Healthier WASHINGTON

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FAQs

Why change Apple Health to an integrated managed care model?

Under the behavioral health organizations (BHOs) there is a single point of accountability and oversight for behavioral health services in every region, so how could it be better to divide accountability among as many as five entities?

Answer: Today, benefits for Medicaid clients are split between a BHO for behavioral health needs, and an MCO for medical needs. There is no single point of accountability for the client. Integrated managed care is first and foremost about improving health outcomes and client care, and this requires care management through a single accountable insurance plan for the client – not two.

For example, a client may be depressed and approach the BHO system for help but does not meet the Access to Care Standards. They don't know who to turn to for help. On the other side, people with serious mental illness have an average lifespan 25 years shorter than those without, and the reason for this is lack of access to *medical care* to treat the chronic illnesses arising from lifelong need for psychiatric pharmaceuticals. Integrated managed care seeks to improve the current system, by placing a single insurance plan accountable for the full array of physical and behavioral health services and health outcomes.

Under the current system, as clients move around the state, the accountability for their health outcomes could transfer across 14 entities: nine BHOs and five MCOs. When integrated managed care is in place, this will be reduced to no more than five and no more than one at a time.

Counties currently have authority over the behavioral health delivery system because county commissioners sit on the BHO board. How will county authorities be able to respond to calls from constituents to fix problems in the system?

Answer: The transition to integrated managed care does not mean there is no role for the county. Counties will play a significant role, even though they are not the direct contract holder or are not at direct financial risk for providing behavioral health services. Counties will have the ability to shape their role. For example, Southwest Washington created a Regional Advisory Council, which is comprised of county commissioners and state legislators, and meets twice a year with the state, MCOs and the public to evaluate the effectiveness of service delivery in the region. HCA is willing to report to any entity chosen by county officials to ensure effective county involvement.

What role will the BHO have after integrated care is implemented?

Answer: The counties have the first right of refusal to act as the Behavioral Health Administrative Service Organization (BH-ASO). The BH-ASO delivers crisis services, administers certain non-Medicaid funding sources, and manages regional functions, such as employing an ombudsman and managing a community behavioral health advisory board. Additionally, The MCO contracts require that the MCO coordinate with county-managed programs, criminal justice, long-term supports and services, tribal entities, etc. via an Allied System Coordination Plan. This will ensure that those established relationships continue to stay strong as well as encourage the MCO to establish necessary relationships. For more information on the role of the BH-ASO and county options, HCA has developed a document outlining a possible continuum of county options.

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Is the state planning to implement the same model statewide that was developed in Southwest Washington?

Answer: No. The Southwest Washington model is not the only model. In mid-adopter regions, HCA is open to discussing regional variations and options with communities. The first step in that discussion is to submit a binding letter of intent to move forward with full integration before 2020.

BHOs are non-profit organizations. Won't this transition to managed care plans result in less funding for a behavioral health system that is already under-funded?

Answer: Apple Health contracts strictly limit administrative overhead to population enrollment. The range of administrative load is 8.5% to 11.8% in 2017.

The contract limits the gains MCOs are able to take from premium dollars.

How do we know that funding for behavioral health services won't be diverted to pay for medical care, once the funds for medical and behavioral health services are blended together and the MCOs are working under a global budget?

Answer: There are a number of reasons this will not be an issue:

- The managed care contracts require the MCOs to provide certain behavioral health services and meet certain performance measures and quality of care standards. In order for the MCOs to provide these services and meet performance measures and quality standards, they must invest in behavioral health services.
- If a client's need for services meets level of care guidelines and is medically necessary, the MCO must ensure the client receives the behavioral health services.
- When managing a global budget, MCOs have incentives to invest in downstream services such as primary care and outpatient behavioral health, in order to meet performance measures and to achieve savings on high-cost upstream services such as emergency room visits.
- Behavioral health providers negotiate their payment rates and payment method with the MCO and should expect to be paid no less than what they are paid in the current BHO structure.

How will the managed care plans develop the needed competence to manage these complex services?

Answer: MCOs are already familiar with clients with serious mental illness and substance use disorder. These clients are among their most complex enrollees, and they currently provide care coordination, complex case management, and health home services to this high-risk population. What will require a knowledge transfer period is for the MCOs to learn the new provider network, service delivery, etc. that has been provided through the BHOs. HCA and DBHR staff stand ready to assist with this knowledge transfer as MCOs are awarded contracts.

Counties already spend a high percentage of their budgets on their jails. If this transition reduces access to behavioral health services, individuals in need of treatment may end up in the county jail rather than in treatment. How do we monitor for this and make sure this transition does not increase the burden on jails?

Answer: There is no reason to expect reduced access to services for people in need of behavioral health treatment. In fact, the transition to integrated care is intended to improve the delivery of medical and behavioral health services, which may result in **reduced** incarceration of individuals with behavioral health conditions. To help ensure this happens, the Health Care Authority will work with counties to develop an "early warning system" that will track flow into the local criminal justice system. And the state's contract will require MCOs to outline their best practice models for assisting with clients in transition.

This transition to integrated managed care seems to be focused on financial and contracting integration, not on clinical integration. How will the transition to integrated managed care support delivery system reform at the clinical level?

Answer: Integrated managed care is necessary but not sufficient to achieve clinical integration. By integrating the way the state purchases and administers medical and behavioral health services, this sets a foundation for managed care plans and providers to work towards integration at the delivery system level.

For example:

- Physical and behavioral health providers will be contracted with the same payers, and can negotiate payment for integrated clinical services with those payers. This does not exist in the current bi-furcated payment system.
- Integrated MCOs will cover all services and bring a patient's health information and history to one source. This model makes it easier to share information between service providers so providers have a whole-person view of the patient and better understand what services the patient does/does not need. This more seamless sharing of information will facilitate coordination and collaboration between different provider types, thus promoting integration at the clinical level.
- MCOs will assist with client care coordination across the full continuum of services, so that care coordination and care management activity is not bi-furcated across multiple entities for a single client.
- MCOs will have a full network of both medical and behavioral health providers, which will allow them to facilitate referrals across provider types.
- Additionally, the recently approved 1115 DSRIP Waiver will complement the transition to integrated managed care, by making significant regional investments in integrated clinical models.

Is the state really going to be able to meet the January 1, 2020 deadline that was set in E2SSB 6312?

Answer: Yes. All counties will operate in an integrated managed care model by January 1, 2020.