and the distance they need to travel to receive treatment.

² About 13-20 percent of children in the U.S. experience a mental disorder in a given year. (See: Perou, R., Bitsko, R.H., Blumberg, S.J., et al. (2013) Mental Health Surveillance among Children—United States, 2005-2011. MMWR Surveillance Summaries, 62, 1-3.) Mental health disorders disrupt completion of important developmental tasks, impact relationships and functioning in families, at school and socially, impact children’s overall physical well-being, and are costly to society. (See: Soni, A. Top Five Most Costly Conditions Among Children, Ages 0-17, 2012: Estimates for the U.S. Civilian Noninstitutionalized Population. Statistical Brief #472. April 2015. Agency for Healthcare Research and Quality, Rockville, MD.)

³ “Partnership Access Line: Child Psychiatric Consultation Program for Primary Care Providers”, <<http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/>>, accessed September 4, 2018.

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Between July 2017 and June 2018, the PAL program received 1,632 calls from providers, of which roughly 51 percent were about children enrolled in Apple Health, as indicated by the providers calling the PAL. Of the total number of calls:

- About 6 percent were about children between the ages of 0 and 5 years old;
- About 39 percent were about children between the ages of 6 and 12 years old; and
- About 55 percent were about children 13 years of age or older.

Expanded PAL Services

SSB 6452 directs the HCA to implement a two-year “partnership access line for moms and kids” pilot program, beginning January 1, 2019, to:

- “Support obstetricians, pediatricians, primary care providers, mental health professionals, and other health care professionals providing care to pregnant women and new mothers through same-day telephone consultations in the assessment and provision of appropriate diagnosis and treatment of depression in pregnant women and new mothers; and
- “Facilitate referrals to children's mental health services and other resources for parents and guardians with concerns related to the mental health of the parent or guardian's child. Facilitation activities include assessing the level of services needed by the child; within seven days of receiving a call from a parent or guardian, identifying mental health professionals who are in-network with the child's health care coverage who are accepting new patients and taking appointments; coordinating contact between the parent or guardian and the mental health professional; and providing post-referral reviews to determine if the child has outstanding needs.”⁴

The pilot program will focus on benefitting Apple Health plan members and will have some capacity to serve individuals not enrolled in Apple Health.

PAL for Moms

The University of Washington began its Perinatal Psychiatry Consultation Line (or “PAL for Moms”) in 2016 with philanthropic (donation) funding. PAL for Moms provides psychiatric consultation to health care providers “on any mental health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g. pregnancy loss, infertility).”⁵ PAL for Moms is currently staffed to respond to calls between 3:00 p.m. and 5:00 p.m. on weekdays. With funding through a contract with HCA, the PAL for Moms program will expand its operations to respond to calls from 9:00 a.m. to 5:00 p.m.

⁴ See SSB 6452, Section 2(3)(b), <<http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6452-S.SL.pdf>>, accessed on September 4, 2018.

⁵ “Perinatal Psychiatry Consultation Line”, <<https://sharepoint.washington.edu/uwpsychiatry/ClinicalServices/ConsultationandTelepsychiatry/Pages/Perinatal-Psychiatry-Consultation.aspx>>, accessed September 4, 2018.



PAL for Kids (Family Assistance Line)

Seattle Children's Hospital will add to its current PAL services by offering a "PAL for Kids" assistance line during business hours. Parents, guardians, and health care practitioners, will be able to call the PAL for Kids to receive help navigating the complex behavioral health system and connect with additional resources. Seattle Children's Hospital will create and maintain a database of Apple Health contracted behavioral health providers that will include information about:

- Which providers are enrolled;
- The age limits for "eligible" patients; and
- Whether the providers are accepting new patients.

By referencing the information in the database, PAL for Kids program staff will assist callers by both identifying and helping to connect with two or more available children's behavioral health treatment providers. These PAL for Kids services are both similar and complimentary to services that Apple Health MCOs provide to fulfill their contractual care coordination requirements.

Apple Health MCO Care Coordination Requirements

Per Revised Code of Washington (RCW) 74.09.492(2), the Apple Health MCOs are required to perform the following tasks to coordinate resources and services for enrolled children who need mental health treatment:

- "Follow up with individuals to ensure an appointment has been secured;
- "Coordinate with and report back to primary care provider offices on individual treatment plans and medication management, in accordance with patient confidentiality laws;
- "Provide information to health plan members and primary care providers about the behavioral health resource line available twenty-four hours a day, seven days a week; and
- "Maintain an accurate list of providers contracted to provide mental health services to children and youth. The list must contain current information regarding the providers' availability to provide services. The current list must be made available to health plan members and primary care providers."⁶

HCA has incorporated these requirements into our current MCO contracts. We have educated the MCOs about these requirements, incorporated oversight of MCOs' compliance with these requirements into our contract monitoring activities, and confirmed that the MCOs are complying with these requirements.

Process for Receiving Input: Convened Work Groups

HCA convened two separate work groups during our process to develop recommendations for this report: (1) an alternative funding model work group; and (2) a non-duplication strategy work group. The work groups met during June, July, and August 2018 to develop recommendations. After

⁶ See RCW 74.09.492(2), <<http://app.leg.wa.gov/RCW/default.aspx?cite=74.09.492>>, accessed on September 4, 2018.



these meetings, HCA drafted this report, distributed the draft to the members of the alternative funding model work group, and processed their feedback prior to finalizing this report.

Appendices A through F include additional information about the convened work groups, their meetings, and contributions to the recommendation process.

Alternative Funding Approaches

SSB 6452 requires HCA to develop an alternative funding model to support both current and expanded PAL services. In the development process, HCA and the Office of the Insurance Commissioner must: “(a) Consider a mechanism that determines the annual cost of operating the partnership access line and collects a proportional share of the program cost from each health insurance carrier; and (b) Differentiate between partnership access line activities eligible for medicaid funding from other nonmedicaid eligible activities.”⁷ In consultation with the Office of the Insurance Commissioner and other partners in the convened funding model work group, we:

- Discovered data collection limitations in the current and expanded PAL services;
- Developed two alternative funding approaches to pay for the portion of the current and expanded PAL services benefitting patients who are not enrolled in Apple Health;
- Considered the involvement of a governing board in the funding approaches; and
- Identified core requirements for the HCA to implement an alternative funding approach.

PAL Services Data Collection Limitations

In both current and expanded PAL services, Seattle Children’s Hospital and the University of Washington collect information from those who call them. Though both Seattle Children’s Hospital and the University of Washington ask callers about the patient’s insurance coverage:

- Callers might not know or could be mistaken about the patient’s insurance coverage;
- Neither Seattle Children’s Hospital nor the University of Washington have a way to verify the patient’s insurance coverage;
- Requiring callers to provide proof of insurance before receiving consultation or assistance line services would likely result in significantly decreased access to those services.

Preserving access to current and expanded PAL services is a priority. Per SSB 6452, the funding approach must differentiate between PAL services that are “eligible for medicaid funding from other nonmedicaid eligible activities.”⁸ Accordingly, we developed two funding approaches.

⁷ See SSB 6452, Section 1(3), <<http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6452-S.SL.pdf>>, accessed on September 4, 2018.

⁸ See SSB 6452, Section 1(3), <<http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6452-S.SL.pdf>>, accessed on September 4, 2018.



Funding Approach 1: Use of Appropriated Funding From an Existing Revenue Source

Under this approach HCA would use:

- Funding from an existing revenue source to pay for the proportion of the PAL program that is not eligible for federal Medicaid reimbursement; and
- Standard Medicaid funding (a combination of General Fund—State and General Fund—Federal funding) to pay for the proportion of the PAL program that is eligible for federal Medicaid reimbursement.

HCA would calculate the proportion of the PAL program that would be eligible for federal Medicaid reimbursement by referencing the ratio between populations in Apple Health enrollment data and Office of Financial Management (OFM) population data.

Sources of Alternative Funds

Examples of existing revenue sources from health care-related entities are the health insurance premium tax,⁹ the B&O tax on hospitals,¹⁰ and the WSHIP assessment.¹¹

- Premium tax — the health care services premium tax is 2 percent of premiums and applies to health care service contractors and health maintenance organizations. A 2-percent premium tax also applies to all other insurers, including disability insurers issuing health insurance plans. TPAs and self-funded group health plans are not subject to premium taxes and would not contribute to the cost of the PAL program in this approach.
- B&O tax on hospitals — the B&O tax on qualifying hospitals is 1.5 percent of gross income derived either from personal and professional services to of hospitals, clinics, and similar health care facilities (for for-profit hospitals) or from personal and professional services to patients (for public or nonprofit hospitals).¹² Health insurance carriers, TPAs, self-funded group health plans, and Apple Health plans are among the primary sources of hospitals' gross income.¹³

⁹ See RCW 48.14.020, <<http://app.leg.wa.gov/RCW/default.aspx?cite=48.14.020>>, and RCW 48.14.0201, <<http://app.leg.wa.gov/RCW/default.aspx?cite=48.14.0201>>, both accessed on September 4, 2018.

¹⁰ See RCW 82.04.260(10), <<http://app.leg.wa.gov/RCW/default.aspx?cite=82.04.260>>, accessed on September 4, 2018.

¹¹ See RCW 48.41.037, <<http://app.leg.wa.gov/RCW/default.aspx?Cite=48.41.037>>, accessed on October 10, 2018.

¹² See “For Profit Hospitals; Scientific R&D”, <<https://dor.wa.gov/file-pay-taxes/before-i-file/business-and-occupation-bo-tax-classification-definitions#0135>>, and “Public/Nonprofit Hospitals; Qualified Co-ops”, <<https://dor.wa.gov/file-pay-taxes/before-i-file/business-and-occupation-bo-tax-classification-definitions#0055>>, both accessed on September 4, 2018.

¹³ The B&O tax on hospitals has some similarities to an assessment that the Massachusetts Department of Health uses to fund the Massachusetts Child Psychiatry Access Program Assessment — an analogous PAL program. Though the B&O tax applies directly to hospitals' gross income, the source of that gross income are individuals and entities that pay hospitals for their personal and professional services. The Massachusetts Department of Health assesses a surcharge from qualifying private individuals and entities, which it



- WSHIP assessment — the WSHIP is a nonprofit health plan providing health benefits to Washington residents denied coverage because of their medical status or unable to obtain comprehensive coverage.¹⁴ “All Disability Carriers, Health Care Service Contractors, and Health Maintenance Organizations licensed under Title 48 RCW that sell health and/or stop-loss¹⁵ coverage in Washington are Members of the Pool... Carriers that exclusively offer only life or dental products are not Members. Insured multiple-employer welfare associations are Members, but Employee Retirement Income Security Act (ERISA) groups are not. (Note: RCW 48.41. provides that the term “Member” shall be expanded to include ERISA groups at such time as permitted by federal law.) The State of Washington’s self-insured Uniform Medical Plan (UMP) is also a Member. The UMP and Members that provide stop-loss insurance are assessed at a rate 1/10 of what other carriers pay per fully-insured covered life.”¹⁶ Currently, the only use of WSHIP assessment revenue is to cover excess WSHIP enrollee medical claim costs. Financing the PAL program from this source would likely result in an increase in the assessment.

Receipt and Disbursement of Funds

HCA would receive both funding from an existing revenue source and the standard Medicaid funding for the PAL program in its operating budget appropriation. With these state and federal funds, HCA would pay Seattle Children’s Hospital and the University of Washington for the PAL program services through HCA’s Medicaid Administration. Apple Health MCOs would not make a separate payment to Seattle Children’s Hospital or to the University of Washington for any PAL services their enrolled members might have received.

Funding Approach 2: Assessment Per Enrolled Child

Under this approach, HCA would use:

- Revenue from a per-covered-life (child) assessment — which the Legislature would create and apply to commercial health insurance carriers, TPAs, and private fully-insured health plans — to pay for the proportion of the PAL program that is not eligible for federal Medicaid reimbursement; and
- Standard Medicaid funding to pay for the proportion of the PAL program that is eligible for federal Medicaid reimbursement.

calculates based on certain payments those qualifying individuals and entities make to Massachusetts acute hospitals and ambulatory surgical centers. This surcharge is in addition to the surcharge that Massachusetts uses to pay for its Pediatric Immunization Program. See “104 CMR: Department of Health, 30.08 Massachusetts Child Psychiatry Access Program Assessment”, <<https://www.mass.gov/files/documents/2018/02/26/104cmr30.pdf>>, accessed on September 4, 2018.

¹⁴ See *2017 ANNUAL REPORT Washington State Health Insurance Pool*, PDF page 4, <<http://wship.org/Docs/2017%20WSHIP%20AR%20-%20FINAL.pdf>>, accessed on October 10, 2018.

¹⁵ Stop-loss coverage is insurance that is purchased by self-insured entities for medical claim costs beyond a specified per-individual level. See *2017 ANNUAL REPORT Washington State Health Insurance Pool*, page 4, <<http://wship.org/Docs/2017%20WSHIP%20AR%20-%20FINAL.pdf>>, accessed on October 10, 2018.

¹⁶ See *2017 ANNUAL REPORT Washington State Health Insurance Pool*, page 4, <<http://wship.org/Docs/2017%20WSHIP%20AR%20-%20FINAL.pdf>>, accessed on October 10, 2018.

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After the Legislature creates the per-covered-child assessment, HCA would require the ability to contract with a vendor, which would calculate and collect the cost-share of the PAL program. The cost-share would be proportional to the number of children enrolled in commercial health insurance plans, TPA plans, private fully-insured health plans, and Apple Health plans. HCA would require additional staffing to manage the contract with the vendor.

Sources of Alternative Funds

HCA's vendor would apply the per-covered-child assessment to health insurance carriers, TPAs as plan administrators, and private fully-insured health plans and manage the associated collection process. This funding method is similar to the method the Washington Vaccine Association uses to help fund the Washington State Childhood Vaccine Program's purchase of vaccines.¹⁷

Receipt and Disbursement of Funds

HCA would receive the per-covered-child assessment revenue payments from the vendor. HCA would then combine that revenue with the standard Medicaid funds from HCA's operating budget appropriation to pay both Seattle Children's Hospital and the University of Washington for the PAL program services through HCA's Medicaid Administration. Apple Health MCOs would not make a separate payment to Seattle Children's Hospital or to the University of Washington for any PAL services their enrolled members might have received.

Involving a Governing Board

While developing alternative funding approaches, HCA considered the Washington Vaccine Association funding model, which includes a fully-authorized, independent governing board that the Legislature authorized to oversee the Washington Vaccine Association's method to help fund the purchase of vaccines.¹⁸ If the Legislature created a similar board that would work with HCA to assist in the administration of either of the above alternative funding approaches, HCA assumes the board would have the following membership and duties. HCA would require additional staffing to support the board.

¹⁷ The Washington Vaccine Association applies a per-dosage assessment on commercial health insurance carriers, TPAs, and private fully-insured health plans; while HCA would contract with a vendor to apply a per-covered-child assessment. See "Washington Vaccine Association: About Us", <<http://www.wavaccine.org/wavaccine.nsf/pages/about-us.html>>, "Chapter 70.290 RCW Washington Vaccine Association", <<http://app.leg.wa.gov/RCW/default.aspx?cite=70.290>>, and "Childhood Vaccine Program", <<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Immunization/ChildhoodVaccineProgram>>, each accessed on September 4, 2018.

¹⁸ See RCW 70.290.030 "Composition of association—Board of directors—Duties." <<http://app.leg.wa.gov/RCW/default.aspx?cite=70.290.030>>, accessed on September 4, 2018.



Board Membership

The board would include both voting and non-voting members. Voting members would include individuals representing HCA, private fully insured health plans, and TPAs that contribute financially to the alternative funding approach. Non-voting members would include individuals representing Seattle Children’s Hospital and the University of Washington.

Board Duties

With either alternative funding approach, the board would:

- Advise HCA on aspects of the contacts between HCA and both Seattle Children’s Hospital and the University of Washington to provide the PAL services;
- Promote the PAL services to health care providers; and
- Review the PAL services’ outcome and program evaluation measures.

If the per-covered-child assessment funds the program, then HCA would not contract with a vendor to calculate and collect the assessment. Rather, the board would contract with the vendor, and HCA would require additional administrative support to both support the board and manage the contract with the vendor.

Core Implementation Requirements

With or without a governing board, HCA identifies the following core implementation requirements.

Timing and Review of the Alternative Funding Approach

HCA will launch the two-year program pilot for expanded PAL services in January 2019 with a combination of funding from an existing revenue source and standard Medicaid funding (both General Fund—State and General Fund—Federal Medicaid Title XIX funding), totaling \$385,000 for the second-half of state fiscal year (SFY) 2019.

Assuming the Legislature will continue funding the expanded PAL services through the end of the program pilot and afterwards, HCA would implement the alternative funding approach on January 1, 2021. At the conclusion of each year, HCA would compare the PAL program cost-split to the estimated proportion of PAL services benefitting members of Apple Health and non-Apple Health plans. Following each annual review, HCA would adjust the mechanism of the funding approach as needed to ensure an appropriate cost-split.

PAL Program Evaluation

For either funding approach, HCA would contract a vendor to evaluate the effectiveness of the current and expanded PAL program services. The vendor would design the evaluation, define any additional PAL program reporting requirements beyond those that SSB 6452 requires, perform the evaluation, and report the results.



HCA Contracts

For either funding approach, HCA would contract separately with both Seattle Children's Hospital and the University of Washington to provide PAL services. In each contract, HCA would also require Seattle Children's Hospital and the University of Washington to collect data, per SSB 6452 and any additional program evaluation requirements, and report that data to HCA.

For the alternative funding approach that includes a per-covered-child assessment, HCA would contract with a vendor to define and manage the assessment.

Recommendations

In collaboration with the alternative funding model work group and the non-duplication strategy work group, HCA developed the following recommendations.

Alternative Funding Approach Recommendation

HCA recommends that the Legislature authorize HCA to initially use Alternative Funding Approach 1 by appropriating funding from an existing revenue source to HCA to pay for the proportion of the PAL program that is not eligible for federal Medicaid reimbursement. HCA will combine that funding with standard Medicaid funding to pay Seattle Children's Hospital and the University of Washington for PAL services through HCA's Medicaid Administration.

Apple Health MCOs would not make a separate payment to Seattle Children's Hospital or to the University of Washington for any PAL services their enrolled members might have received.

HCA will administer this alternative funding approach without involving a governing board.

Assuming legislative funding and authorization, this funding model will begin on January 1, 2021. HCA will initially calculate the proportion of the PAL program that is eligible for federal Medicaid reimbursement by referencing the ratio between populations in Apple Health enrollment and OFM population data. This funding model approach enables the Legislature, HCA, the Office of the Insurance Commissioner, and other members of the convened work group to:

- Review the results of the funding model and determine if additional infrastructure of a board and/or a per-covered-child assessment is warranted; and
- Have sufficient time to vet the possibility of applying a per-covered-child assessment in the context of the Employee Retirement Income Security Act (ERISA) legal requirements.¹⁹

HCA will contract with a vendor to evaluate the effectiveness of the current and expanded PAL program services. HCA will contract separately with both Seattle Children's Hospital and the University of Washington to provide PAL services. In each contract, HCA will also require Seattle

¹⁹ The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See: "Health Plans & Benefits", <<https://www.dol.gov/general/topic/health-plans/erisa>>, accessed on September 4, 2018.



Children’s Hospital and the University of Washington to collect data, per SSB 6452 and any additional program evaluation requirements, and report that data to HCA. HCA’s contract with Seattle Children’s Hospital will require the components of the non-duplication strategy. (Note: See below for a description of the non-duplication strategy.)

At the conclusion of each year, HCA would compare the PAL program cost-split to the estimated proportion of PAL services benefitting members of Apple Health and non-Apple Health plans. Following each annual review, HCA would adjust the mechanism of the funding approach as needed to ensure an appropriate cost-split.

Non-Duplication Care Coordination Process

Federal law prohibits Medicaid to use federal dollars to pay two different providers for the same service. This is referred to as “duplication of payment.” HCA uses federal and state funds to pay the per-member per-month premium to its MCOs. Care coordination services are a deliverable for this payment in the MCO contracts. HCA also uses federal match funds to pay for the services being delivered under the scope of the PAL for Kids contract, which would now include care coordination services. Using federal dollars to pay both of these entities to provide care coordination services would be deemed a “duplication of payment” by the Centers for Medicare and Medicaid Services (CMS). Therefore, HCA convened a work group of representatives from Seattle Children’s Medical Center PAL for Kids program and Apple Health MCO care coordination staff to design a process that would:

- Ensure non-duplication of services between Seattle Children’s Hospital and Apple Health MCOs; and
- Provide a “no wrong door” approach to assisting families in connecting their children to behavioral health providers for services.

After PAL for Kids staff receive a call for referral assistance for a child enrolled in one of the MCO plans, Seattle Children’s Hospital will send a letter to the primary care provider, the family, and the child’s MCO. The letter will include:

- The names and contact information of at least two available behavioral health treatment providers;
- A message to the family that the PAL for Kids program is notifying the child’s MCO about the request for assistance, and that the MCO may call the family to help with:
 - Assuring the child accesses services through one of these providers;
 - Offering assistance to connect the child with a different provider; and
 - Providing any other related services.

PAL for Kids staff will follow-up with the caller to determine whether the child accessed services through the referral. This will provide useful feedback about the outcome of their intervention and MCO referral.



After the MCO receives the letter from the PAL for Kids program, the MCO will call the family to determine whether:

- The child has accessed services through one of the behavioral health treatment providers that PAL for Kids offered;
- The family needs assistance by the MCO to secure access with the treatment provider; and
- The family needs any additional services (e.g., durable medical equipment, therapy services, etc.).

The MCO will add the child to the case management list as needed. The MCO will also:

- Ensure the child’s primary care provider is informed about the status of the child’s treatment; and
- Follow up with the behavioral health treatment provider to:
 - Ensure the child had the appointment; and
 - Identify what additional services the child might need, as identified by the provider in that appointment.

Moving forward, the MCO will continue to assure the child receives services, per the treatment plan.

Proposed Plan to Implement Recommendations

In this section, HCA proposes implementation tasks and estimated financial impact to implement the recommendations.

Appendix G includes more detailed implementation information about the recommended and non-recommended alternative funding models, both involving and not involving a governing board.

Implementation Tasks

Prior to launching the expanded PAL services on January 1, 2019, HCA will need to complete the following tasks, collaborating with partner organizations as needed:

- Design non-duplication policies, procedures, and materials for the PAL for Kids pilot program;
- Define data collection, reporting, and future program evaluation requirements for the current and expanded PAL services; and
- Sign professional services contracts with Seattle Children’s Hospital and the University of Washington for the first year of the PAL for Moms and Kids pilot program.

For HCA to have the resources to implement the alternative funding model and related recommendations, the Legislature will need to appropriate sufficient funding for the SFY 2020–2021 and the SFY 2022–2023 biennia.



After the Legislature appropriates the funding, HCA will contract with a vendor to perform the evaluation of the current and expanded PAL program and report the results to the Legislature annually.

Estimated Financial Impact

HCA estimates the following financial impact from implementing the alternative funding model recommendation, based on the following data:

- OFM statewide population forecasts;
- Caseload Forecast Council population forecasts for relevant Apple Health caseloads;
- Current PAL program contract costs;
- Expanded PAL services cost estimates in the fiscal note for SSB 6452;
- Program evaluation contract cost estimates; and the
- Standard Medicaid reimbursement rate of 50 percent for eligible expenses from the General Fund (GF)—State fund.

At the time HCA writes this report, caseload forecasts only extend through the end of SFY 2021. For the purposes of this estimated financial impact analysis, we assume zero caseload population growth and zero contract cost increases between SFY 2021 and SFY 2022. As the expanded PAL services become more established and demand for those services potentially grows, we assume that any need for contract cost increases will result in a supplemental budget request. While the implementation timeline extends through SFY 2023, our financial analysis only extends through SFY 2022.

Table 1: Estimated Cash Receipts (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—Federal Medicaid Title XIX	\$434,550	\$561,990	\$601,172	\$409,113
TOTAL	\$434,550	\$561,990	\$601,172	\$409,113

Estimated cash receipts from Medicaid reimbursement is highest at \$601,172 during SFY 2021. (See Table 1.) There is a higher Medicaid reimbursement amount for the first half of the fiscal year (July 2020 through December 2020) than during the second half of the fiscal year (January 2021 through June 2021). This is because the alternative funding model takes effect on January 1, 2021.

Table 2: Estimated Expenditures (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—State	\$719,450	\$1,430,010	\$1,440,828	\$1,532,887
GF—Federal Medicaid Title XIX	\$434,550	\$561,990	\$601,172	\$409,113
TOTAL	\$1,154,000	\$1,992,000	\$2,042,000	\$1,942,000



Total estimated expenditures are lowest in SFY 2019 because:

- The contracts for the PAL for Moms and Kids pilot program begin during the second half of the fiscal year (January 2019 through June 2019); and
- The contract for the program evaluation begins during SFY 2020 and concludes in SFY 2021. (See Table 2.)

HCA assumes the contract costs will remain stable through SFY 2022, though the cost-split between GF—State and GF—Federal Medicaid Title XIX will vary due to the alternative funding model implementation.

Table 3: Estimated Full-Time Equivalents (FTEs)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
FTEs	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0

HCA's assumes that we will not require any additional FTEs to implement the recommended funding model. (See Table 3.)

Appendix H includes details for the financial impact estimates for HCA's recommended funding model, as well as the non-recommended options.

Conclusion

Our goal is for children, pregnant women, and new mothers with behavioral health treatment needs to receive expert care. The Legislature has responded to this need by expanding the current PAL program to include the PAL for Moms and Kids pilot program at Seattle Children's Hospital and the University of Washington. Both the current and expanded PAL program services will support clinicians' efforts to provide evidence-based behavioral health services and increase access for individuals and families seeking assistance with behavioral health challenges.

In compliance with SSB 6452, HCA convened work groups to develop recommendations that will:

- Enable the Legislature to ensure the sustainability of the PAL program funding; and
- Strengthen the coordination between the PAL for Kids pilot program at Seattle Children's Hospital and existing Apple Health MCO care coordination efforts.

The alternative funding model work group decided to recommend an approach that uses funding from an existing revenue source to pay for the proportion of the current and expanded PAL services that are not Medicaid reimbursable, without including a governing board. This approach uses an existing method of taxation or assessment and collection.



We recognize the following benefits to using funding from an existing revenue source as the alternative funding model instead of a per-covered-child assessment and/or including a governing board:

- It is a simpler, more cost-effective method to administer the funds for the current and expanded PAL services;
- While the expanded PAL services become more established and demand for those services potentially grows, we will have time to explore the need to build additional infrastructure (such as a per-covered-child assessment and/or involving a governing board) to support the program; and
- It avoids creating potentially unnecessary administrative infrastructure prior to the Legislature deciding whether to continue funding the expanded PAL services beyond the program pilot period.

The non-duplication strategy work group produced a care coordination model that provides a “no wrong door” approach to assisting families in connecting their children to behavioral health providers for services. Shortly after drafting the model, CMS approved it and acknowledged that it satisfies the federal requirement of not paying for duplicative services using federal funds.

While HCA is already preparing to implement the non-duplication strategy by the time the PAL for Kids service begins on January 1, 2019, HCA awaits the Legislature’s decision about the alternative funding model recommendation. In the meantime, HCA will continue to partner with members of the convened work groups to successfully implement the PAL for Moms and Kids pilot program.



Appendix A: Convened Work Groups

HCA convened two separate work groups during our process to develop recommendations for this report: (1) an alternative funding model work group; and (2) a non-duplication strategy work group.

Alternative Funding Model Work Group

HCA convened and participated in a work group to determine a recommendation for an alternative funding approach for the PAL program between June 2018 and August 2018.

Work Group Members

HCA included representatives from the following organizations as members of the alternative funding model work group:

- University of Washington;
- Seattle Children’s Hospital;
- Apple Health MCOs, including:
 - Amerigroup Washington,
 - Community Health Plan of Washington,
 - Coordinated Care of Washington,
 - Molina Healthcare of Washington, and
 - United Health Care Community Plan;
- Organizations connecting families to children's mental health services and providers, including:
 - Washington Chapter of the American Academy of Pediatrics, and
 - Partners for Our Children;
- Health insurance carriers, as defined in RCW 48.44.010, and identified by the Association of Washington Healthcare Plans, including:
 - Aetna Health Insurance,
 - Centene Corporation,
 - Cigna HealthCare,
 - Kaiser Foundation Health Plan,
 - Premera Blue Cross; and
- Washington State Office of the Insurance Commissioner.

The work group also included representatives from the following organizations:

- Association of Washington Healthcare Plans;
- Washington State Governor’s Office;
- Washington State House of Representatives; and
- Washington State Department of Health.



Work Group Process

HCA convened three alternative funding model work group meetings that were open to the public and occurred at HCA's main building.²⁰ We also provided the option for members and other guests to participate via webinar.

During the work group's meeting on June 15, 2018, HCA staff and other presenters:

- Outlined the legislative requirements of SSB 6452;
- Gave examples of other funding models in Pennsylvania, Massachusetts, and Washington State;
- Explained the timeline for the PAL alternative funding model recommendation process; and
- Requested suggestions and other feedback from work group members related to the alternative funding model.

During the work group's meeting on August 3, 2018, HCA staff and other presenters:

- Gave an overview of current and expanded PAL services;
- Led a discussion about PAL alternative funding models that incorporated suggestions and other feedback HCA received from work group members after the meeting on June 15, 2018;
- Briefly discussed the non-duplication recommendation that the non-duplication strategy work group produced. (Note: See below for a description of the non-duplication strategy.)

During the work group's meeting on August 24, 2018, HCA staff:

- Gave an overview of alternative funding model and administrative options (displayed in a matrix) and described some implementation components for each;
- Led a discussion about the options presented within the matrix — during which, work group members stated their preferences about which alternative funding model and administrative option they preferred;
- Discussed next steps for the non-duplication strategy implementation and the legislative report submission process.

The preferences that the work group members expressed during their last meeting were to:

- Use existing General Fund—State revenue and not increase tax rates to pay for the proportion of the PAL program that is not eligible for federal Medicaid reimbursement; and
- Ensure a simple, cost-effective administration of the alternative funding model that does not include a governing board — at least not prior to the conclusion of the “PAL for Moms and Kids” pilots.

After these meetings, HCA drafted this report, distributed the draft to the members of the alternative funding model work group, and processed their feedback prior to finalizing this report.

²⁰ HCA's main building is located at: Cherry Street Plaza, 626 8th Avenue SE, Olympia, WA 98501.
Partnership Access Line
December 1, 2018



Appendices B through D include materials from the three alternative funding model group meetings, and Appendix E includes written suggestions and other feedback HCA received from work group members.

Non-Duplication Strategy Work Group

HCA convened and participated in a work group to determine a recommendation for a strategy to ensure that the services of Seattle Children's Hospital's PAL for Kids referral line do not duplicate existing requirements for Apple Health MCOs as required by RCW 74.09.492.

Work Group Members

HCA included representatives from the following organizations as members of the non-duplication strategy work group, which HCA convened separately as a part of the alternative funding model work group:

- Seattle Children's Hospital;
- Apple Health MCOs, including:
 - Amerigroup Washington,
 - Community Health Plan of Washington,
 - Coordinated Care of Washington,
 - Molina Healthcare of Washington, and
 - United Health Care Community Plan;

Work Group Process

HCA convened one non-duplication strategy work group meeting that was open to the public and occurred at HCA's main building. We also provided the option for members and other guests to participate via webinar.

During the work group's meeting on July 2, 2018, HCA staff and other presenters:

- Reviewed SSB 6452;
- Presented information about the PAL case management and referral program at Seattle Children's Hospital;
- Discussed a case management and referral model that the Massachusetts Child Psychiatry Access Program (analogous to PAL) uses;
- Discussed the Apple Health MCO case management program, as defined in HCA's contracts with the MCOs; and
- Worked collaboratively with work group members to develop a recommendation for a non-duplication strategy.

After this meeting, HCA presented the non-duplication strategy to the Centers for Medicare and Medicaid (CMS). CMS approved HCA's strategy to avoid duplication of services.

Appendix F includes materials from the non-duplication strategy work group meeting on July 2, 2018.

Partnership Access Line
December 1, 2018



Appendix B: Alternative Funding Model Work Group Meeting Materials for June 15, 2018

This appendix contains materials from the PAL alternative funding model work group meeting that occurred on June 15, 2018, including: the agenda, meeting summary, and PowerPoint presentation.



Meeting Agenda



Partnership Access Line (PAL) Alternative Funding Model Recommendation Process Convened Workgroup Meeting #1

Friday, 6/15/2018, 3:00-4:30 p.m.
 Cherry Street Plaza
 626 8th Ave. SE, Olympia, WA 98501
 1 Floor - Sue Crystal 106A & 106B
 (GoToWebinar Registration Available)

Attendees:					
<input type="checkbox"/>	Health Care Authority (HCA)	<input type="checkbox"/>	Department of Health (DOH)	<input type="checkbox"/>	Office of Insurance Commissioner (OIC)
<input type="checkbox"/>	Seattle Children's Hospital (SCH)	<input type="checkbox"/>	University of Washington (UW)	<input type="checkbox"/>	Medicaid Managed Care Organizations (MCOs)
<input type="checkbox"/>	Health Insurance Carriers, per RCW 48.44.010	<input type="checkbox"/>	Organizations connecting families to children's mental health services and providers		
Main Outcome: Clarify the workgroup's tasks, process timeline, and next steps					

No	Agenda Items	Time	Lead	Summary Meeting Notes
1.	Welcome and Introductions	10 min	MaryAnne Lindeblad, HCA	
2.	SSB 6452 Legislative Requirements	15 min	Mary Fliss, HCA / All	
3.	Examples of Other Models: <ul style="list-style-type: none"> • Pennsylvania • Massachusetts • Washington Vaccines 	30 min	Dean Runolfson, HCA / Dr. Robert Hilt, SCH / SheAnne Allen, DOH	
4.	Timeline for the PAL Alternative Funding Model Recommendation Process	15 min	Dean Runolfson, HCA	
5.	PAL Alternative Funding Model Suggested Options	15 min	Dean Runolfson, HCA	
6.	Next Steps and Wrap-Up	5 min	Mary Fliss, HCA	

Action Items/Decisions					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status

Meeting Summary



PAL Alternative Funding Model Convening

Summary of Meeting

June 15, 2018

Purpose

The purpose of this meeting is per the requirements in Section 1 of SSB 6452 to discuss recommendations for the Partnership Access Line (PAL) alternative funding model process.

1. Agenda:

- Welcome
- SSB 6452 Legislative Requirements
- Example of Other Models
- Timeline for the PAL Alternative Funding Model Recommendation Process
- PAL Alternative Funding Model Suggested Options
- Next Steps and Wrap-up

2. SSB 6452 Legislative Requirements

- In the last legislative session, SSB 6452 passed. It has three basic requirements, listed below:
 1. Contract for Partnership Access Line (PAL) expanded services beginning in January 2019.
 - HCA will be contracting with the University of Washington and Seattle Children's hospital on two new services: PALs Mom related to maternal depression and PALs Kids referral line. A two year pilot project for these services as outlined in the bill on page 4.
 - University of Washington will administer PAL for Moms.
 - Seattle Children's Hospital will administer the PAL for Kids.
 2. Develop a funding model recommendation that assesses the costs of current and expanded PAL services across Washington health insurers.
 - This workgroup has been convened to create a plan for the funding model. The plan must include the current PAL service for primary care providers, the new service for depression in pregnant and new moms as well as referral services for children's mental health services.
 - Plan is due to the legislature by December 1, 2018
 3. Assure no duplication with existing Medicaid Managed Care Organization (MCO) requirements.
- The scope of work as outlined in section one of SSB 6542 states that all three aspects of PAL will be included in this work: the current PAL line, the expansion for depression in pregnant women & new mothers, and the expansion to include referrals.



3. Examples of Other Models:

- Pennsylvania: Telephonic Psychiatric Consultation Service
 - This program is similar to PAL in that it has the consultation for primary care providers for children’s mental health, mental health treatment referrals for children, and peer resources. The difference is that it does not provide services for maternal depression and is Medicaid only.
 - They funded their model by increasing the capitation for each of their 8 MCO’s. Based on the cost of the program and how many children are enrolled. It is broken out into regions and the state contracts with 3 institutions to run the program.
- Massachusetts: Child Psychiatry Access Program
 - Provides the same kind of services that Washington State’s legislature wants to include: consultation for both children’s mental health and maternal depression, and mental health treatment referrals for children.
 - It’s funded by using the universal vaccine mechanism to apply a surcharge to public and private insurers, proportional to the outpatient visits. This enables them to cover all insurance carriers. This is tracked annually to compare the ratio of outpatient visits with those called into the program.
 - Overall, this program is more robustly funded and has more staffing hours to each of their regions. They also have many years in consult access and referral access. They went through a process of how to share the cost for this program.
 - According to Massachusetts state law 104.30.08(3)(d), the allocation method is based on actual expenditures from the previous fiscal year. (See <https://www.mass.gov/law-library/104-cmr> and select “104 CMR 30.00 Fiscal Administration” and navigate to 30.08: Massachusetts Child Psychiatry Access Program Assessment).
 - It’s important that we make our Medicaid, Managed Care, and commercial plans aware of this service and that this is incredibly popular with providers in having real-time access to psychiatrists. In addition, it results in more timely access to effective treatment and more appropriate medications. In some cases, reduction in medication.
- Washington Vaccines: Childhood Vaccine Program
 - Washington State Department of Health Contracts with the Washington Vaccine Association (WVA).
 - Washington is universal state, which means we provide all vaccines for all kids under the age of 19. We serve approximately 1100 providers/offices and offer approximately 3.5 million doses of vaccines a year.
 - Between state and federal funds, Washington spends \$165 million total.
 - Washington Vaccine Association pays approximately 40% of the vaccines. Federal funds pay for 58% of vaccines and state-funded health insurance programs pay for 2% of vaccines.

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- WVA uses a dose-based assessment method to collect funds from health insurance carriers and third party administrators for the cost of the vaccines. Then the provider gets reimbursed for the administration charge.

4. Timeline for the PAL Alternative Funding Model Recommendation Process

- HCA is requesting this workgroup to provide suggestions and thoughts regarding the funding model by June 28th.
- In July, HCA will use the feedback to create the first drafted recommendation. It will include the funding model and the non-duplication with the Medicaid MCO's.
- HCA will meet with the MCO's and institutions providing those services to work out the details.
- The first draft will be sent to this group by July 27 to review in advance of the next meeting on August 3. At that meeting, the group will discuss any additional suggestions or feedback. HCA will take those recommendations to make revisions.
- The second draft will be sent to the group to review in advance of this workgroup's third meeting on August 24. After this meeting, the recommendations will be finalized through internal review before it is submitted to the Office of Management and Budget and Legislature.
- For further details on the timeline, please refer to the PowerPoint Presentation from June 15.
- The PAL program receives more than 1,500 calls per year, averaging more than 125 calls per month. The PAL tends to get fewer calls between July and September compared to the rest of the year. According to the data PAL staff collect from primary care providers during their call about their patients' insurance coverage, about half of the calls are about kids covered by Medicaid. However, the PAL does not verify the kids' insurance data.

5. PAL Alternative Funding Model Suggested Options

- HCA will email this group the form to fill out with recommendations and suggestions. Members are welcome to forward the form to anyone outside of this workgroup who might be able to provide helpful suggestions.
- Please respond by Thursday, June 28 to PALFundingModel@hca.wa.gov.
- As we're building this pilot to start January 1, 2019, this funding model assist in determining what kind of infrastructure is needed for this plan. In addition, working with the MCO's as we develop the documentation and tracking.
- For those interested in receiving the other PowerPoint presentations from Dr. Hilt's group with more information regarding PAL, please send your request to the above email. Plans can also find more information about PAL at www.seattlechildrens.org/PAL.

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PowerPoint Presentation



Partnership Access Line (PAL) Alternative Funding Model Recommendation Process Convened Workgroup Meeting #1



Agenda

- Welcome and Introductions
- SSB 6452 Legislative Requirements
- Examples of Other Models:
 - Pennsylvania
 - Massachusetts
 - Washington Vaccines
- Timeline for the PAL Alternative Funding Model Recommendation Process
- PAL Alternative Funding Model Suggested Options
- Next Steps and Wrap-Up

2

SSB 6452 Legislative Requirements: Overview

- Contract for Partnership Access Line (PAL) expanded services beginning in Jan. 2019
- Develop a funding model recommendation that assesses the costs of current and expanded PAL services across Washington health insurers
- Assure no duplication with existing Medicaid Managed Care Organization (MCO) requirements

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SSB 6452 Legislative Requirements: Expanded PAL Services

- Expand services will include the two-year pilot program “PAL for Moms and Kids” with two parts:
- University of Washington (UW) will administer PAL for Moms; existing service is grant-funded:
 - Consultation services to primary care providers treating depression in pregnant women and new mothers
 - Fiscal note budget is about \$121k in Jan. 2019-Jun. 2019 and projected to be about \$393k in Jul. 2019-Jun. 2020

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SSB 6452 Legislative Requirements: Expanded PAL Services

- Seattle Children's Hospital (SCH) will administer the PAL for Kids:
 - Referrals to children's mental health services and other resources for parents and guardians with concerns related to their child's mental health
 - Fiscal note budget is about \$264k in Jan. 2019-Jun. 2019 and projected to be about \$780k in Jul. 2019-Jun. 2020

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SSB 6452 Legislative Requirements: Current PAL Services

- Since 2008, Health Care Authority has contracted with SCH to deliver current Partnership Access Line (PAL) services: child psychiatric consultation, education, and website
 - Current annual contract budget is about \$812k
 - Seattle Children's Hospital estimates that about 51% of consultations are about Medicaid children and about 49% of consultations are about children with other or unknown insurance coverage

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SSB 6452 Legislative Requirements: Funding Model Plan

- Recommend a plan to the Legislature and Children’s Mental Health Work Group by Dec. 1, 2018 that:
 - Includes an alternative funding model for current and expanded PAL services
 - Considers a mechanism that determines the annual cost of operating the PAL and collects a proportional share of the program cost from each health insurance carrier

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SSB 6452 Legislative Requirements: Non-Duplication

- Recommend a strategy to ensure that expanded PAL services do not duplicate existing MCO requirements codified in [RCW 74.09.492](#)

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Examples of Other Models

- Pennsylvania: Telephonic Psychiatric Consultation Service
- Massachusetts: Child Psychiatry Access Program
- Washington: Childhood Vaccine Program

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Examples of Other Models: Pennsylvania

- [Telephonic Psychiatric Consultation Service \(TiPS\)](#)
- Provides similar statewide services that will be in PAL: consultation for primary care providers for children's mental health, mental health treatment referrals for children, and peer resources
- Does not provide services for maternal depression
- Serves only Medicaid clients

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Examples of Other Models: Pennsylvania

- Increased the capitation for each of their 8 MCOs, proportional to number of kids in each MCO and the TiPS program costs
- The MCOs cooperatively contract with 3 institutions that cover separate regions of the state to run the TiPS program

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Examples of Other Models: Massachusetts

- [Massachusetts Child Psychiatry Access Program \(MCPAP\)](#)
- Provides same statewide services that will be in PAL: consultation for primary care providers for both children's mental health and maternal depression, and mental health treatment referrals for children
- Serves all insurance types: about 44% Medicaid and 56% other sources of coverage

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Examples of Other Models: Massachusetts

- Uses universal vaccine mechanism (similar to Washington's Child Vaccine Program) to apply surcharge to public and private insurers, proportional to outpatient visits and the MCPAP program costs
- Annually track the proportion of calls for each insurer to compare to proportion of outpatient visits; very close

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Examples of Other Models: Washington Vaccines

- Washington State [Childhood Vaccine Program](#)
 - Washington State Department of Health contracts with the [Washington Vaccine Association](#) (WVA)
 - Universal coverage: all vaccines for all kids under age 19
 - About \$165 million in state and federal funds purchase 3.5 million doses of vaccine, administered in about 1,100 active clinic offices

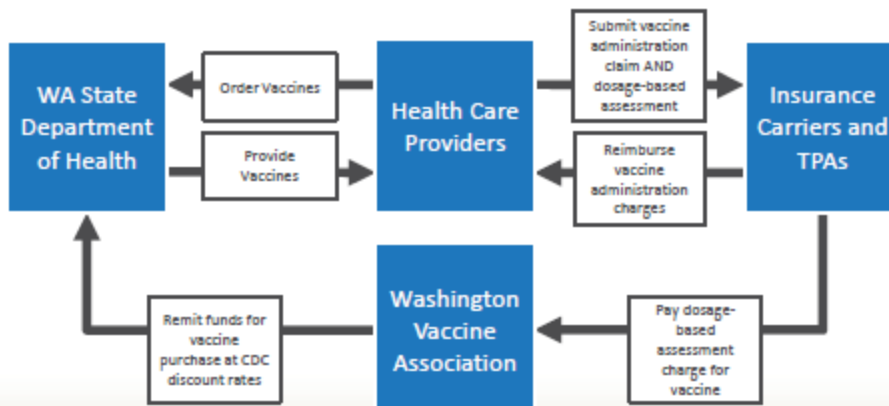
14

Examples of Other Models: Washington Vaccines

- WVA uses a dosage-based assessment method to collect funds from health insurance carriers and third-party administrators (TPAs) for the cost of vaccines in the Childhood Vaccine Program
 - Apple Health (Medicaid) remits payment directly to the Department of Health

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Examples of Other Models: Washington Vaccines Dosage-Based Assessment Methodology



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Timeline for the PAL Alternative Funding Model Recommendation Process

DATE	TASK
6/15/2018	Convened Workgroup Meeting #1: clarify the tasks, process timeline, and next steps
6/28/2018	Suggestions for funding each PAL service due
July 2018	Develop and draft recommendation for funding and non-duplication* *Meeting with HCA, MCOs, SCH, and UW
7/27/2018	Send first draft recommendation to Workgroup for review
8/3/2018	Convened Workgroup Meeting #2: review first draft recommendation

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Timeline for the PAL Alternative Funding Model Recommendation Process

DATE	TASK
August 2018	Revise the draft recommendation
8/17/2018	Send second draft recommendation to Workgroup for review
8/24/2018	Convened Workgroup Meeting #3: review second draft recommendation
9/7/2018	Submit the final recommendation to HCA Legislative Affairs and Analysis
10/26/2018	Submit to the Office of Management and Budget (OFM)
11/30/2018	Submit to the Legislature

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PAL Alternative Funding Model Suggested Options

- Form to enter suggestions for the funding model:
 - Recommended funding model must agree with requirements in [SSB 6542](#)
- By Thursday, Jun. 28, 2018, please email suggestions to: PALFundingModel@hca.wa.gov
- Discuss current suggestions (time permitting)

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Next Steps and Wrap-Up

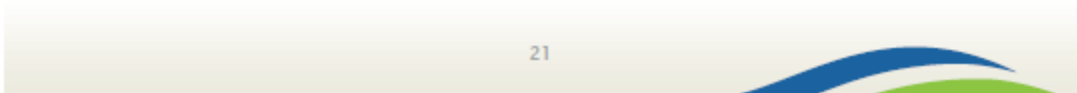
- Email funding model suggestions form
- Consider emailed suggestions and work with the OIC on the draft funding recommendation
- Work with Medicaid MCOs on the draft non-duplication recommendation
- Email the draft recommendation before our next convened workgroup meeting on Aug. 3, 2018

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Next Steps and Wrap-Up

THANK YOU!



Appendix C: Alternative Funding Model Work Group Meeting Materials for August 3, 2018

This appendix contains materials from the PAL alternative funding model work group meeting that occurred on August 3, 2018, including: the agenda, meeting summary, PowerPoint presentations, and draft PAL alternative funding approaches and non-duplication strategy.



Meeting Agenda



Partnership Access Line (PAL) Alternative Funding Model Recommendation Process Convened Workgroup Meeting #2

Friday, 8/3/2018, 3:00-4:00 p.m.
 Cherry Street Plaza
 626 8th Ave. SE, Olympia, WA 98501
 1 Floor - Sue Crystal 106A & 106B
 (GoToWebinar Registration Available)

Attendees:					
<input type="checkbox"/>	Health Care Authority (HCA)	<input type="checkbox"/>	Department of Health (DOH)	<input type="checkbox"/>	Office of Insurance Commissioner (OIC)
<input type="checkbox"/>	Seattle Children's Hospital (SCH)	<input type="checkbox"/>	University of Washington (UW)	<input type="checkbox"/>	Medicaid Managed Care Organizations (MCOs)
<input type="checkbox"/>	Health Insurance Carriers, per RCW 48.44.010	<input type="checkbox"/>	Organizations connecting families to children's mental health services and providers		
Main Outcome: Review the first draft of the recommendations for PAL services funding model and non-duplication					

No	Agenda Items	Time	Lead	Summary Meeting Notes
1.	Welcome and Introductions	5 min	Mary Fliss, HCA	
2.	Overview of Current PAL Services and "PAL for Kids" Referral Services at Seattle Children's Hospital	10 min	Rebecca Barclay, UW	
3.	Overview of "PAL for Moms" Services at University of Washington	10 min	Deborah Cowley, UW	
4.	Discuss PAL Alternative Funding Models	20 min	Mary Fliss, HCA Dean Runolfson, HCA	
5.	Discuss Non-Duplication Recommendation	10 min	Gail Kreiger, HCA	
6.	Next Steps and Wrap-Up	5 min	Mary Fliss, HCA	

Action Items/Decisions					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status

Meeting Summary



PAL Alternative Funding Model Convening

Summary of Meeting

August 3, 2018

Purpose

The purpose of this meeting is review the first draft of the recommendations for PAL services funding model and non-duplication.

1. Agenda:

- Welcome
- Overview of Current PAL Services and "PAL for Kids" Referral Services at Seattle Children's Hospital
- Overview of "PAL for Moms" Consultation Services at University of Washington
- Discuss PAL Alternative Funding Model
- Discuss Non-Duplication Recommendation
- Next Steps and Wrap-up

2. Overview of Current PAL Services and "PAL for Kids" Referral Services at Seattle Children's Hospital

- Dr. Rebecca Barclay presented an overview of PAL and its services.
- It is a child psychiatry consultation to primary care program that has been available in Washington since 2008. Primary care providers anywhere in the state can call to be connected to a child psychiatrist to get in the moment care recommendations for their patients.
- Seattle Children's Hospital has 10 child psychiatrists on staff and 3 are on the phones each day from 8 am to 5 pm. They have worked to prioritize live-answer and direct-connect to be as accessible as possible for providers. The day after the call, they send a secure fax or email to the providers outlining what they discussed, and attach a feedback form.
- The expansion program for PAL referral is planned for 2019.
- Dr. Hilt sent the articles on the evidence of the program that Seattle Children's published to Bridget, who forwarded that email out to all stakeholders during the meeting.
- In the past, when the PAL line received direct calls from family caregivers, they were informed that the PAL is a provider consultation line and encouraged to have their family member's provider call instead. The new process under the expanded plan will provide consultation to family caregivers as well as referring them to another provider.
- Please see the PowerPoint presentation titled "Partnership Access Line (PAL), a child psychiatry consultation to primary care program" for more details.

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3. Overview of “PAL for Moms” Consultation Services at University of Washington

- Dr. Deborah Cowley provided an overview of the program.
- This program is designed to enhance maternal functioning, prevent adverse pregnancy outcomes, and help improve bonding and attachment.
- PAL for Moms provides psychiatric consultation to healthcare providers caring for women with behavioral health needs during and shortly after pregnancy.
- The pilot program under this legislation will expand consultation hours, add staff, and integrate the service with PAL line from Seattle Children’s so there is collaboration in the outreach.
- There are currently 3 perinatal psychiatrists working on this consultation line from 3 -5 pm, and it has been donor funded since 2016.
- Approximately 85% of calls are about the safety of medications and treatments during pregnancy. They also provide resource information on non-pharmacological treatments.
- University of Washington’s user survey had a very high rate of satisfaction. In addition, the most common comment was that UW needs to do more to promote awareness about this consultation line.
- Please see the PowerPoint presentation titled “Partnership Access Line (PAL) for Moms” for more details.

4. Discuss PAL Alternative Funding Models

- The group reviewed and discussed the document titled: “Partnership Access Line (PAL) Alternative Funding Approaches and Non-Duplication Strategy.”
- Seattle Children’s Hospital and the University of Washington have developed evidence-based programs to support clinicians’ efforts to provide behavioral health services for children and youth.
- The HCA is required by SSB 6452 to recommend a plan to the Legislature by December 1, 2018 regarding an alternative funding model and a strategy to ensure non-duplication of services.
- Two funding approaches have been developed and outlined by HCA in the document being reviewed:
 1. Use of Current Assessments: exact funding source to be determined from within the General Fund – State. Examples include the health insurance premium tax or the business and occupation tax on hospitals.
 2. Assessment per Enrolled Child. This approach creates a new infrastructure for non-Medicaid and Medicaid parties to share the cost for these services. The cost-allocation method uses the proportion of children enrolled in Apple Health/Medicaid, fully-insured plans, self-insured plans, and third-party administrators (TPAs) to determine each entity’s share on a per-covered-life basis.
- Please see the document titled “Partnership Access Line (PAL) Alternative Funding Approaches and Non-Duplication Strategy” for more details.

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5. Discuss Non-Duplication Recommendation

- HCA contracts with Managed Care Organizations (MCO's) to provide case management services. The agency has to abide by a specific framework for federal regulations; which requires non-duplication of services.
- SSB 6452 includes services in the PAL for Kids referral service that is similar to the MCOs' case management services, and requires HCA to develop a strategy to avoid duplication of services.
- HCA representatives met with MCO representatives and their case managers, and with Dr. Hilt and his staff at Seattle Children's Hospital, to discuss how to design the PAL for Kids referral service and satisfy the non-duplication requirement. The group developed a solution, and CMS determined it met the non-duplication requirement.
- Please see pages 5 and 6 of the document titled: "Partnership Access Line (PAL) Alternative Funding Approaches and Non-Duplication Strategy" for more details.


6. Next Steps and Wrap-up

- As we continue to refine this model, HCA encourages stakeholders to provide any additional comments or suggestions by emailing our designated email address: PALFundingModel@hca.wa.gov.
- The next meeting is scheduled on August 24, when the group will review and discuss HCA's draft alternative funding plan.

pg. 3




PowerPoint Presentations



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Partnership Access Line (PAL), a child psychiatry consultation to primary care program

Rebecca Barclay, MD
Associate Director Partnership Access Line
Child and Adolescent Psychiatrist, Seattle Children's Hospital



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PARTNERSHIP ACCESS LINE
Child Psychiatric Consultation
for Primary Care Providers



Seattle Children's
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Any primary care provider in Washington may call PAL to talk with a child and adolescent psychiatrist about any patient (regardless of insurance).

PAL child psychiatrists are affiliated with the University of Washington and Seattle Children's Hospital.

3 child psychiatrists are available M-F 8am to 5pm. Direct connect rate is greater than 85%, which means busy primary care providers can pick up the phone and talk with a consultant without delay when needed, for as long as needed. The next day, PCP receives a written note summarizing the consultation.

Partnered with medication review program for message consistency.



Consultation topics include care for ADHD, autism, substance use disorders, family/relational issues, bullying, trauma, etc.

PAL psychiatrists discuss patients with complex care needs, often already being treated with multiple psychotropics without previous psychiatrist involvement. In more than 85% of consultations, the consultation includes a discussion of psychosocial or non-medication interventions.

PAL social workers are available to answer resource questions initiated by PCP or by child psychiatrist.

If needed to augment phone consultation to the PCP, patients may also be seen by a PAL child psychiatrist from a tele-video location or in-person.

PAL started in 2008 in WA. By end of June 2018, 12,403 elective consults had occurred about 9,933 patients. 6,554 second opinion medication reviews had occurred.

About last year's PAL calls (July 2017-June 2018):
51.5% of PAL calls discussed patients with Medicaid insurance, and 48.5% were about patients with non-Medicaid insurance.

6% of all patients were children 0-5 years old,
39% were 6-12 year-olds, and
55% were 13+ year-olds.



PAL also:

Offers four free psychiatric education conferences at sites across Washington every year. >1500 practitioners have attended. Category I CME is provided.

Publishes a free, expert-reviewed care guide that summarizes essential topics for pediatric mental health care in primary care. The care guide includes diagnostic and treatment summaries, rating scales, and handouts that PCPs may share with families. It is available at seattlechildrens.org/pal or paper copy.

Community providers are asked to give feedback after each consultation.

Feedback is strongly positive.

Word of mouth among PCPs has encouraged widespread use of PAL by the primary care provider community.

Evaluations of the PAL service have found desired care system and practice changes, such as increased engagement in therapy care by foster children and reduced antipsychotic use statewide after PAL program start.



In 2019, a referral assistance service will be offered by PAL.

PAL is creating a database of mental health treaters across Washington. The database will be actively managed by the PAL referral coordinator team. It will be kept up-to-date regarding each treater's practice scope and availability.

Families or PCP will call PAL to request referral assistance.

PAL referral coordinator will:

- talk about specific care needs with caller (family or PCP),
- interact with PAL created database and speak directly with community mental health treater to confirm appropriateness of fit, availability, and willingness to accept individual patient,
- if family initiated request, coach family to promptly schedule a first appointment with identified, available treater,
- if PCP initiated request, provide to PCP specific information regarding the identified treater, which PCP will then communicate to family.
- simultaneously communicate the referral recommendations made to the applicable child Medicaid managed care plan contact

PAL will continue program goal of collaboration with primary care providers by communicating the outcome of family-initiated referral assistance request with the patient's primary care provider.





PARTNERSHIP ACCESS LINE

Child Psychiatric Consultation Program
for Primary Care Providers

1-866-599-7257

Partnership Access Line (PAL) for Moms

Deborah Cowley MD

8/3/18



WHY WE SHOULD CARE



- Maternal functioning and suicide
- Adverse pregnancy outcomes
- Poor bonding/attachment
- Effects in children
 - Language, communication, social skills, cognition, sleep, emotional and behavioral control
 - Elevated risks of internalizing and externalizing disorders later in life
- Annual two generational cost - \$22,000

MATERNAL MENTAL HEALTH IN WASHINGTON



- 90,000 deliveries in WA State annually
- 10,000 women have perinatal depression or anxiety
- 1,000 see a psychiatrist; 2,000 receive any mental health care




VISION

Every woman in Washington State who needs perinatal mental health treatment will have access to clinical care or consultation.

PERINATAL PSYCHIATRY CONSULTATION LINE

UW Medicine
DEPARTMENT OF PSYCHIATRY
AND BEHAVIORAL SCIENCES



**Perinatal Psychiatry
Consultation Line**

*Providing telephone consultation to healthcare
providers caring for women with mental health
needs during pregnancy and postpartum*

(206) 685 – 2924
Weekdays from 3-5 PM

- Free phone consultation to health care providers about pregnant and postpartum women with mental health problems
- Perinatal psychiatrists respond to calls 3-5pm on weekdays
- Consultation about diagnosis, treatment, medications in pregnancy
- Began January, 2016



PAL FOR MOMS (Jan-June 2019)

- **Expand consultation line hours**
 - Perinatal psychiatrists will respond to calls 1-5pm on weekdays
- **Add staff member**
 - Will respond to calls all day (9-5), track calls, assess outcomes, provide referral information, increase awareness of the service among state health care providers
- **Integrate service with PAL**
 - Collaborate on outreach (e.g. talks for providers as part of PAL conferences around the state)

PAL FOR MOMS (beginning July 2019)

- **Further expand consultation line hours**
 - Perinatal psychiatrists will respond to calls **9am-5pm on weekdays**
- Continued staff support
- Continued integration with PAL



PAL FOR MOMS

- Questions?



Draft PAL Alternative Funding Approaches and Non-Duplication Strategy

Partnership Access Line (PAL) Alternative Funding Approaches and Non-Duplication Strategy

Introduction

The health of Washington State’s children is a priority. Recent events and published reports highlight the increasing prevalence of mental health challenges in children¹.

Seattle Children’s Hospital and the University of Washington have developed evidenced-based programs to support clinicians’ efforts to provide behavioral health services.

- Seattle Children’s Hospital launched its Partnership Access Line (PAL) in 2008. The PAL is a program that provides child psychiatry consultation to primary care practitioners caring for children under age 19 with behavioral health needs. The PAL currently receives its funding through a contract with the Washington State Health Care Authority (HCA).
- The University of Washington began its Perinatal Psychiatry Consultation Line (or “PAL for Moms”) in 2016. PAL for Moms provides psychiatric consultation to healthcare providers caring for women with behavioral health needs during and shortly after pregnancy.

Additionally, to support parents’ navigation in the complex behavioral health referral system, Seattle Children’s Hospital will expand its services to offer a “PAL for Kids” referral line that parents and guardians, as well as primary care providers, can call to receive referrals to available child behavioral health treatment providers.

The 2018 Legislature unanimously passed [Substitute Senate Bill \(SSB\) 6452](#). The legislation requires the HCA to recommend a plan to the Legislature and the Children’s Mental Health Work Group by December 1, 2018, that includes:

1. An alternative funding model for current and expanded PAL services; and
2. A strategy to ensure no duplication exists between PAL and “PAL for Kids” services of Seattle Children’s Hospital and the requirements of Apple Health (Medicaid) Managed Care Organizations (MCOs).

In the development of the alternative funding model, the HCA and the Office of Insurance Commissioner must consider a mechanism that determines the annual cost of operating the PAL programs and collects a proportional share of the programs’ cost from each health insurance carrier.

In this document we provide an excerpt from SSB 6452, describe two alternative funding approaches that we developed with input from the Office of the Insurance Commissioner and work group participants, present considerations for implementing those approaches, and briefly summarize our non-duplication strategy.

¹ About 13-20% of children in the U.S. experience a mental disorder in a given year. (See: Perou, R., Bitsko, R.H., Blumberg, S.J., et al. (2013) Mental Health Surveillance among Children—United States, 2005-2011. *MMWR Surveillance Summaries*, 62, 1-3.) Mental health disorders disrupt completion of important developmental tasks, impact relationships and functioning in families, at school and socially, impact children’s overall physical well-being, and are costly to society. (See: Soni, A. Top Five Most Costly Conditions Among Children, Ages 0-17, 2012: Estimates for the U.S. Civilian Noninstitutionalized Population. Statistical Brief #472. April 2015. Agency for Healthcare Research and Quality, Rockville, MD.)

Partnership Access Line (PAL)

Alternative Funding Approaches and Non-Duplication Strategy

Excerpt from Section 1 of SSB 6452

- (1) The health care authority shall convene the University of Washington, Seattle children's hospital, medicaid managed care organizations, organizations connecting families to children's mental health services and providers, health insurance carriers as defined in [RCW 48.44.010](#), and the office of the insurance commissioner to recommend:
 - (a) An alternative funding model for the partnership access line; and
 - (b) A strategy to ensure that expanded services for the partnership access line identified in subsection (2) of this section do not duplicate existing requirements for medicaid managed care organizations as required by [RCW 74.09.492](#).
- (2) The funding model must identify potential sources to support:
 - (a) Current partnership access line services for primary care providers;
 - (b) An expansion of partnership access line services to include consultation services for primary care providers treating depression in pregnant women and new mothers; and
 - (c) An expansion of partnership access line services to include referrals to children's mental health services and other resources for parents and guardians with concerns related to their child's mental health.
- (3) In the development of the alternative funding model, the authority and office of the insurance commissioner must:
 - (a) Consider a mechanism that determines the annual cost of operating the partnership access line and collects a proportional share of the program cost from each health insurance carrier; and
 - (b) Differentiate between partnership access line activities eligible for medicaid funding from other nonmedicaid eligible activities.
- (4) By December 1, 2018, the authority must recommend a plan to the appropriate committees of the legislature, and the children's mental health work group created in chapter . . . , [Laws of 2018 \(Engrossed Second Substitute House Bill No. 2779\)](#), if chapter . . . , Laws of 2018 ([Engrossed Second Substitute House Bill No. 2779](#)) is enacted by the effective date of this section.
- (5) This section expires December 30, 2018.

Funding Approach 1: Use of Current Assessments

Washington State currently has several assessments being collected which are deposited into the General Fund - State. Under this approach, a portion of an already existing assessment source would be used to pay for the non-Medicaid enrolled children. The cost-split would be based on the clinicians' using the service representation of coverage being either Medicaid or non-Medicaid.

Partnership Access Line (PAL)

Alternative Funding Approaches and Non-Duplication Strategy

The portion of the service cost attributed to Medicaid would be paid for through HCA's Medicaid administration, using the standard Medicaid funding to pay for PAL services benefiting children covered by Medicaid. The Medicaid MCOs would not make a separate payment.

To access General Fund – State, a portion of the current health insurance premium tax² could be used.

- The tax is 2% of premiums, and is paid by health care service contractors and health maintenance organizations. A 2% premium tax is also applied to all other insurers, including disability insurers issuing health insurance plans.

A portion of these funds would be transferred to the HCA. The HCA would combine these funds with the Medicaid administration revenue to remit payment to Seattle Children's Hospital and the University of Washington. The HCA would hold the contracts with Seattle Children's Hospital and the University of Washington.

Third-party administrators (TPAs) and self-funded group health plans are not subject to premium taxes and therefore would not contribute to the cost of the PAL program.

The HCA would maintain its current administration of the PAL's contract, minimizing state administrative costs. Seattle Children's Hospital and the University of Washington would not need to change their program administration to accommodate this model.

Alternative versions of this model include changing the cost-split basis and/or changing the revenue source.

- In lieu of basing the cost-split on the representation of clinicians using the services, the relative proportion of Medicaid/non-Medicaid enrolled children served would be used as the basis for apportioning the cost of the program. This method is referenced in the legislation. A source of that information would need to be identified.
- In lieu of using a portion of the health insurance premium tax, a portion of the currently assessed business and occupation tax on hospitals³ taxes could be used. A similar fund source is used in Massachusetts where they operate a similar PAL and referral program. The Massachusetts Department of Health assesses a surcharge from qualifying private individuals and entities on certain payments they make to Massachusetts acute hospitals and ambulatory surgical centers⁴.

Again, these funds would be transferred to the HCA. The HCA would combine these funds with the Medicaid administration revenue to remit payment to Seattle Children's Hospital and the University of Washington.

² See RCW 48.14.020, < <http://app.leg.wa.gov/RCW/default.aspx?cite=48.14.020>>, and RCW 48.14.0201, <<http://app.leg.wa.gov/RCW/default.aspx?cite=48.14.0201>>, both accessed on July 31, 2018.

³ See RCW 82.04.260(10), < <http://app.leg.wa.gov/RCW/default.aspx?cite=82.04.260>>, accessed on July 31, 2018

⁴ See 104 CMR: Department of Health, 30.08 Massachusetts Child Psychiatry Access Program Assessment, <<https://www.mass.gov/files/documents/2018/02/26/104cmr30.pdf>>, accessed on July 31, 2018. This surcharge is in addition to the surcharge that Massachusetts uses to pay for its Pediatric Immunization Program.

Partnership Access Line (PAL)

Alternative Funding Approaches and Non-Duplication Strategy

Funding Approach 2: Assessment per Enrolled Child

This approach creates a new infrastructure for non-Medicaid and Medicaid parties to share the cost for these services. The cost-allocation method uses the proportion of children enrolled in Apple Health/Medicaid, fully-insured plans, and TPAs to determine each entity's share on a per-covered-life basis.

Under this approach statutory authority would direct the state to create a public/private Board whose purpose would be to oversee the administration of the assessments.

- The Board would include voting seats for a designated representative from the Association of Washington Health Plans, the director (or director's designee) of the HCA, representatives from fully-insured plans and TPAs. In addition, representatives from Seattle Children's Hospital and the University of Washington will have non-voting seats on the Board.
- The Board would also advise on promoting the service to providers, supporting the services being provided and reviewing quality, value and achievement of desired outcomes.
- The Board would be required to engage a contractor to administer the assessment mechanism. The plan developed would consider the source of this information and the role of the contractor to gather and validate this enrollment information.

The HCA would continue in its role of contracting for the services. In addition, the HCA would receive the payments from the contractor and remit the Medicaid, carrier and TPA payments to Seattle Children's Hospital and the University of Washington.

Implementing the Funding Approaches

The following is a sub-set of steps necessary for implementation:

1. The Legislature would need to amend the laws governing the premium taxes (i.e., RCW 48.14.020 and RCW 48.14.020) to allow the HCA to use a portion of that tax revenue to pay PAL services benefiting children not covered by Medicaid under approach 1.
Alternatively, if approach 2 were to be adopted, the legislature would need to create the Children's Service Board in statute with the purpose of collecting a new assessment from insurers and TPAs proportional to the cost of the PAL services and the number of insurers' and TPAs' enrolled children. The Board would also monitor the program's clinical outcomes, as per above.
2. The HCA would need to have the means to receive the assessments and combine them with Medicaid funds to remit to Seattle Children's Hospital and the University of Washington.
3. The HCA would contract with Seattle Children's Hospital and the University of Washington to provide the services, define performance metrics, report on the services provided and collect clinical utilization and outcome data.
4. The HCA would monitor the PAL contracts with Seattle Children's Hospital and the University of Washington and track the PAL program reporting requirements related to service delivery, outcomes, quality and expenditures.

Partnership Access Line (PAL) Alternative Funding Approaches and Non-Duplication Strategy

Non-Duplication Strategy

The HCA must produce a strategy to ensure that the services of Seattle Children's Hospital's PAL for Kids referral line do not duplicate existing requirements for Medicaid MCOs as required by RCW 74.09.492. In this section, we summarize the requirements of the Medicaid MCOs and the PAL for Kids referral line services, and describe a collaboration method to ensure non-duplication.

Medicaid MCO Requirements

Per [RCW 74.09.492\(2\)](#), the Medicaid MCOs are required to perform the following tasks to coordinate resources and services for enrolled children who need mental health treatment:

- (a) Follow up with individuals to ensure an appointment has been secured;
- (b) Coordinate with and report back to primary care provider offices on individual treatment plans and medication management, in accordance with patient confidentiality laws;
- (c) Provide information to health plan members and primary care providers about the behavioral health resource line available twenty-four hours a day, seven days a week; and
- (d) Maintain an accurate list of providers contracted to provide mental health services to children and youth. The list must contain current information regarding the providers' availability to provide services. The current list must be made available to health plan members and primary care providers.

Seattle Children's Hospital "PAL for Kids" Referral Line

Beginning in 2019, Seattle Children's Hospital will launch its PAL for Kids referral line, which parents and guardians, as well as primary care providers, can call to receive referrals to available child behavioral health treatment providers. Seattle Children's Hospital will create and maintain a database of MCO-enrolled behavioral health providers that will include information about:

- The MCO plan(s) in which the providers are enrolled;
- The age limits for "eligible" patients; and
- Whether the providers are accepting new patients.

The PAL for Kids referral coordinator at Seattle Children's Hospital will assist the caller by identifying two or more available treatment providers, and provide a referral to the treatment provider(s).

Method to Avoid Duplication

Strategic collaboration between Seattle Children's Hospital and the Medicaid MCOs will ensure non-duplication of services and provide a "no wrong door" approach to assisting families connect their children to behavioral health providers for services.

After the referral coordinator receives a call for referral assistance for a child enrolled in one of the MCO plans, Seattle Children's Hospital will send a letter to the primary care provider, the family, and the child's MCO. The letter will include:

- The names and contact information of the behavioral health treatment providers in the referral;

Partnership Access Line (PAL)

Alternative Funding Approaches and Non-Duplication Strategy

- A message to the family that the PAL for Kids program is notifying the child's MCO about the referral, and that the MCO may call the family to assist with:
 - Assuring the child accesses services through one of these providers;
 - Offering assistance to connect the child with a different provider; and
 - Providing any other related services.

PAL for Kids staff will follow-up with the caller to determine whether the child accessed services through the referral. This will provide useful feedback about the outcome of their intervention and MCO referral.

After the MCO receives the letter from the PAL for Kids program, the MCO will call the family to determine whether:

- The child has accessed services through one of the referred behavioral health treatment providers;
- The family needs assistance by the MCO to secure access with the treatment provider; and
- The family needs any additional services.

The MCO will add the child to case management list, as needed. They MCO also ensure that the child's primary care provider is informed about the status of the child's treatment. The MCO will also follow up with the behavioral health treatment provider to ensure that the child had the appointment, and to identify what additional services the child might need, as identified in that appointment. Moving forward, the MCO will continue to assure the child receives services as indicated in the treatment plan.



Appendix D: Alternative Funding Model Work Group Meeting Materials for August 24, 2018

This appendix contains materials from the PAL alternative funding model work group meeting that occurred on August 24, 2018, including: the agenda, meeting summary, and draft PAL implementation plan funding source and administration matrix.



Meeting Agenda



Partnership Access Line (PAL) Alternative Funding Model Recommendation Process Convened Workgroup Meeting #3

Friday, 8/24/2018, 3:00-4:00 p.m.
 Cherry Street Plaza
 626 8th Ave. SE, Olympia, WA 98501
 1 Floor - Sue Crystal 106A & 106B
 (GoToWebinar Registration Available)

Attendees:					
<input type="checkbox"/>	Health Care Authority (HCA)	<input type="checkbox"/>	Department of Health (DOH)	<input type="checkbox"/>	Office of Insurance Commissioner (OIC)
<input type="checkbox"/>	Seattle Children's Hospital (SCH)	<input type="checkbox"/>	University of Washington (UW)	<input type="checkbox"/>	Medicaid Managed Care Organizations (MCOs)
<input type="checkbox"/>	Health Insurance Carriers, per RCW 48.44.010	<input type="checkbox"/>	Organizations connecting families to children's mental health services and providers		
Main Outcome: Collect feedback about PAL services alternative funding model options					

No	Agenda Items	Time	Lead	Summary Meeting Notes
1.	Welcome and Introductions	5 min	Mary Fliss, HCA	
2.	Overview of the PAL Alternative Funding Model Implementation Plan: Funding Source and Administration Matrix	5 min	Dean Runolfson, HCA	
3.	Discuss the Options Described in the Matrix	40 min	Mary Fliss, HCA	
4.	Next Steps for the Non-Duplication Strategy	5 min	Gail Kreiger, HCA	
5.	Next Steps for the Legislative Report Submission Process and Wrap-Up	5 min	Dean Runolfson, HCA Mary Fliss, HCA	

Action Items/Decisions					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status

Meeting Summary



PAL Alternative Funding Model Convening

Summary of Meeting

August 24, 2018

Purpose

The purpose of this meeting is to discuss: (1) the overview of the PAL Alternative Funding Model Implementation Plan; (2) the options described in the matrix; and (3) next steps for the Non-Duplication Strategy and the Legislative Report submission process.

1. Agenda:

- Welcome
- Overview of the PAL Alternative Funding Model Implementation Plan: Funding Source and Administrative Matrix
- Discuss the Options Described in the Matrix
- Next Steps for the Non-Duplication Strategy
- Next Steps for the Legislative Report Submission Process and Wrap-up

2. Overview of the PAL Alternative Funding Model Implementation Plan: Funding Source and Administrative Matrix

- HCA staff presented an overview of the draft document titled “Partnership Access Line (PAL) Alternative Funding Implementation Plan: Funding Source and Administrative Matrix”. Please refer to this document for more details.
- The columns refer to the funding source. The rows represent the administration of the funding source.
- All four options have common elements:
 - Health Care Authority (HCA) will contract with the University of Washington (UW) and Seattle Children’s Hospital (SCH) to provide PAL Services.
 - SCH and UW would report performance metrics, service utilization, outcomes, quality, and expenditures.
 - HCA will collaborate with the Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) to evaluate the PAL program services.
- Option 1: HCA would manage using General Fund—State funding to pay for the proportion of the program that serves children that are not enrolled in Apple Health. HCA would determine the cost-split by comparing the Apple Health enrollment numbers and the total state population that is estimated by the Office of Financial Management (OFM). HCA would revisit the cost-split on an annual basis.
- Option 2: HCA would hire a contractor to create and manage the per-covered-life assessment calculation and collection process.
- Option 3: This option is similar to Option 1, but it involves a governing board.

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- Option 4: This option is similar to Option 2, but it involves a governing board.

3. Discuss the Options Described in the Matrix

- HCA used feedback from stakeholders to develop these options.
- It appears the carriers' preference is to pursue the simplest alternative funding approach as a pilot, and to consider additional changes after a couple years.
- The recommendation is to use General Fund—State funding without involving a governing board. Some reasons for this recommendation are: (1) insurance carriers already pay taxes that contribute to the General Fund—State funding; and (2) this option is relatively inexpensive to administer.
- SCH is working toward implementing the expanded PAL services. The expanded PAL services two-year pilot program will initially be for Apple Health clients. When there is additional demand for the expanded PAL services, it might be necessary to adjust the pilot program's budget accordingly.
- SCH has a database into which they enter data from their consultations for tracking and reporting purposes. In addition, they collect provider feedback in survey forms. SCH staff will send information about the data the PAL program collects to HCA.

4. Next Steps for the Non-Duplication Strategy

- HCA will meet with the MCOs and SCH in October to work on the non-duplication strategy.
- Previously, HCA worked with the MCOs and SCH to develop a process to ensure non-duplication:
 - If SCH staff receives a referral request for a child enrolled in one of the Apple Health MCOs, SCH will send a letter to the family and to the child's Managed Care Organization (MCO). The MCO will be responsible to ensure that the patient connects with a provider.
- The focus of the meeting in October will be to streamline this process and develop the content of the letter.

5. Next Steps for the Legislative Report Submission Process and Wrap up

- The convened work group process has informed the HCA's efforts to develop the legislative report that is due by the end of this year.
- HCA's first draft of the legislative report is due on September 7, 2018, and the final draft is due on September 28, 2018. HCA will provide convened work group participants an opportunity to comment on the draft report before September 28, 2018.
- HCA encourages stakeholders to provide any additional comments or suggestions by emailing: PALFundingModel@hca.wa.gov.



Draft PAL Implementation Plan Funding Source and Administration Matrix

Partnership Access Line (PAL) Alternative Funding Implementation Plan Funding Source and Administration Matrix

FUNDING SOURCE		Per Covered Life Assessment
ADMINISTRATION	HCA Only	<p>OPTION 1:</p> <ol style="list-style-type: none"> 1. Appropriation of General Fund — State (i.e., from any existing state revenue source) to pay for non-Apple Health services, such as: <ul style="list-style-type: none"> o Insurance Premium Tax o Hospital Business and Occupation Tax 2. Use HCA Medicaid enrollment data and OFM population estimate data to calculate Apple Health/ non-Apple Health cost-split 3. Contract with Seattle Children’s Hospital and the University of Washington to provide PAL services 4. Review the funding model annually for the two years, beginning in 2021 and adjust the cost-split accordingly 5. Seattle Children’s Hospital and the University of Washington to report performance metrics, service utilization, outcomes, quality, and expenditures 6. Collaborate with DSHS-RDA for program evaluation <p>OPTION 2:</p> <ol style="list-style-type: none"> 1. Hire a contractor to create and manage the per covered life assessment calculation and collection process 2. Contract with Seattle Children’s Hospital and the University of Washington to provide PAL services. 3. Seattle Children’s Hospital and the University of Washington to report performance metrics, service utilization, outcomes, quality, and expenditures. 4. Collaborate with DSHS-RDA for program evaluation
	Governing Board	<p>OPTION 3:</p> <ol style="list-style-type: none"> 1. Establish a governing board 2. Appropriation of General Fund — State (i.e., from any existing state revenue source) to pay for non-Apple Health services, such as: <ul style="list-style-type: none"> o Insurance Premium Tax o Hospital Business and Occupation Tax 3. Use HCA Medicaid enrollment data and OFM population estimate data to calculate Apple Health/ non-Apple Health cost-split 4. Contract with Seattle Children’s Hospital and the University of Washington to provide PAL services 5. Review the funding model annually for the two years, beginning in 2021 and adjust the cost-split accordingly 6. Seattle Children’s Hospital and the University of Washington to report performance metrics, service utilization, outcomes, quality, and expenditures 7. Collaborate with DSHS-RDA for program evaluation <p>OPTION 4:</p> <ol style="list-style-type: none"> 1. Establish a governing board 2. Hire a contractor to create and manage the per covered life assessment calculation and collection process 3. Contract with Seattle Children’s Hospital and the University of Washington to provide PAL services. 4. Seattle Children’s Hospital and the University of Washington to report performance metrics, service utilization, outcomes, quality, and expenditures. 5. Collaborate with DSHS-RDA for program evaluation



Appendix E: Alternative Funding Model Work Group Emailed Suggestions and Feedback

HCA emailed all PAL alternative funding model work group members on June 15, 2018, to request suggestions or feedback about the PAL alternative funding model by no later than June 28, 2018. We received responses from members representing the following organizations:

- Amerigroup Washington;
- Anthem, Inc.;
- Association of Washington Healthcare Plans;
- Seattle Children’s Hospital (which had two respondents);
- United Health Care Community Plan; and
- Washington Chapter of the American Academy of Pediatrics.

This appendix includes respondents’ suggestions and other feedback, including a letter HCA received from the Association of Washington Healthcare Plans.

Suggestions for the PAL Alternative Funding Model

Organization	Suggestions
Amerigroup Washington	“The cost should be divided amongst all insurers who’s clients use it including Commerical insurance, Medicaid and Medicare. Each companies share should be proportional to their enrollment.”
Anthem, Inc.	“Is the Washington Poison Control Center a good model for this? Also the Vaccines for Children Program? Both are public health programs provided at no cost to everyone, regardless of insurance. I’m just wondering if these might be something we can model this after.”
Association of Washington Healthcare Plans	“Please see attached letter from AWHP”
Seattle Children’s Hospital (Respondent 1)	“I would start by ensuring the private plans and the PAL contracting/overseeing agency (currently HCA, though might be something else in the future) accept a core principle, that organizing around service payment just for individual telephone consults or other countable widgets of service would be a terrible way to fund what PAL does. Without a system of underwriting to make consultants, program staff, and support services available at the immediate convenience of primary care providers, then providers won’t call and patients would not receive the benefits of the service. I can’t reserve child psychiatrist availability to consult without underwriting, otherwise we all get scheduled up with patients and become unavailable. If we can’t get to an agreement on this principle, then the PAL service would fall apart.



Organization	Suggestions
	<p>“A side benefit of underwriting child psychiatry consulting availability to the private plans could be, if they wanted to follow in HCA’s footsteps, also tasking the PAL consultants with providing some selected doc-to-doc medication reviews. HCA pharmacy division currently reimburses us per completed review, but the availability itself is created by PAL. As I raised in our last meeting, provider willingness and engagement in a review process is greatly enhanced by being able to be flexibly available whenever providers are.</p> <p>“I think the ideal funding plan would involve Medicaid and the private plans sharing the total expense for the program based on an insurer’s number of youth covered lives, perhaps with an annual assessment carried out by HCA and the office of the insurance commissioner, or some other authority. That is something which could be assessed annually without plans necessarily learning about their competitors’ enrollment figures (which may raise concerns for the plans), and it would be a fully predictable expense of “X” amount per covered child per year. And having this assessment happen behind the scenes would not require primary care docs to pull up their patients’ insurance card and ID number when calling PAL, which would introduce a new barrier for providers to use the service on the fly to help their patients. For current PAL that is roughly 50 cents per child per year, for expanded PAL with maternal mental health and referral assistance services would be in the ballpark of \$1 per child per year (though ongoing funding needs will be better determined by the pilot).</p> <p>“Some of what PAL does, to provide mental health care education to providers, is not part of the usual mission of the health plans. But it is a powerful tool for us to not only elevate a provider’s treatment skills in greater depth, but it is also a key community outreach tool for PAL to let providers know the service exists. Most of the people who use PAL to support their patients do so because either they went to one of our conferences, or they know someone who went to a conference and learned about us that way. So I would want that to be specifically included in what the joint funding would support, and not peeled out as a non-covered service from the private health plans’ perspective.”</p>
Seattle Children’s Hospital (Respondent 2)	<p>“Medicaid and the private plans could share the total expense for the program based on an insurer’s number of youth covered lives, and it would be a fully predictable expense of “X” amount per covered child per year. The current program’s funding model allows child and adolescent psychiatrists, program staff and support services at the immediate convenience of primary care providers at their; M-F, 9a-5p. The current system reserves child and adolescent psychiatrist’s time to deliver services.</p> <p>“However, organizing payment around service (telephone consults) or other countable widgets of service limits our staffing model and access.”</p>
United Health Care Community Plan	<p>“Please provide additional information on the following:</p> <ul style="list-style-type: none"> • How the PAL program works now and how this will change with the added programs



Organization	Suggestions
	<ul style="list-style-type: none"> • The Massachusetts model in general • How the Massachusetts and/or Pennsylvania models could be customized to meet Washington's needs and the intent of the legislation"
<p>Washington Chapter of the American Academy of Pediatrics</p>	<p>"We respectfully suggest that the funding approach for the existing PAL line and the expanded PAL line be based on the population of children and new mothers in the state who could potentially benefit from this program's services. For several reasons, we believe funding the line based on insured lives would be a sound practice. Doing so reflects that the population of children and new mothers have the potential need for timely, high quality behavioral health services to prevent worsening of symptoms, suffering, and increased cost in the near term or over the life course. We suggest that insurers could consider that the entire population could at some point become their own insured patient and thus collectively insurers have an interest in assuring this highly cost-effective service supports children and families in a timely way. Providers do not and cannot know which insurance company a child is on and we also know that insurance coverage is transitory. It is also not feasible to bill out PAL services in an incremental way. The providers need to be available in real time and thus the service needs underwriting. Without it, providers would need to turn to more lucrative billable services, defeating the purpose of continuous weekday availability.</p> <p>"As we have mentioned, we estimate the per child cost of this service to be about \$1 per child.</p> <p>"This cost needs to be considered in the context that children's care is wildly inexpensive for almost the entire pediatric population, despite rapidly rising healthcare costs as a whole. We posit that a modest upstream investment is a highly worthwhile expense toward children's health and future care utilization. For example, through the expanded PAL line, a mental health professional on the line could assess acuity and prioritize rapid resources for a family to avoid more expensive care in an emergency department or hospital. Secondly, over the medium or long term we know that identifying disease early and providing timely high quality care improves outcomes; helping children early can change the trajectory for chronic disease. Mental health problems that begin in childhood can persist or worsen over time: 50% of adults with mental health disorders experience emergence of their symptoms by age 14. Thus collective action on a modest investment for upstream services is in everyone's interest.</p> <p>"The PAL line and expanded PAL line support goals of insurers, including:</p> <ol style="list-style-type: none"> 1.) Supporting integration. 2.) Leveraging the PCP office. Most children's behavioral health needs present and are treated in the PCP office. PCP's are the default behavioral health provider for children. The line maximizes and grows PCP skills and makes appropriate referral supports when a specialist is needed. 3.) The line can support improvement in performance on HEDIS quality measures such as ADHD and antipsychotic medications.



Organization	Suggestions
	<p>4.) The line has shown to improve medication management. This is important given the high volume of stimulants prescriptions and the upside risk of antipsychotics for insured.</p> <p>5.) Finally the PAL line and expanded PAL line promote the use of high quality care. The line improves the quality of care PCPs provide through educating and supporting them. When in place, the expanded PAL line will have the capacity to track on any quality concerns and help direct patients to the best resources available in their community.</p> <p>"We also suggest that this program be centrally administered as working with multiple plans is not feasible for PAL or value added to children and families. Furthermore, we place a high value on the information this line can collect in the aggregate and how it will instruct us about need and access in totality, vs. the fragmented information that can occur one insurer at a time. Centralized contracting, goals, and data collection expectations will foster a true look at population health and access."</p>

Other Feedback

Organization	Feedback
Amerigroup Washington	(None)
Anthem, Inc.	"Have we engaged our Finance leadership? In my current role as a pharmacist I do not make decisions about funding and this is not my area of expertise. I would consider engaging Finance leaders when considering Funding Models."
Association of Washington Healthcare Plans	"Please see attached letter from AWHP"
Seattle Children's Hospital (Respondent 1)	"I would also advise that the program should ultimately have one contracting point to communicate with and report to which helps to represent the group's interests, rather than 10 different masters and 10 different sets of expectations."
Seattle Children's Hospital (Respondent 2)	"Value Statement "PAL provides collaborative support to pediatric primary care providers and their patient-care teams to enhance their ability to promote and manage their patients' behavioral health as a fundamental component of overall health and wellness."
United Health Care Community Plan	(None)
Washington Chapter of the American Academy of Pediatrics	(None)



Association of Washington Healthcare Plans Letter to HCA



P.O. Box 7215 Olympia WA 98507

Mr. Dean Runolfson
Management Analyst 5
Program Initiatives and Analytics
Clinical Quality and Care Transformation
Washington State Health Care Authority

Submitted by electronic mail

Re: HCA Workgroups on PAL Funding and Prevention of Duplication 9SB 6452)

Dear Dean:

The Association of Washington Healthcare Plans (AWHP) represents commercial and Medicaid managed care health plans in Washington State, covering over 6.9 million residents. AWHP's member plans are committed to ensuring that our enrollees have affordable coverage that supports quality healthcare. Thank you for the opportunity to comment on both aspects of your efforts to implement and prepare the legislative report required by SB 6452.

We recommend a broadly-based funding approach. SB 6452 directs the Health Care Authority's (HCA) report to include consideration of a funding mechanism that includes carriers. The legislature does not preclude recommendation of broader based funding to include all those who utilize the Partnership Assistance Line (PAL) to support delivery of care. While the legislation calls out *who* HCA should work with to prepare the recommendations, the law does not preclude a recommendation for broader funding sources.

To that end, AWHP strongly urges the HCA to consider recommending that the Legislature utilize general fund monies to pay for PAL. Health plans already contribute to the general fund through premium taxes, which have grown significantly for some time with new enrollment and rising premiums. Providers pay licensing fees and other taxes that are directed to the general fund. A separate new assessment will increase the cost of coverage to enrollees. The impact of this: a downturn in enrollment and utilization of behavioural health services.

There is also an impact on the Medicaid managed care market. Today, the Medicaid Managed Care Organizations (MCO) pay for primary care provider services when the PCPs access the PAL. Those payments are included in the MCO rate, which by law must be actuarially sound in relation to the covered benefits under a Medicaid MCO plan. A new assessment will also drive up Medicaid managed care rates.



We recommend against a new assessment to fund PAL and ask that the discussion of funding methodologies in the HCA legislative report analyze this dynamic¹.

Duplication of Services Another reason to consider using general fund monies for PAL is avoiding duplication of services and refraining from creating a mandated consulting vendor for a particular service. While the legislature has designated PAL as worthy of funding through a state program, providers or issuers may use other existing referral lines. For some carriers, this would be a duplicate service that would need to be paid without any benefit. In addition to avoiding duplication, we suggest that the report to the Legislature include an assessment of whether other telehealth services may be better in some circumstances than PAL for enrollees and devise a mechanism to either opt out of PAL or incentivize continued innovation in developing telehealth services to support behavioral health delivery for Washington's children.

Timing of Implementation Even though we strongly urge no new assessments, if the HCA recommends funding that results in an assessment, carriers must include the assessment in their rate filings to ensure they actuarially sound. With a late April or May filing date as the norm, 2020 rates will have been filed before any bill is passed or effective. Therefore, implementation must wait until 2021. A general fund source does not include this complication or delay of implementation.

Acknowledge the Effect on Benefits and Billing that must be resolved to effectively expand PAL utilization and scope. Use of telehealth services continues to increase. Multiple CPT codes associate with differences in complexity and the behavioural health condition being addressed during a PAL call. On behalf of its members, HCA asks that as part of its report, HCA recommend a clear definition of the included services the legislature mandates as part of the PAL telehealth service model. This is also important for the prevention of dual payment streams for one service, as well as defining the new mandate that a PAL assessment would represent.

Carriers also urge HCA to include a discussion of whether the maternal newborn pilot being developed is insurance blind or is limited to the Medicaid MCOs. In 2017, legislation passed that includes very similar pediatric behavioural health services, which the MCOs are currently implementing. For that reason, the SB 6452 report and any recommended funding methodology should distinguish between those services and new PAL services for the MCOs.

The Childhood Vaccine Association Program The Washington State Childhood Vaccine Association program was identified as a potential model for the PAL funding. However, we suggest that the WVA is not an analogous funding model. The Washington Childhood Vaccine program was established to access the lowest cost rates for covered vaccines, resulting in cost savings to the state and carriers. The state pays for Medicaid, and commercial carriers are assessed. The program funds already identified and mandated vaccines which have easily identifiable unit costs for delivery and utilization.

This is not the case with the PAL line. Behavioural health services are mandated in the fully insured commercial and Medicaid markets. But a service providing consultative services is not

¹ Both Pennsylvania and Massachusetts, two states referenced by HCA as potential models, derive either a portion or all their funding for their programs from state general funds.





mandated today for commercial carriers. Commercial carriers employ medical expertise to provide direction to PCPs and decide on appropriate covered services for an enrollee. These interactions do not have unit costs or utilization useful to developing a fair payment formula.

More Information About PAL is needed Another question is whether we are discussing a funding methodology that is translatable to other telemedicine services or is discrete and distinguishable from telehealth, and not to be billed as a telehealth – telemedicine service. The PAL program should specify coding and billing parameters for both the PCP and the PAL if funding is to shift or expand to other funding sources that the state.

How would payment for uninsured beneficiaries be handled? Does PAL have a mechanism or process that confirms and identifies the type of coverage under which the consultation is covered? Our understanding is that currently PAL does not have the ability to go beyond tagging an encounter as Medicaid or commercial. AWHP seconds the discussion in the kick-off meeting about the need for specific details about PAL functionality, current scope of services and how it is paid for today before we can recommend a methodology.

Timeline and Process for Building the Report We want to acknowledge HCA's internal process for preparing a report but ask that additional time be built into the discussion phase of any methodology. Requiring final recommendations by September 1 means that less time is spent developing content than will be spent formatting the report. We hope that HCA flex its internal process to support more time for meaningful discussion, particularly since the program we are asked to fund isn't yet fully explained to stakeholders in either its current or future state.

We do look forward to our continued work with HCA on this program.

Sincerely,
Association of Washington Healthcare Plans
By:

A handwritten signature in black ink that reads "Meg L. Jones".

Meg L. Jones
Executive Director

cc: Jane Beyer, Office of the Insurance Commissioner

Appendix F: Non-Duplication Strategy Work Group Meeting Materials for July 2, 2018

This appendix contains materials from the non-duplication strategy work group meeting that occurred on July 2, 2018, including the agenda, PowerPoint presentation, and excerpts from the 2015-2018 Apple Health contract.



Meeting Agenda

	Non-Duplication with PAL Model Case Management AGENDA	July 2, 2018 at 1 PM Sue Crystal A/B Conference Room
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Attendees			
	<u>Amerigroup Washington, Inc.</u>	<u>Coordinated Care Corporation</u>	<u>UnitedHealthcare Community Plan (cont'd)</u>
<input type="checkbox"/>	Caitlin Safford, Govt Relations Director	<input type="checkbox"/>	Andrea Tull, Director, Government Relations, G&A-Government Relations
<input type="checkbox"/>	Jennifer Brown, Pharmacy Program Manager	<input type="checkbox"/>	Christy Schneck, Director, Case Management, MED-Case Management
<input type="checkbox"/>	Julian Thompson, Director, Behavioral Health Services	<input type="checkbox"/>	Jessica L. Molberg, Director, Clinical, MED-Case Management
<input type="checkbox"/>	Lani Spencer, RVP, Healthcare Management Services	<input type="checkbox"/>	Melanie Abella, Director, Case Management, MED-Case Management
<input type="checkbox"/>	Tonya Niverson, Manager, Case Management	<input type="checkbox"/>	Sasha D. Waring, Medical Director, MED-Medical Affairs
	<u>Community Health Plan</u>	<input type="checkbox"/>	<u>Molina Healthcare of Washington, Inc.</u>
<input type="checkbox"/>	Donna Arcieri, Operations	<input type="checkbox"/>	Kathie Olson, AVP Healthcare Services
<input type="checkbox"/>	Julie Liebrand	<input type="checkbox"/>	Kelly Anderson, Director Healthcare Services
<input type="checkbox"/>	Mark Bean, Finance/Actuary	<input type="checkbox"/>	Krista Edmundson, Government Contracts Manager
<input type="checkbox"/>	Sarah Kwiatkowski		<u>UnitedHealthcare Community Plan</u>
<input type="checkbox"/>	Sylvia Gil	<input type="checkbox"/>	Cindy Spain, VP, Integrated Clinical Services
<input type="checkbox"/>	Yusuf Rashid, Pharmacy	<input type="checkbox"/>	Dr. Melet Winston, Chief Medical Officer
Please Review & Bring: ➤ Agenda			
Desired Outcome: ➤ Develop recommendation to assure no duplication with existing MCO requirements			
Conference Bridge: (360) 407-3780 PIN Code: 419787#			

Meeting	Time	Lead
Welcome & Introductions	5 minutes	Gail
Review SSB 6452	10 minutes	Gail
SCMC Case Management & Referral Program	40 minutes	Rebecca Barclay, MD, Associate Director PAL, SCH
Massachusetts' Model	15 minutes	Gail
Managed Care Case Management Programs = Review of Contract Language = Presentation by Plans	60 minutes	MCOs
Discussion of Options	40 minutes	All
Develop Recommendation	40 minutes	All
Next Steps and Wrap-Up	10 minutes	All
Next Meeting:		
Adjourn		



PowerPoint Presentation



Non-Duplication with Partnership Access Line (PAL) Model Case Management Meeting

July 2, 2018



Agenda

- Welcome and Introductions
- SSB 6452 Legislative Requirements
- SCMC Case Management & Referral Program
- Massachusetts' Model
- Managed Care Case Management Programs
 - ❖ Review of Contract Language
 - ❖ Presentation by Plans
- Discussion of Options
- Develop Recommendation

2

SSB 6452 Legislative Requirements

- Contract for Partnership Access Line (PAL) expanded services beginning in January 2019
- Develop a funding model recommendation that assesses the costs of current and expanded PAL services across Washington health insurers
 - ❖ Assigned to another committee
- Assure no duplication with existing Medicaid Managed Care Organization (MCO) requirements
 - ❖ Our task today

3

SSB 6452 Legislative Requirements: Non-Duplication


- Recommend a strategy to ensure that expanded PAL services do not duplicate existing MCO requirements codified in [RCW 74.09.492](#)
- First draft of recommendation due July 27, 2018
- Seattle Children's Hospital (SCH) administers the PAL for Kids:
 - Referrals to children's mental health services and other resources for parents and guardians with concerns related to their child's mental health

4

SSB 6452 Legislative Requirements: Expanded Services

- Seattle Children's Hospital (SCH) administers the PAL for Kids:
 - Referrals to children's mental health services and other resources for parents and guardians with concerns related to their child's mental health

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Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Partnership Access Line - PAL An Overview

Rebecca Barclay, MD
Associate Director Partnership Access Line
Child and Adolescent Psychiatrist, Seattle Children's Hospital

Slides prepared with assistance of Robert Hill, MD, Professor of Psychiatry, University of Washington and Director Partnership Access Line, MDT Consults, and 2nd Opinion Consult Services in WA, AK, and WY



Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

PARTNERSHIP ACCESS LINE
Child Psychiatric Consultation
for Primary Care Providers

Partnership Access Line
December 1, 2018

Ways to Assist Primary Care Mental Health

1. Educate
2. Consult
 - Provider elective requests
 - 3rd party requested consults
3. Collaborate care with care managers
4. Integrate mental health clinicians
 - Off site but with well-linked systems
 - On site or co-located
5. Traditional referral to mental health care

Other Unique Aspects of PAL

- Free psychiatric care education conferences
 - 4 times a year in WA
 - 2 times a year in WY
- Free, expert reviewed care guide for providers at seattlechildrens.org/pal
- Quarterly fidelity audits and team consult approach to ensure consistent care

Telemedicine

- Can improve rural access, but does not inherently increase total system capacity



Telephone Consultations

- “Just in time” assistance when primary care clinician (PCC) wants it
- Teachable moments with their own patient
 - Most effective way to learn a new best practice
- Reach a large audience easily
 - No technology barrier
- Match intervention to level of PCC engagement
 - Call as often as you want
 - No specific mental health training commitment
- No technology barriers

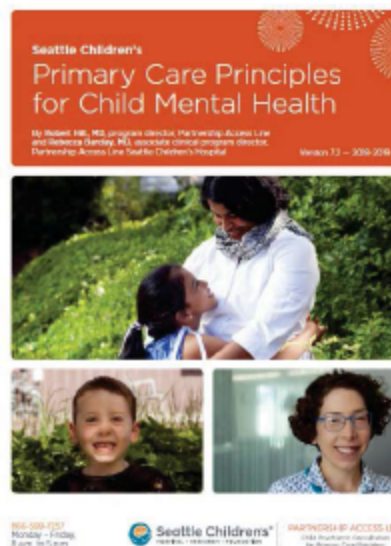


Program Development in WA

- Pilot plan put in a bill (2SHB 1088) passed in April 2007
- Started providing the new service, the Partnership Access Line, in March 2008
- PAL Wyoming added 3 years later
- PAL Plus in 2016
- WA PAL in numbers
 - ✓ By end of June 2018, 12,403 elective consults have occurred in WA alone regarding 9,933 patients.
 - ✓ Second Opinion Network medication reviews, 6,554.

Educate

- CME (>1500 practitioners by 2018)
- Local resource awareness
- Websites/Books/handouts for families
- Annual Care Guide for PCCs
 - Free at seattlechildrens.org/pal
- Education's value limited if not learning on own patient



Care Guide Examples

Depression Resources

Information for Families

Books families may find helpful:
 The Disturbed Depression Association
 The Depressed Child: Questioning The
 Diagnostic Child (2005), by Peter
 Helsing, Tracy Witt, and David

Books children may find helpful:
 Taking Depression to School (2005)
 Children's Hope Institute: Questioning
 Feeling Good: The New Moral Therapies
 My Feeling Better Workbook: Help for
 My Teen (for elementary school-age
 children) Patricia Hoffman, Amyrose A. L.
 by Ben Cohen and Elizabeth Verick

Crisis Hotlines:
 National Crisis Hotline: 1-800-985-4333
 1-800-985-4333

Websites families may find helpful

Guide to depression medications for
 children
 National Institute of Mental Health
 www.nimh.nih.gov/health/topics/child-
 adolescent-depression.shtml
 National Alliance for Mental Illness
 www.namh.org/child-adolescent
 American Psychiatric Association
 www.psychiatry.org/child-adolescent
 American Academy of Child and Adolescent
 Psychiatry
 www.aacap.org

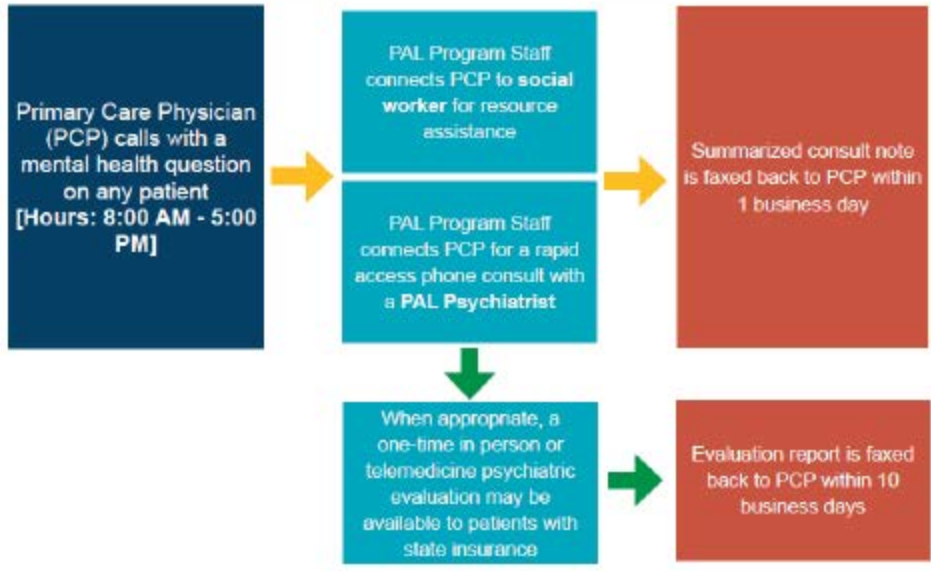
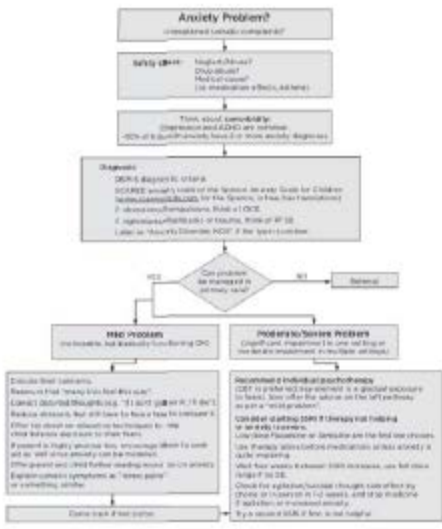
Eating Attitudes Test® (EAT-2)

Instructions: This is a screening measure to help you determine whether you
 need professional attention. This screening measure is not designed to
 make the place of a professional consultation. Please fill out the EAT-2 form
 at a school, home or other location. All of your responses are

Part A: Complete the following statements:

1. I often feel	2. I often feel	3. I often feel	4. I often feel
1. I often feel	2. I often feel	3. I often feel	4. I often feel
5. I often feel	6. I often feel	7. I often feel	8. I often feel
9. I often feel	10. I often feel	11. I often feel	12. I often feel
13. I often feel	14. I often feel	15. I often feel	16. I often feel
17. I often feel	18. I often feel	19. I often feel	20. I often feel
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25. I often feel	26. I often feel	27. I often feel	28. I often feel
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37. I often feel	38. I often feel	39. I often feel	40. I often feel
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49. I often feel	50. I often feel	51. I often feel	52. I often feel
53. I often feel	54. I often feel	55. I often feel	56. I often feel
57. I often feel	58. I often feel	59. I often feel	60. I often feel
61. I often feel	62. I often feel	63. I often feel	64. I often feel
65. I often feel	66. I often feel	67. I often feel	68. I often feel
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85. I often feel	86. I often feel	87. I often feel	88. I often feel
89. I often feel	90. I often feel	91. I often feel	92. I often feel
93. I often feel	94. I often feel	95. I often feel	96. I often feel
97. I often feel	98. I often feel	99. I often feel	100. I often feel

Part C: Professional attention: Yes/No/Not sure
 In the past 6 months have you:



Consult Follow-Up Note



PARTNERSHIP ACCESS LINE
Mental Health Consultation Outreach

Faxed on next
business day

Dear Doctor,

On 6/27/2018, you had a telephone discussion with Rebecca Barclay of the Partnership Access Line regarding your patient First Last name, (DOB: 1/1/2000). Based on the information you provided to our program, we offered some suggestions for how to better help Blake. Below is a summary of those care suggestions as recorded by Rebecca Barclay, which you might find helpful for future reference.

Psychosocial treatment advice discussed:

Especially considering his history of performing better with caffeine, consider whether sleep debt may be contributing to impulsivity, hyperactivity, and oppositional symptoms. Review careful sleep hygiene and routines with this family. If he is not getting sufficient sleep, try to address that first before initiating medication.

Ideas that were discussed for monitoring your patient:

To advance with stimulant medication, consider starting dose Ritalin LA 30 mg daily or Concerta 30 mg daily (the Concerta would deliver slightly more medication, as it is roughly equivalent to Ritalin 15 mg total daily). If immediate release is preferred, methylphenidate IR 5 mg qam and noon is equivalent to Ritalin LA 10 mg daily.

Typical stimulant monitoring includes following vitals, weight, appetite, growth, sleep, mood lability, and cardiac symptoms. Confirm there is no personal or family cardiac history, which would impact use of the stimulant.

These care suggestions are based on the clinical information we received over the phone. This advice should not supersede the best clinical judgement of an in-person care provider. Please call us again at 866-599-7257 if there is anything else we can do to help you.



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Some things we have learned

- **Getting providers to try anything new is a challenge**
 - Word of mouth among colleagues recruits our participants
 - CME meetings also spread the word
 - Geography makes lunchtime meetings impractical
 - Mailings are not great for recruitment
- **Health plan messaging about the service would be very welcome**



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Program Lessons

- **PCCs manage very complex mental health cases particularly in rural areas**
 - ~2/3rd of PAL calls about kids with “Serious Emotional Disturbance” (CGAS < 50)
 - ~3 MH related problems per patient
 - 1/3 receiving two or more medications at first contact w/ PAL



See Hill et al., Feb 2013, JAMA Pediatrics
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Program Lessons con't

- **Despite the complexity, full consults were less requested than we expected**
 - ~1 out of 10 Medicaid consult calls results in an appointment
 - ~2/3 of the time, we recommended care remain with the PCC (± a therapist)
- **By providing these supports, feel that PCCs can do a great job caring for kids**



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Program Lessons con't

- **Care coordination is a necessary component**
 - ~½ of all callers receive PAL Social Work assistance
 - Identifying therapists and other resources
- **PAL program impacts a different part of care system than Second Opinion Reviews**
 - minimal patient overlap

Program Lessons con't

- **A small “virtual” team can work**
 - A base group of 3 child psychiatrist FTEs and 2 MSW and 2 admin can support a huge geographic area with ~1.7 million children
- **If program size is large enough, immediate accessibility improves**
 - Having 3 or more docs on duty means direct connect rates increase



Program Lessons con't

- **PCCs that use the service love it, but not everyone uses it**
 - Very positive PAL feedback survey data after the calls (PCC overall satisfaction 4.63/5)
 - ✓ Increased the PCC's mental health care skills
 - ✓ Helped the PCC to manage their patient's care
 - ✓ More PAL contacts → higher feedback survey scores
- **Providers who don't call are unaware of the service, feel they don't have time to call, or prefer not to deliver mental health services**

Program Lessons con't

- **PCCs usually call because they want medication advice**
 - primary focus 58% of the time
 - ✓ ~½ PAL recommended to start a medication
 - ✓ ~¼ PAL recommended to stop a medication

Program Lessons con't

- **PAL consults steer kids into more psychosocial services (EBP therapies)**
 - ~9/10 calls recommend new psychosocial treatments
 - CBT and behavioral therapy recommendations
 - Significant increase in foster children utilizing psychotherapy appointments after the PAL call (WA FFS Medicaid data)

Change Examples: Antipsychotics

Impact of both PAL consults and 2nd opinion medication reviews

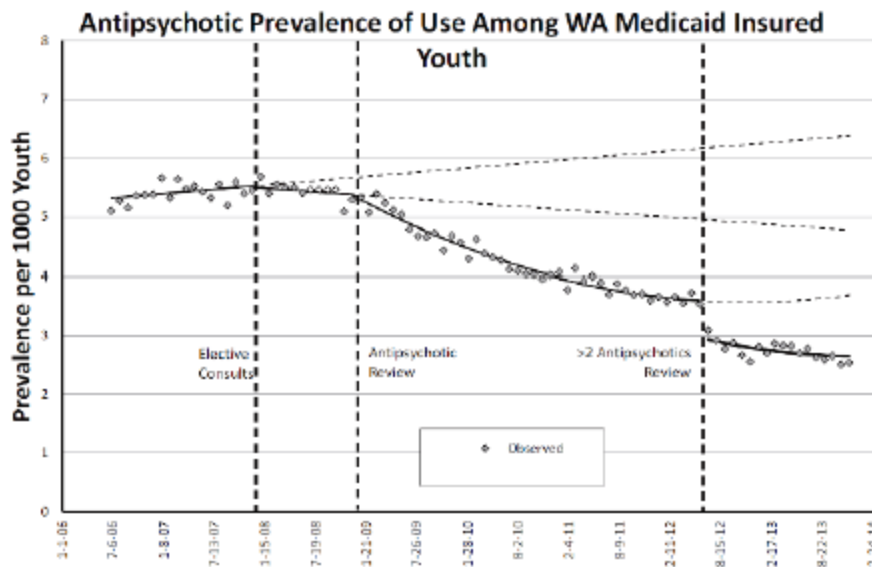
- **PAL Giving Antipsychotic Advice:**
 - ✓ 1 in 4 PAL primary care calls discussed antipsychotic use
 - ✓ 60% were already taking an antipsychotic at the time of call
 - ✓ 27% advised decreasing or stopping the med
 - ✓ New psychosocial treatments (like psychotherapy) were advised for 86% of antipsychotic discussion calls



Change Examples: Antipsychotics

- Between 2008 and 2013 (a reported study period)
 - 1008 antipsychotic discussing PAL calls
 - 870 antipsychotic 2nd opinion medication reviews

Reported Study (2008 and 2013)



Massachusetts' Case Management & Referral Model

- “Interface” maintains a statewide database
- Two referral assistance access points
 - Statewide mental health referral helpline
 - which parents can call directly
 - Massachusetts Child Psychiatry Access Program team (three local sites)
 - Primary care practices requesting referral support
- MCPAP and the statewide line both use the same real-time updated referral database

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MCPAP Resource & Referral (R&R)

- For Providers
 - List of BH resources in their area, vetted for availability, provided within 3 days of request
- For Patients
 - R & R specialist works directly with family to identify needs, and provide vetted referrals within 10 days
- The R & R specialists also
 - consult with MCPAP clinicians, who then support primary care delivery
 - track management issues over time (referral outcomes)

From www.mcpap.com

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Washington State Health Care Authority

WILLIAM JAMES COLLEGE
INTERFACE Referral Service

HELPLINE: 800-244-6843
(toll free)
Mon - Fri, 9am - 5pm
What to Expect When You Call

Home About Us Communities Mental Health Topics Guides Publications For Teens Contact Us

Serving Communities Across Massachusetts

Meet the INTERFACE Leadership

Referral Helpline

Tools for Providers

In Crisis?
What to Expect When You Call

Recent News

Being Fit in Middle Age May Protect Against Dementia, Study Finds, *TIME*, Jan 27 2018.

Depression Among the Elderly: A Call to Action, *Psychiatry*, Jan 27 2018.

How to Get the Most Out of Your Health Insurance, *Forbes*, Jan 18 2018.

More News on Mental Health Issues

Massachusetts' Bold Goal: 25% in assessment and early identification of mental health concerns in children. Pediatricians are seeing a significant increase in cases of primary mental health needs, and William James INTERFACE is supporting families in making early connections as research has shown that 92.2% of children with mental health conditions...

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Washington State Health Care Authority

Next Steps and Wrap-Up

THANK YOU!

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Partnership Access Line
December 1, 2018

Excerpts from the 2015-2018 Apple Health Contract

14 CARE COORDINATION

The Contractor shall provide the services described in this section for all Enrollees who need care coordination, regardless of acuity level. The Contractor shall either provide the additional services described in Exhibit C, Health Homes to those Enrollees who are determined eligible for Health Home or shall contract with a Qualified Health Home to provide such services.

14.1 Continuity of Care

The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for Enrollees is not interrupted and that transitions from one setting or level of care to another are promoted (42 C.F.R. § 438.208).

- 14.1.1 For changes in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions found in the Access to Care and Provider Network Section of this Contract.
- 14.1.2 If possible and reasonable, the Contractor shall preserve Enrollee provider relationships through transitions.
- 14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's medical condition requires.
- 14.1.4 Unless otherwise required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new Enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:
 - 14.1.4.1 The Enrollee's prescription expires. If the Enrollee's prescription expires before he or she is able to be evaluated by a participating provider, the Contractor shall facilitate the receipt of a primary care visit and shall not deny the prescription.
 - 14.1.4.2 A participating provider examines the Enrollee to evaluate the continued need for the prescription, and if necessary, oversees medically appropriate changes that do not threaten the health of the Enrollee.
 - 14.1.4.2.1 If the Enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the Enrollee's safety and the safety of others is considered in the decision.
 - 14.1.4.3 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.
 - 14.1.4.4 Allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has documented established relationships. The Contractor

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shall take the following steps:

- 14.1.4.4.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.
- 14.1.4.4.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.
- 14.1.4.4.3 If the established non-participating provider or the Enrollee will not cooperate with a necessary transition, the Contractor may transfer the Enrollee's care to a participating provider within ninety (90) calendar days of the Enrollee's enrollment effective date.
- 14.1.4.4.4 The Contractor may choose to pay the established non-participating provider indefinitely to provide care to the Enrollee if the non-participating provider will accept payment rates the Contractor has established for non-participating providers as payment in full.
- 14.1.4.4.5 The Contractor shall apply utilization management decision-making standards to non-contracted providers no more stringent than standards for participating providers.

14.2 Identification of Individuals with Special Health Care Needs

- 14.2.1 Within ninety (90) calendar days of enrollment, beginning the first of the month after the month of enrollment, the Contractor shall identify every new individual with special health care needs whether or not the Enrollee meets Health Home criteria.
 - 14.2.1.1 To identify individuals with special health care needs, the Contractor may review administrative data, such as PRISM, diagnoses of acute conditions requiring care coordination services such as catastrophic injuries, children with elevated blood lead screen levels, chronic conditions, indicators of potential for high risk pregnancy, Foster Care, SSI or Title V designation, social complexity (history of homelessness, language barriers, diagnoses of substance use disorder or serious, persistent mental health conditions, domestic violence or arrests), Enrollees with unmet care needs or evidence of being underserved or through Enrollee responses to Contractor interviews or surveys.
- 14.2.2 On the 15th of the month following each quarter, the Contractor shall submit a report to HCA of individuals identified with special health care needs. The report shall include:



- 14.3.3.1 The assessment shall include, at minimum, an evaluation of the Enrollee's physical, behavioral, and oral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.
- 14.3.3.2 The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure that arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community-based social services.
- 14.3.3.3 The IHA shall be maintained in the Enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.
- 14.3.4 The Contractor shall establish business rules, including policies and procedures regarding screening, referral and co-management of individuals with both behavioral health and physical health conditions. Both behavioral health and physical health care managers or Disease Management coaches will be trained on the protocols.
 - 14.3.4.1 The Contractor shall require and ensure that primary care providers and care coordinators employed by the Contractor or in the Contractor's provider network shall be trained on standardized, validated screening tools used in the conduct of an IHA and an age appropriate evaluation, to evaluate at a minimum:
 - 14.3.4.1.1 Delays in child development;
 - 14.3.4.1.2 Behavioral health conditions including substance use disorders;
 - 14.3.4.1.3 Adverse Childhood Experiences; and
 - 14.3.4.2 The Contractor shall provide a toll free line for primary care providers and other medical specialists to call for technical and referral assistance when behavioral health conditions, requiring treatment or developmental delays are suspected or identified.
 - 14.3.4.2.1 Available information shall include assistance in arranging for consultations, including mental health treatment referrals and substance use disorder treatment and treatment by providers with appropriate expertise and experience in mental health, substance use disorder or developmental issues.
 - 14.3.4.2.2 Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to Contracted providers.
- 14.3.5 The Contractor shall develop care coordination plan for individuals with special health care needs that do not meet Health Home referral criteria, so long as the following are true:



comprehensive medication therapy management services, oral health services, or community resources.

14.3.8.1 Care coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.

14.3.9 The Contractor shall develop policies and procedures to govern coordination of assessments and evaluations with mental health, substance use disorder and other providers, and if an Enrollee chooses to change enrollment to another AH plan, the Contractor's care management staff will coordinate transition of the Enrollee to the new plan's care management system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure that Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208 (b)(3)).

14.4 Coordination Between the Contractor and External Entities

14.4.1 The Contractor shall coordinate with, and refer Enrollees to health care and social services/programs as appropriate including, but not limited to:

14.4.1.1 Area Agencies on Aging;

14.4.1.2 BHOs for coordination of mental health services, including Licensed Substance Use Disorder providers and Community Mental Health Agencies;

14.4.1.3 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Apple Health MCOs;

14.4.1.4 County-managed treatment and social service programs (e.g. Access to Recovery, Criminal Justice Treatment Account Services);

14.4.1.5 Dental services, including the promotion of oral health screening and prevention;

14.4.1.6 DOH and LHJ services, including Title V services for children with special health care needs;

14.4.1.7 DSHS divisions, including:

14.4.1.7.1 Aging and Long-Term Support Administration (ALTSA) including Home and Community Services;

14.4.1.7.2 Juvenile Justice and Rehabilitation Administration;

14.4.1.7.3 Children's Administration;

14.4.1.7.4 Developmental Disabilities Administration;

14.4.1.7.5 Behavioral Health Administration; and



and reporting completed by WHA, according to the terms and schedule defined by the WHA.

- 14.4.5 The Contractor shall coordinate Enrollee information, including initial assessments and care plans, with other managed care entities as needed when an Enrollee changes from one MCO to another, changes from one Health Home lead to another or receives services through a BHO, to reduce duplication of services and unnecessary delays in service provision for Enrollees.
- 14.4.6 For Enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC Enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the Enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.
- 14.4.7 The Contractor shall participate in the local Accountable Communities of Health (ACH) in each Regional Service Areas in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies but must participate as follows:
 - 14.4.7.1 Serve in a leadership or other supportive capacity;
 - 14.4.7.2 Participate in the design and implementation of transformation projects;
 - 14.4.7.3 Collaborate with provider networks to implement Value Based Purchasing Models; and
 - 14.4.7.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

14.5 Transitional Care

- 14.5.1 The Contractor shall ensure transitional care services described in this Section are provided to all Enrollees who are transitioning from one setting to another.
- 14.5.2 The Contractor shall provide Transitional Care services to Enrollees who participate in Health Home services in accord with Exhibit C, Health Homes. When a Health Home Enrollee moves from one service area to another, the Contractor in the new service area shall ensure the Enrollee receives Contractor-based care coordination services or other services to ensure the care plan established by the Health Home Care Coordinator in the previous county of residence continues for the Enrollee. If Health Home services were not available in the previous county of residence, the Contractor shall ensure a Health Home-eligible Enrollee receives Health Home services in the new service area consistent with Exhibit C of this Contract.
- 14.5.3 The Contractor shall maintain written operational agreements with BHOs.
- 14.5.4 Contractor shall work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which will support the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or by way of incorporation to Contractor's subcontracts with the Contractor's contracted state and



as a skilled nursing facility or residential mental health facility within seven (7) calendar days post-discharge to support: discharge instructions, assess the environment for safety issues, conduct medication reconciliation, assess adequacy of support network and services, and linkage of the Enrollee to appropriate referrals;

14.5.4.1.10 Scheduled outpatient mental health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; and

14.5.4.1.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.

14.5.5 The Contractor shall request from Enrollees permission to share information with clinical and non-clinical providers to facilitate care transitions.

14.6 Skilled Nursing Facility Coordination

14.6.1 The Contractor is responsible for medically necessary Skilled Nursing Facility (SNF) or Nursing Facility (NF) stays when the Contractor determines that nursing facility care is more appropriate than acute hospital care. The Contractor shall coordinate with hospital or other acute care facility discharge planners and nursing facility care managers or social workers, as described in the Coordination Between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the Enrollee to or from a SNF or NF.

14.6.2 The Contractor shall coordinate with the SNF or NF to provide care coordination and transitional care and shall ensure coverage of all medically necessary services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.

14.6.2.1 If the Contractor, in coordination with the NF or SNF, anticipates the Enrollee will be in the facility for additional days after an Enrollee no longer meets criteria for medically necessary skilled nursing or rehabilitative care, the Contractor shall coordinate with the Aging and Long-Term Support Administration (AL TSA) Home and Community Services (HCS) to:

14.6.2.1.1 Determine functional, financial and institutional eligibility, if necessary; and

14.6.2.1.2 Assist the Enrollee to explore all options available for care, including whether the Enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for long term services and supports (LTSS).

14.6.2.2 If the Enrollee is discharged to his or her home or a community residential setting the Enrollee remains enrolled in AH. The Contractor shall coordinate



needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider;

14.8.1.2 Follow-up up to ensure an appointment has been secured; and

14.8.1.3 Coordinate with the PCP regarding development of a treatment plan, including medications management. (Chapter 74.09 RCW).

14.9 Care Coordination with Behavioral Health Organizations (BHOs)

14.9.1 The Contractor shall have an operational agreement with all Behavioral Health Organizations (BHO)s operating in the Contractor's Service Areas that, in addition to Transitional Care, addresses comprehensively the day-to-day operational requirements to coordinate physical and behavioral health care services and fully recognizes the shared responsibility for their mutual Enrollees' health care.

14.9.2 The operational agreement shall address the following areas:

14.9.2.1 Exchange of Enrollee health information to include:

14.9.2.1.1 Diagnosis;

14.9.2.1.2 Treatment, including treatment plan;

14.9.2.1.3 Medications;

14.9.2.1.4 Labs/Testing; and

14.9.2.1.5 Treating providers, with contact information.

14.9.2.2 Transitions in care between the Contractor and BHOs, and BHOs and the Contractor.

14.9.3 The Contractor shall require providers to coordinate with BHO providers and provide all required information to facilitate such coordination, and shall provide written instructions to its primary care and mental health professionals on how to access mental health services for Enrollees. Instructions shall include information on when an Enrollee should be referred to the Behavioral Health Organization (BHO) for an evaluation and when the Enrollee should receive services from a provider contracted with the Contractor for mental health services.

14.10 Health Home for Individuals with Special Health Care Needs

The Contractor shall establish and implement a Health Home program that meets the requirements of this Section and Exhibit C, Health Homes by becoming a Qualified Health Home or contracting with a Qualified Health Home. The Contractor shall subcontract with organizations such as regional support networks, substance use disorder treatment facilities and long term care agencies, to provide a full range of Health Home services. All Enrollees meeting the diagnoses and risk criteria defined by the HCA and identified through the 834 report as Health Home eligible shall be referred to Health Home services.



- 14.13.2.1 Provide transitional care coordination services to Enrollees when they enter a correctional facility, including:
 - 14.13.2.1.1 Working with the facility to define the responsible party at the facility who will provide care coordination activities in the facility;
 - 14.13.2.1.2 Ensuring the facility is aware of the Enrollee's special needs, such as a PRISM score of 1 or higher, substance use disorder, mental health needs, or chronic health condition, and is aware of medications and supplies the enrollee needs; and
 - 14.13.2.1.3 Providing information to enable the facility to maintain the Enrollee's medication regimen while the Enrollee is incarcerated.
- 14.13.2.2 Provide services and care coordination for Enrollees upon release from a correctional facility or state hospital, including:
 - 14.13.2.2.1 Coordinating with the facility to get copies of the Enrollee's medical records at the time of discharge;
 - 14.13.2.2.2 Requesting that the Enrollee sign a Release of Information to allow exchange of health care information between systems;
 - 14.13.2.2.3 Using an evidence based approach to care coordination as the Enrollee transitions from incarceration to the community;
 - 14.13.2.2.4 Ensuring expedited prior authorization for medications or supplies prescribed while the Enrollee was incarcerated;
 - 14.13.2.2.5 Prioritize care coordination for Enrollees with special needs, such as a PRISM score of 1 or higher, substance use disorder, mental health needs, or chronic health condition;
 - 14.13.2.2.6 Providing the Enrollee with an overview of benefits for which the Enrollee is eligible through the MCO;
 - 14.13.2.2.7 Discuss with the Enrollee how to access a PCP, notify the Enrollee who their PCP is or help the Enrollee to find a PCP; and
 - 14.13.2.2.8 Assist the Enrollee to access the following services:
 - 14.13.2.2.8.1 Transportation to Medicaid appointments;
 - 14.13.2.2.8.2 Follow-up appointments for behavioral health or medical services;



Appendix G: Alternative Funding Model Implementation

This appendix includes the following information:

- Implementation tasks to implement the recommended alternative funding model that uses funding from an existing revenue source without including a governing board; and
- Additional implementation tasks and high-level, estimated financial impacts to implement an each of the non-recommended alternative funding models, with or without including a governing board.

Using Appropriated Funding from an Existing Revenue Source Without a Governing Board

Implementation Tasks

Table G.1 lists implementation tasks to implement the recommended alternative funding model that uses funding from an existing revenue source without including a governing board.

Table G.1. Implementation Tasks for Using Funding from an Existing Revenue Source Without a Governing Board

Task	Done by Whom	Estimated Due Date
1. Design non-duplication policies, procedures, and materials for the PAL for Kids pilot program	HCA with Seattle Children's Hospital and Apple Health MCOs	12/15/2018
2. Define data collection, reporting, and future program evaluation requirements for the current and expanded PAL services	HCA with Seattle Children's Hospital and the University of Washington	12/15/2018
3. Sign professional services contracts with Seattle Children's Hospital and the University of Washington for the first year of the PAL for Moms and Kids pilot program	HCA	12/31/2018
4. Launch the PAL for Moms and Kids pilot program	Seattle Children's Hospital and the University of Washington	1/1/2019



Task	Done by Whom	Estimated Due Date
5. Pass the state fiscal year (SFY) 2020–2021 biennial budget, which includes sufficient General Fund—State appropriation to HCA to implement the alternative funding model and related recommendations	Legislature	4/30/2019
6. Renew the professional services contract with Seattle Children's Hospital for the current PAL program	HCA	6/30/2019
7. Sign a program evaluation contract with the vendor	HCA	8/1/2019
8. Report to the Governor, appropriate committees of the Legislature, and the Children's Mental Health Work Group with findings and recommendations for improving current and expanded PAL services and service delivery	HCA with vendor	12/30/2019
9. Renew the professional services contracts with Seattle Children's Hospital and the University of Washington for the second year of the PAL for Moms and Kids pilot program	HCA	12/31/2019
10. Pass the SFY 2021 supplemental budget, which includes sufficient General Fund—State appropriation to HCA to implement the alternative funding model and related recommendations	Legislature	3/31/2020
11. Renew the professional services contract with Seattle Children's Hospital for the current PAL program	HCA	6/30/2020
12. Renew the program evaluation contract with the vendor	HCA	8/1/2020
13. Report to the Governor, appropriate committees of the Legislature, and the Children's Mental Health Work Group with findings and recommendations for improving current and expanded PAL services and service delivery	HCA with vendor	12/30/2020
14. Renew the professional services contracts with Seattle Children's Hospital and the University of Washington for the second year of the PAL for Moms and Kids pilot program	HCA	12/31/2020
15. Launch the alternative funding model for current and expanded PAL program services	HCA	1/1/2021
16. Pass the SFY 2022–2023 biennial budget, which includes sufficient General Fund—State appropriation to HCA to continue the alternative funding model and related recommendations	Legislature	4/30/2020
17. Renew the professional services contract with Seattle Children's Hospital for the current PAL program	HCA	6/30/2021



Task	Done by Whom	Estimated Due Date
18. Compare the PAL program cost-split to the estimated proportion of PAL services benefitting members of Apple Health and non-Apple Health plans	HCA	6/30/2021
19. Submit to OFM an adjustment to the mechanism of the funding approach as needed to ensure an appropriate cost-split for the current and expanded PAL program services	HCA	9/30/2021
20. Report to the Governor, appropriate committees of the Legislature, and the Children's Mental Health Work Group with findings and recommendations for improving current and expanded PAL services and service delivery	HCA with vendor	12/30/2021
21. Renew the professional services contracts with Seattle Children's Hospital and the University of Washington for the second year of the PAL for Moms and Kids pilot program	HCA	12/31/2021
22. Pass the SFY 2023 supplemental budget, which includes any needed adjustment to the mechanism of the funding approach to ensure an appropriate cost-split for the current and expanded PAL program services beginning July 1, 2022	Legislature	3/31/2022
23. Renew the professional services contract with Seattle Children's Hospital for the current PAL program	HCA	6/30/2022
24. Compare the PAL program cost-split to the estimated proportion of PAL services benefitting members of Apple Health and non-Apple Health plans	HCA	6/30/2022
25. Submit to OFM an adjustment to the mechanism of the funding approach as needed to ensure an appropriate cost-split for the current and expanded PAL program services	HCA	9/30/2022
26. Report to the Governor, appropriate committees of the Legislature, and the Children's Mental Health Work Group with findings and recommendations for improving current and expanded PAL services and service delivery	HCA with vendor	12/30/2022
27. Renew the professional services contracts with Seattle Children's Hospital and the University of Washington for the second year of the PAL for Moms and Kids pilot program	HCA	12/31/2022
28. Pass the SFY 2024–2025 biennial budget, which includes any final needed adjustment to the mechanism of the funding approach to ensure an appropriate cost-split for the current and expanded PAL program services beginning July 1, 2023	Legislature	4/30/2023



Using a Per-Covered-Child Assessment Without a Governing Board

Additional Implementation Tasks

To implement the per-covered-child assessment alternative funding model without a governing board, HCA assumes the tasks in table G.2. These tasks are in addition to those for implementing the recommended alternative funding model that uses funding from an existing revenue source without involving a governing board.

Table G.2. Implementation Tasks for Using a Per-Coved-Child Assessment Without a Governing Board

Task	Done by Whom	Estimated Due Date
1. Pass the state fiscal year (SFY) 2020–2021 biennial budget, which creates the “Per-Covered-Child Assessment Fund”, authorizes HCA to collect the per-covered-child assessment (or to contract with a vendor to perform that function), and includes sufficient General Fund—State appropriation to HCA to implement the alternative funding model and related recommendations	Legislature	4/30/2019
2. Issue a job announcement for staff to support the per-covered-child assessment contract and related processes	HCA	8/1/2019
3. Hire additional staff to support the per-covered-child assessment contract and related processes	HCA	10/1/2019
4. Pass the SFY 2021 supplemental budget, which continues to include the “Per-Covered-Child Assessment Fund”, continues to authorize HCA to collect the per-covered-child assessment (or to contract with a vendor to perform that function), and continues to include sufficient General Fund—State appropriation to HCA to implement the alternative funding model and related recommendations	Legislature	3/31/2020
5. Select a vendor to calculate and administer the per-covered-life assessment	HCA	4/1/2020
6. Sign a professional services contract with a vendor to calculate and administer the per-covered-child assessment	HCA	7/1/2020
7. Renew the professional services contract with the vendor to calculate and administer the per-covered-child assessment	HCA	7/1/2021
8. Renew the professional services contract with the vendor to calculate and administer the per-covered-child assessment	HCA	7/1/2022



Estimated Financial Impact

HCA estimates the following financial impact from implementing an alternative funding model that uses funding from an existing revenue source and includes a governing board, based on the following data:

- OFM statewide population forecasts;
- Caseload Forecast Council population forecasts for relevant Apple Health caseloads;
- Current PAL program contract costs;
- Expanded PAL services cost estimates in the fiscal note for SSB 6452;
- Program evaluation contract cost estimates;
- Staffing cost estimates; and the
- Standard Medicaid reimbursement rate of 50 percent for eligible expenses from the General Fund (GF)—State fund.

At the time HCA writes this report, caseload forecasts only extend through the end of SFY 2021. For the purposes of this estimated financial impact analysis, we assume zero caseload population growth and zero contract cost increases between SFY 2021 and SFY 2022. As the expanded PAL services become more established and demand for those services potentially grows, we assume that any need for contract cost increases will result in a supplemental budget request. While the implementation timeline extends through SFY 2023, our financial analysis only extends through SFY 2022.

In addition, HCA assumes for the purposes of this estimated financial impact analysis that the proportion of the PAL program that will be Medicaid reimbursable when using the per-covered-child assessment will be about the same as it would be using funding from the GF—State fund.

Table G.3. Estimated Cash Receipts (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—Federal Medicaid Title XIX	\$434,550	\$606,490	\$704,172	\$502,113
Per-Covered-Child Assessment Fund	\$0	\$0	\$512,694	\$1,289,358
TOTAL	\$434,550	\$606,490	\$1,216,865	\$1,791,470

Estimated cash receipts from Medicaid reimbursement is highest at \$704,172 during SFY 2021. (See Table G.3.) There is a higher Medicaid reimbursement amount for the first half of the fiscal year (July 2019 through December 2020) than during the second half of the fiscal year (January 2021 through June 2021). This is because the alternative funding model takes effect on January 1, 2021.



Table G.4. Estimated Expenditures (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—State	\$719,450	\$1,474,510	\$1,543,828	\$1,625,887
GF—Federal Medicaid Title XIX	\$434,550	\$606,490	\$704,172	\$502,113
TOTAL	\$1,154,000	\$2,081,000	\$2,248,000	\$2,128,000

Total estimated expenditures are lowest in SFY 2019 because:

- The contracts for the PAL for Moms and Kids pilot program begin during the second half of the fiscal year (January 2019 through June 2019);
- The contract for the for the program evaluation begins during SFY 2020; and
- The contract for the vendor to calculate and administer the per-covered-child assessment begins during the second half of SFY 2020. (See Table G.4.)

HCA assumes the contract costs will remain stable in SFY 2021 and SFY 2022, though the cost-split between GF—State and GF—Federal Medicaid Title XIX will vary due to the alternative funding model implementation.

Table G.5. Estimated FTEs

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
FTEs	0.0	1.0	1.0	1.0
TOTAL	0.0	1.0	1.0	1.0

HCA assumes that we will require an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) to manage the contract with the vendor that will calculate and administer the per-covered-child assessment. (See Table G.5.)

Including a Governing Board With Either Alternative Funding Model

Additional Implementation Steps to Include a Governing Board

To include a governing board with either of the alternative funding models, HCA assumes the tasks in table G.6. These tasks are in addition to those for implementing either alternative funding model without a governing board.

Table G.6. Additional Implementation Steps to Include a Governing Board

Task	Done by Whom	Estimated Due Date
1. Begin drafting a bill to create the governing board	HCA with Legislative staff	6/1/2019
2. Pass a bill to create the governing board	Legislature	3/31/2020



Task	Done by Whom	Estimated Due Date
3. Select members of the governing board	Governor's Office	10/1/2020
4. Schedule and prepare for quarterly board meetings	HCA	11/1/2020
5. Hold a quarterly governing board meeting	HCA and Governing Board	1/20/2021
6. Hold a quarterly governing board meeting	HCA and Governing Board	4/21/2021
7. Hold a quarterly governing board meeting	HCA and Governing Board	7/21/2021
8. Hold a quarterly governing board meeting	HCA and Governing Board	10/27/2021
9. Hold a quarterly governing board meeting	HCA and Governing Board	1/26/2022
10. Hold a quarterly governing board meeting	HCA and Governing Board	4/27/2022
11. Hold a quarterly governing board meeting	HCA and Governing Board	7/27/2022
12. Hold a quarterly governing board meeting	HCA and Governing Board	10/26/2022
13. Hold a quarterly governing board meeting	HCA and Governing Board	1/25/2023
14. Hold a quarterly governing board meeting	HCA and Governing Board	4/26/2023

Estimated Financial Impact: Using Funding From an Existing Revenue Source with a Governing Board

HCA estimates the following financial impact from implementing an alternative funding model that uses funding from an existing revenue source and includes a governing board, based on the following data:

- OFM statewide population forecasts;
- Caseload Forecast Council population forecasts for relevant Apple Health caseloads;
- Current PAL program contract costs;
- Expanded PAL services cost estimates in the fiscal note for SSB 6452;
- Program evaluation contract cost estimates;
- Staffing cost estimates; and the
- Standard Medicaid reimbursement rate of 50 percent for eligible expenses from the General Fund (GF)—State fund.

At the time HCA writes this report, caseload forecasts only extend through the end of SFY 2021. For the purposes of this estimated financial impact analysis, we assume zero caseload population growth and zero contract cost increases between SFY 2021 and SFY 2022. We also assume board members will not incur additional expenses. As the expanded PAL services become more established and demand for those services potentially grows, we assume that any need for contract cost increases will result in a supplemental budget request. While the implementation timeline extends through SFY 2023, our financial analysis only extends through SFY 2022.



Table G.7. Estimated Cash Receipts (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—Federal Medicaid Title XIX	\$434,550	\$660,990	\$721,172	\$529,113
TOTAL	\$434,550	\$660,990	\$721,172	\$529,113

Estimated cash receipts from Medicaid reimbursement is highest at \$721,172 during SFY 2021. (See Table G.7.) There is a higher Medicaid reimbursement amount for the first half of the fiscal year (July 2010 through December 2020) than during the second half of the fiscal year (January 2021 through June 2021). This is because the alternative funding model takes effect on January 1, 2021.

Table G.8. Estimated Expenditures (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—State	\$719,450	\$1,529,010	\$1,560,828	\$1,652,887
GF—Federal Medicaid Title XIX	\$434,550	\$660,990	\$721,172	\$529,113
TOTAL	\$1,154,000	\$2,190,000	\$2,282,000	\$2,182,000

Total estimated expenditures are lowest in SFY 2019 because:

- The contracts for the PAL for Moms and Kids pilot program begin during the second half of the fiscal year (January 2019 through June 2019);
- The contract for the for the program evaluation begins during SFY 2020; and
- HCA will hire additional staff during the second half of SFY 2020 to support the governing board. (See Table G.8.)

HCA assumes the contract costs will remain stable in SFY 2021 and SFY 2022, though the cost-split between GF—State and GF—Federal Medicaid Title XIX will vary due to the alternative funding model implementation.

Table G.9. Estimated Full-Time Equivalents (FTEs)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
FTEs	0.0	2.0	2.0	2.0
TOTAL	0.0	2.0	2.0	2.0

HCA's assumes that we will require an additional 1.0 FTE Washington Management Service 3 (WMS3) and an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) to:

- Manage the contract with the vendor that will calculate and administer the per-covered-child assessment; and
- Support the governing board. (See Table G.9.)



Estimated Financial Impact: Assessment Per-Covered-Child with a Governing Board

HCA estimates the following financial impact from implementing an alternative funding model that uses an assessment per-covered-child and includes a governing board, based on the following data:

- OFM statewide population forecasts;
- Caseload Forecast Council population forecasts for relevant Apple Health caseloads;
- Current PAL program contract costs;
- Expanded PAL services cost estimates in the fiscal note for SSB 6452;
- Program evaluation contract cost estimates;
- Staffing cost estimates; and the
- Standard Medicaid reimbursement rate of 50 percent for eligible expenses from the General Fund (GF)—State fund.

At the time HCA writes this report, caseload forecasts only extend through the end of SFY 2021. For the purposes of this estimated financial impact analysis, we assume zero caseload population growth and zero contract cost increases between SFY 2021 and SFY 2022. As the expanded PAL services become more established and demand for those services potentially grows, we assume that any need for contract cost increases will result in a supplemental budget request. While the implementation timeline extends through SFY 2023, our financial analysis only extends through SFY 2022.

In addition, HCA assumes for the purposes of this estimated financial impact analysis that the proportion of the PAL program that will be Medicaid reimbursable when using the per-covered-child assessment will be about the same as it would be using funding from the GF—State fund.

Table G.10. Estimated Cash Receipts (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—Federal Medicaid Title XIX	\$434,550	\$660,990	\$771,172	\$569,113
Per-Covered-Child Assessment Fund	\$0	\$0	\$623,200	\$1,289,358
TOTAL	\$434,550	\$660,990	\$1,394,372	\$1,858,470

Estimated cash receipts from Medicaid reimbursement is highest at \$771,172 during SFY 2021. (See Table G.10.) There is a higher Medicaid reimbursement amount for the first half of the fiscal year (July 2010 through December 2020) than during the second half of the fiscal year (January 2021 through June 2021). This is because the alternative funding model takes effect on January 1, 2021.



Table G.11. Estimated Expenditures (in Dollars)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF—State	\$719,450	\$1,529,010	\$1,610,828	\$1,692,887
GF—Federal Medicaid Title XIX	\$434,550	\$660,990	\$771,172	\$569,113
TOTAL	\$1,154,000	\$2,190,000	\$2,382,000	\$2,262,000

Total estimated expenditures are lowest in SFY 2019 because:

- Contracts for the PAL for Moms and Kids pilot program and the program evaluation begin during the second half of the fiscal year (January 2019 through June 2019);
- The contract for the vendor to calculate and administer the per-covered-child assessment begins during the second half of SFY 2020; and
- HCA will hire additional staff during the second half of SFY 2020 to manage the per-covered-child assessment and support the governing board. (See Table G.11.)

Table G.12. Estimated Full-Time Equivalents (FTEs)

	SFY 2019	SFY 2020	SFY 2021	SFY 2022
FTEs	0.0	2.0	2.0	2.0
TOTAL	0.0	2.0	2.0	2.0

HCA assumes that we will require an additional 1.0 FTE Washington Management Service 3 (WMS3) and an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) with existing administrative support to:

- Manage the contract with the vendor that will calculate and administer the per-covered-child assessment; and
- Support the governing board. (See Table G.12.)



Appendix H: Financial Impact Estimate Details

This appendix includes details about the cost-split estimates, estimated expenditures, and estimated cash receipts for the financial impact estimates for each of the alternative funding approaches included in this report.

PAL Program Cost-Split Estimates

HCA calculates the proportion of the PAL program that would be eligible for federal Medicaid reimbursement by referencing the ratio between populations in Apple Health enrollment data and Office of Financial Management (OFM) population data. (See Table H.1.)

Table H.1. Population Forecasts

Forecast	SFY 2021	SFY 2022
OFM Statewide Population Forecast (ages 0–20)¹	2,005,639	2,024,025
Apple Health Population Forecast (ages 0–20):²	852,785	852,785
Categorically Needy Children ³	781,787	781,787
State Children’s Health Insurance Program (SCHIP) ⁴	70,998	70,998
Apple Health Population Forecast (ages 0-20) Percentage⁵ of OFM Statewide Population Forecast (ages 0-20)	42.5%	42.1%

NOTES:

1. HCA calculated the state fiscal year (SFY) population estimate by averaging the sums of the population estimates for ages 0 through 20 (inclusive) for each calendar year included in the SFY. See: Forecast of the State Population by Age and Sex, Washington State Office of Financial Management, Forecasting and Research Division, November 2017, “Single Year” worksheet, <https://ofm.wa.gov/sites/default/files/public/dataresearch/pop/stfc/stfc2017/stfc_2017.xlsx>, accessed on September 4, 2018.
2. To ensure an efficient and conservative calculation of the Apple Health Population Forecast, HCA did not attempt to calculate population estimates for ages 0 through 20 (inclusive) within the “Categorically Needy Blind and People with Disabilities” forecast produced by the Washington State Caseload Forecast Council. The Council’s publically available population forecasts do not detail the populations by age, and the Categorically Needy Blind and People with Disabilities includes both children and adults.
3. For SFY 2021, we averaged the monthly Categorically Needy Children population forecasts for July 2020 through June 2021 (inclusive). At the time HCA writes this report, the forecasts do not extend beyond June 2021. For SFY 2022, we assumed the same forecast as we calculated for SFY 2021. See: Washington State Caseload Forecast Council, Human Services, “Categorically Needy Children”, <http://www.cfc.wa.gov/Monitoring/MS_ACC_CN_Children.xlsx>, accessed on September 4, 2018.
4. For SFY 2021, we averaged the monthly SCHIP population forecasts for July 2020 through June 2021 (inclusive). At the time HCA writes this report, the forecasts do not extend beyond June 2021. For SFY 2022, we assumed the same forecast as we calculated for SFY 2021. See:



Washington State Caseload Forecast Council, Human Services, "State Children's Health Insurance Program (SCHIP)", <http://www.cfc.wa.gov/Monitoring/MS_ACC_SCHIP.xlsx>, accessed on September 4, 2018.

- HCA calculated the percentage by dividing "Apple Health Population Forecast (ages 0–20)" by "OFM Statewide Population Forecast (ages 0–20)" and multiplying by 100 percent.

Financial Impact Estimate Details for Using Appropriated Funding from an Existing Revenue Source Without a Governing Board

Table H.2. Estimated Expenditures (in Dollars): Funding From an Existing Revenue Source Without a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	769,000	769,000	769,000	769,000
Non-Medicaid Portion:	0	0	221,013	444,996
GF-State	0	0	221,013	444,996
Medicaid Portion:	769,000	769,000	547,987	324,004
GF-State	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	264,000	780,000	780,000	780,000
Non-Medicaid Portion:	195,360	577,200	411,374	451,362
GF-State	195,360	577,200	411,374	451,362
Medicaid Portion:	68,640	202,800	368,626	328,638
GF-State	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	121,000	393,000	393,000	393,000
Non-Medicaid Portion:	89,540	290,820	207,269	227,417
GF-State	89,540	290,820	207,269	227,417
Medicaid Portion:	31,460	102,180	185,731	165,583
GF-State	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Program Evaluation Contract:⁴	0	50,000	100,000	0
GF-State	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
TOTAL ESTIMATED COST	1,154,000	1,992,000	2,042,000	1,942,000
TOTAL GF-State	719,450	1,430,010	1,440,828	1,532,887
TOTAL GF-Federal Medicaid Title XIX	434,550	561,990	601,172	409,113



Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
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NOTES:

1. HCA assumes no PAL contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. In SFY 2022, we apply the 42.1 percent cost-split for the annual expenditure to reflect the fiscal model. We assume a 50-percent Medicaid match each year.
2. The PAL for Kids (Seattle Children's Hospital) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. In SFY 2022, we apply the 42.1 percent cost-split for the annual expenditure to reflect the fiscal model. We assume a 50-percent Medicaid match each year.
3. The PAL for Moms (University of Washington) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. In SFY 2022, we apply the 42.1 percent cost-split for the annual expenditure to reflect the fiscal model. We assume a 50-percent Medicaid match each year.
4. HCA estimates the cost of the program evaluation contract, based on previous experience and preliminary discussions with a research organization. We assume the contract will begin toward the beginning of SFY 2020, and we assume a 50-percent Medicaid match each year.

Table H.3. Estimated Cash Receipts (in Dollars): Funding From an Existing Revenue Source Without a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	384,500	384,500	273,993	162,002
Medicaid Portion:	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	34,320	101,400	184,313	164,319
Medicaid Portion:	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	15,730	51,090	92,865	82,792
Medicaid Portion:	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Program Evaluation Contract:⁴	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
TOTAL ESTIMATED CASH RECEIPTS¹	434,550	561,990	601,172	409,113
TOTAL GF-Federal Medicaid Title XIX	434,550	561,990	601,172	409,113

NOTES:

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Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
1. For the portion of the PAL contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.				
2. For the portion of the PAL for Kids (Seattle Children's Hospital) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.				
3. For the portion of the PAL for Moms (University of Washington) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.				
4. All of the program evaluation contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.				

Financial Impact Estimate Details for a Per-Covered-Child Assessment Without a Governing Board

Table H.4. Estimated Expenditures (in Dollars): Per-Covered-Child Assessment Without a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	769,000	769,000	769,000	769,000
Non-Medicaid Portion:	0	0	221,013	444,996
GF-State	0	0	221,013	444,996
Medicaid Portion:	769,000	769,000	547,987	324,004
GF-State	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	264,000	780,000	780,000	780,000
Non-Medicaid Portion:	195,360	577,200	411,374	451,362
GF-State	195,360	577,200	411,374	451,362
Medicaid Portion:	68,640	202,800	368,626	328,638
GF-State	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	121,000	393,000	393,000	393,000
Non-Medicaid Portion:	89,540	290,820	207,269	227,417
GF-State	89,540	290,820	207,269	227,417
Medicaid Portion:	31,460	102,180	185,731	165,583
GF-State	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Per-Covered-Child Assessment Contract:⁴	0	0	100,000	80,000
GF-State	0	0	50,000	40,000
GF-Federal Medicaid Title XIX	0	0	50,000	40,000
Program Evaluation Contract:⁵	0	50,000	100,000	0
GF-State	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0

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Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
HCA FTE - MAPS2:⁶	0	89,000	106,000	106,000
GF-State	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED COST	1,154,000	2,081,000	2,248,000	2,128,000
TOTAL GF-State	719,450	1,474,510	1,543,828	1,625,887
TOTAL GF-Federal Medicaid Title XIX	434,550	606,490	704,172	502,113

NOTES:

1. HCA assumes no PAL contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.
2. The PAL for Kids (Seattle Children's Hospital) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.
3. The PAL for Moms (University of Washington) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021.
4. HCA estimates that the cost of the Per-Covered-Child Assessment contract will be slightly more than 5 percent of the total current and expanded PAL services contract costs (\$1,942,000) for SFY 2020, based on preliminary discussions with a vendor that provides similar services in other states. Also from those preliminary discussions, HCA assumes that the cost of the Per-Covered-Child Assessment contract will decrease during SFY 2021 to just over 4 percent, because the vendor incurred additional expenditures to establish the assessment system during SFY 2020.
5. HCA estimates the cost of the program evaluation contract, based on previous experience and preliminary discussions with a research organization. We assume the contract will begin toward the beginning of SFY 2020, and we assume a 50-percent Medicaid match each year.
6. HCA assumes the need to hire an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) on October 1, 2019 to manage the Per-Covered-Child Assessment contract's request for proposals process, and continue to monitor and manage that contract. This cost estimate includes: salaries and wages, employee benefits, goods and services, travel, and capital outlays.



Table H.5. Estimated Cash Receipts (in Dollars): Per-Covered-Child Assessment Without a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	384,500	384,500	384,500	606,998
Non-Medicaid Portion:	0	0	110,507	444,996
Per-Covered-Life Assessment Fund	0	0	110,507	444,996
Medicaid Portion:	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	34,320	101,400	390,000	615,681
Non-Medicaid Portion:	0	0	205,687	451,362
Per-Covered-Life Assessment Fund	0	0	205,687	451,362
Medicaid Portion:	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	15,730	51,090	289,365	475,792
Non-Medicaid Portion:	0	0	196,500	393,000
Per-Covered-Life Assessment Fund	0	0	196,500	393,000
Medicaid Portion:	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Per-Covered-Child Assessment Contract:⁴	0	0	50,000	40,000
GF-Federal Medicaid Title XIX	0	0	50,000	40,000
Program Evaluation Contract:⁵	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
HCA FTE - MAPS2:⁶	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED CASH RECEIPTS	434,550	606,490	1,216,865	1,791,470
TOTAL GF-Federal Medicaid Title XIX	434,550	606,490	704,172	502,113
TOTAL Per-Covered-Life Assessment Fund	0	0	512,694	1,289,358

NOTES:

1. For the portion of the PAL contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
2. For the portion of the PAL for Kids (Seattle Children's Hospital) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
3. For the portion of the PAL for Moms (University of Washington) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
4. All of the Per-Covered-Child Assessment contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
5. All of the program evaluation contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
6. All of the MAPS2 position cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.



Financial Impact Estimate Details for Using Appropriated Funding From an Existing Revenue Source With a Governing Board

Table H.6. Estimated Expenditures (in Dollars): Funding From an Existing Revenue Source With a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	769,000	769,000	769,000	769,000
Non-Medicaid Portion:	0	0	221,013	444,996
GF-State	0	0	221,013	444,996
Medicaid Portion:	769,000	769,000	547,987	324,004
GF-State	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	264,000	780,000	780,000	780,000
Non-Medicaid Portion:	195,360	577,200	411,374	451,362
GF-State	195,360	577,200	411,374	451,362
Medicaid Portion:	68,640	202,800	368,626	328,638
GF-State	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	121,000	393,000	393,000	393,000
Non-Medicaid Portion:	89,540	290,820	207,269	227,417
GF-State	89,540	290,820	207,269	227,417
Medicaid Portion:	31,460	102,180	185,731	165,583
GF-State	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Program Evaluation Contract:⁴	0	50,000	100,000	0
GF-State	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
HCA FTE - WMS3:⁵	0	109,000	134,000	134,000
GF-State	0	54,500	67,000	67,000
GF-Federal Medicaid Title XIX	0	54,500	67,000	67,000
HCA FTE - MAPS2:⁶	0	89,000	106,000	106,000
GF-State	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED COST	1,154,000	2,190,000	2,282,000	2,182,000
TOTAL GF-State	719,450	1,529,010	1,560,828	1,652,887
TOTAL GF-Federal Medicaid Title XIX	434,550	660,990	721,172	529,113

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NOTES:

1. HCA assumes no PAL contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.
2. The PAL for Kids (Seattle Children's Hospital) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.
3. The PAL for Moms (University of Washington) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021.
4. HCA estimates the cost of the program evaluation contract, based on previous experience and preliminary discussions with a research organization. We assume the contract will begin toward the beginning of SFY 2020, and we assume a 50-percent Medicaid match each year.
5. HCA assumes the need to hire an additional 1.0 FTE Washington Management Service 3 (WMS3) on October 1, 2019 to stand up and manage the governing board. This cost estimate includes: salaries and benefits, employee benefits, goods and services, travel, and capital outlays. The Department of Health has similar staffing for the Washington Vaccine Association Board.
6. HCA assumes the need to hire an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) on October 1, 2019 to stand up and manage the governing board. This cost estimate includes: salaries and benefits, employee benefits, goods and services, travel, and capital outlays. The Department of Health has similar staffing for the Washington Vaccine Association Board.

Table H.7. Estimated Cash Receipts (in Dollars): Funding From an Existing Revenue Source With a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	384,500	384,500	273,993	162,002
Non-Medicaid Portion:	0	0	0	0
Per-Covered-Life Assessment Fund	0	0	0	0
Medicaid Portion:	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	34,320	101,400	184,313	164,319
Non-Medicaid Portion:	0	0	0	0
Per-Covered-Life Assessment Fund	0	0	0	0
Medicaid Portion:	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319



Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL for Moms (University of Washington) Contract:³	15,730	51,090	92,865	82,792
Non-Medicaid Portion:	0	0	0	0
Per-Covered-Life Assessment Fund	0	0	0	0
Medicaid Portion:	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Program Evaluation Contract:⁴	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
HCA FTE - WMS3:⁵	0	54,500	67,000	67,000
GF-Federal Medicaid Title XIX	0	54,500	67,000	67,000
HCA FTE - MAPS2:⁶	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED CASH RECEIPTS	434,550	660,990	721,172	529,113
TOTAL GF-Federal Medicaid Title XIX	434,550	660,990	721,172	529,113

NOTES:

1. For the portion of the PAL contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
2. For the portion of the PAL for Kids (Seattle Children's Hospital) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
3. For the portion of the PAL for Moms (University of Washington) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
4. All of the program evaluation contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
5. All of the WMA3 position cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
6. All of the MAPS2 position cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.

Financial Impact Estimate Details for Per-Covered-Child Assessment With a Governing Board

Table H.8. Estimated Expenditures (in Dollars): Per-Covered-Child Assessment With a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	769,000	769,000	769,000	769,000
Non-Medicaid Portion:	0	0	221,013	444,996
GF-State	0	0	221,013	444,996
Medicaid Portion:	769,000	769,000	547,987	324,004
GF-State	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002



Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL for Kids (Seattle Children's Hospital) Contract:²	264,000	780,000	780,000	780,000
Non-Medicaid Portion:	195,360	577,200	411,374	451,362
GF-State	195,360	577,200	411,374	451,362
Medicaid Portion:	68,640	202,800	368,626	328,638
GF-State	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	121,000	393,000	393,000	393,000
Non-Medicaid Portion:	89,540	290,820	207,269	227,417
GF-State	89,540	290,820	207,269	227,417
Medicaid Portion:	31,460	102,180	185,731	165,583
GF-State	15,730	51,090	92,865	82,792
GF-Federal Medicaid Title XIX	15,730	51,090	92,865	82,792
Per-Covered-Child Assessment Contract:⁴	0	0	100,000	80,000
GF-State	0	0	50,000	40,000
GF-Federal Medicaid Title XIX	0	0	50,000	40,000
Program Evaluation Contract:⁵	0	50,000	100,000	0
GF-State	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
HCA FTE - WMS3:⁶	0	109,000	134,000	134,000
GF-State	0	54,500	67,000	67,000
GF-Federal Medicaid Title XIX	0	54,500	67,000	67,000
HCA FTE - MAPS2:⁷	0	89,000	106,000	106,000
GF-State	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED COST	1,154,000	2,190,000	2,382,000	2,262,000
TOTAL GF-State	719,450	1,529,010	1,610,828	1,692,887
TOTAL GF-Federal Medicaid Title XIX	434,550	660,990	771,172	569,113

NOTES:

1. HCA assumes no PAL contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.
2. The PAL for Kids (Seattle Children's Hospital) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021. We assume a 50-percent Medicaid match each year.



Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
3. The PAL for Moms (University of Washington) contract will take effect during the second-half of SFY 2019. Per the SFY 2019 budget the Legislature passed, we apply a 26.0 percent cost-split from January 1, 2019, through June 30, 2019, and we assume the same cost-split through December 31, 2020. We assume no contract cost increase from SFY 2020 through SFY 2022. In SFY 2021, we apply the 42.5 percent cost-split for half the annual expenditure to reflect the launch of the fiscal model on January 1, 2021.				
4. HCA estimates that the cost of the Per-Covered-Child Assessment contract will be slightly more than 5 percent of the total current and expanded PAL services contract costs (\$1,942,000) for SFY 2020, based on preliminary discussions with a vendor that provides similar services in other states. Also from those preliminary discussions, HCA assumes that the cost of the Per-Covered-Child Assessment contract will decrease during SFY 2021 to just over 4 percent, because the vendor incurred additional expenditures to establish the assessment system during SFY 2020.				
5. HCA estimates the cost of the program evaluation contract, based on previous experience and preliminary discussions with a research organization. We assume the contract will begin toward the beginning of SFY 2020, and we assume a 50-percent Medicaid match each year.				
6. HCA assumes the need to hire an additional 1.0 FTE Washington Management Service 3 (WMS3) on October 1, 2019 to stand up and manage the governing board. This cost estimate includes: salaries and benefits, employee benefits, goods and services, travel, and capital outlays. The Department of Health has similar staffing for the Washington Vaccine Association Board.				
7. HCA assumes the need to hire an additional 1.0 FTE Medical Assistance Program Specialist 2 (MAPS2) on October 1, 2019 to stand up and manage the governing board. This cost estimate includes: salaries and benefits, employee benefits, goods and services, travel, and capital outlays. The Department of Health has similar staffing for the Washington Vaccine Association Board.				

Table H.9. Estimated Cash Receipts (in Dollars): Per-Covered-Child Assessment With a Governing Board

Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
PAL Contract:¹	384,500	384,500	495,007	606,998
Non-Medicaid Portion:	0	0	221,013	444,996
Per-Covered-Life Assessment Fund	0	0	221,013	444,996
Medicaid Portion:	384,500	384,500	273,993	162,002
GF-Federal Medicaid Title XIX	384,500	384,500	273,993	162,002
PAL for Kids (Seattle Children's Hospital) Contract:²	34,320	101,400	390,000	615,681
Non-Medicaid Portion:	0	0	205,687	451,362
Per-Covered-Life Assessment Fund	0	0	205,687	451,362
Medicaid Portion:	34,320	101,400	184,313	164,319
GF-Federal Medicaid Title XIX	34,320	101,400	184,313	164,319
PAL for Moms (University of Washington) Contract:³	31,460	102,180	382,231	558,583
Non-Medicaid Portion:	0	0	196,500	393,000
Per-Covered-Life Assessment Fund	0	0	196,500	393,000
Medicaid Portion:	31,460	102,180	185,731	165,583



Implementation Components	SFY 2019	SFY 2020	SFY 2021	SFY 2022
GF-Federal Medicaid Title XIX	31,460	102,180	185,731	165,583
Per-Covered-Child Assessment Contract:⁴	0	0	50,000	40,000
GF-Federal Medicaid Title XIX	0	0	50,000	40,000
Program Evaluation Contract:⁵	0	25,000	50,000	0
GF-Federal Medicaid Title XIX	0	25,000	50,000	0
HCA FTE - WMS3:⁶	0	54,500	67,000	67,000
GF-Federal Medicaid Title XIX	0	54,500	67,000	67,000
HCA FTE - MAPS2:⁷	0	44,500	53,000	53,000
GF-Federal Medicaid Title XIX	0	44,500	53,000	53,000
TOTAL ESTIMATED CASH RECEIPTS	434,550	660,990	1,394,372	1,858,470
TOTAL GF-Federal Medicaid Title XIX	434,550	660,990	771,172	569,113
TOTAL Per-Covered-Life Assessment Fund	0	0	623,200	1,289,358

NOTES:

1. For the portion of the PAL contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
2. For the portion of the PAL for Kids (Seattle Children's Hospital) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
3. For the portion of the PAL for Moms (University of Washington) contract cost that is eligible for Medicaid reimbursement, HCA assumes a 50-percent Medicaid match each year.
4. All of the Per-Covered-Child Assessment contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
5. All of the program evaluation contract cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
6. All of the WMA3 position cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.
7. All of the MAPS2 position cost is eligible for Medicaid reimbursement. HCA assumes a 50-percent Medicaid match each year.

