Tailored Approaches for Medicaid Physical-Behavioral Health Integration in Washington State: Lessons for States

Webinar
September 22, 2020

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Questions?

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Welcome & Introductions
Welcome and Introductions
Overview of Washington State’s Journey to Integration
Regional Approaches to Integration
Moderated Q&A
Today’s Presenters

- **Logan Kelly, MPH**, Senior Program Officer, Center for Health Care Strategies
- **Catherine Teare, MPP**, Associate Director, High-Value Care, California Health Care Foundation
- **Teresa Claycamp, MA, LMHC**, Integrated Managed Care Program Manager, Washington State Health Care Authority
- **Joe Valentine, MSW**, Executive Director, North Sound Behavioral Health Administrative Services Organization,
- **Isabel Jones, MPP**, Deputy Director, Behavioral Health and Recovery Division, King County Washington
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Welcome Remarks

Catherine Teare, MPP
Associate Director, High-Value Care
California Health Care Foundation
Introduction to Physical-Behavioral Health Integration

Logan Kelly, MPH
Senior Program Officer
Center for Health Care Strategies
Why States are Pursuing Integration

- Poor health outcomes and high costs for individuals with behavioral health needs
  - Medicaid spending is 4x higher for individuals with behavioral health conditions, largely due to increased physical health spending
  - Many experience gaps in care due to poor coordination and information sharing between providers

- Challenges in access to care, quality of care, and fragmentation

- Evidence that clinical integration can improve health outcomes and quality of life, reduce costs

Integrated care: “The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care.” (Agency for Healthcare Research and Quality, 2013)

Financial integration: Integration of purchasing and management of physical and behavioral health services, often through integrated managed care organizations (MCOs)

Clinical integration: Processes to advance integrated care at the point of service delivery.

<table>
<thead>
<tr>
<th>COORDINATED KEY ELEMENT: COMMUNICATION</th>
<th>CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY</th>
<th>INTEGRATED KEY ELEMENT: PRACTICE CHANGE</th>
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<tbody>
<tr>
<td>Level 1 Minimal collaboration</td>
<td>Level 3 Basic collaboration onsite</td>
<td>Level 5 Close collaboration approaching an integrated practice</td>
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<tr>
<td>Level 2 Basic collaboration at a distance</td>
<td>Level 4 Close collaboration onsite with some system integration</td>
<td>Level 6 Full collaboration in a transformed/merged integrated practice</td>
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Behavioral Health Financing Models by State

Primary Model of Behavioral Health Financing* (2019)

**KEY**
- Integrated financing in managed care organizations
- Behavioral health benefits carved out to behavioral health organizations or to fee-for-service
- Physical and behavioral health benefits financed in FFS
- Specialty integrated plans for individuals with serious behavioral health needs

Overview of Washington State’s Journey to Integration

Teresa Claycamp, MA, LMHC, Integrated Managed Care Program Manager, Washington State Health Care Authority
Tailored Approaches for Medicaid Physical-Behavioral Health Integration in Washington State: Lessons for States

Teresa Claycamp MA LMHC
Alice Lind BSN MPH
Health Care Authority
Overview

- Goal and design of Integrated Managed Care program
- Role of Managed Care Organizations (MCOs) across the state
- Role of the Behavioral Health – Administrative Service Organizations (BH-ASOs)
- Implementation of the program since 2015
- Initial outcomes in two regions
2014: Initial Legislative Direction

- Substitute Senate Bill (SSB) 6312 passed in 2014
  - Changed how the State purchases mental health and substance use disorder services in the Medicaid program
  - Directed the State to fully integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care by 2020
  - Directed the State to integrate mental health and substance use disorder services through Behavioral Health Organizations (BHOS) as an interim step to 2020
  - Created a pathway for regions to fully integrate early, starting in April 2016
### Why Integrate?

<table>
<thead>
<tr>
<th>Current Silos</th>
<th>Integrated System</th>
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<tbody>
<tr>
<td>✷ No single entity with accountability, nor with the data and information necessary to manage the whole person</td>
<td>✷ One managed care plan is accountable for keeping people healthy, both mind and body</td>
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<tr>
<td>✷ Consumers with co-occurring disorders navigating disparate systems with no single point of contact</td>
<td>✷ Individuals have 1 point of contact for questions and information</td>
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<td>✷ Care coordination is duplicated</td>
<td>✷ Individuals have 1 Care Coordinator</td>
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<td>✷ Access to Care standards set an arbitrary barrier to higher-level services</td>
<td>✷ Access to care standards eliminated – care is based on level of care guidelines</td>
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<tr>
<td>✷ Bi-furcated funding streams make it challenging for providers to move to integrated care models.</td>
<td>✷ Over time, providers and MCOs can work together to establish new payment methodologies and integrated care models</td>
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Update on Implementation 2016-2020
## Managed Care Organizations per Region

<table>
<thead>
<tr>
<th>Managed care region</th>
<th>Amerigroup</th>
<th>Community Health Plan</th>
<th>Coordinated Care</th>
<th>Molina Healthcare</th>
<th>United Healthcare</th>
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<td><strong>As of January 2019</strong></td>
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<td>Greater Columbia</td>
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<td>King</td>
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<td>North Central</td>
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<td>Pierce</td>
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<td>Spokane</td>
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<td>Southwest</td>
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<td><strong>As of July 2019</strong></td>
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<td>North Sound</td>
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<tr>
<td><strong>Coming January 2020</strong></td>
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<td>Thurston-Mason</td>
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<td>Great Rivers</td>
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<tr>
<td>Salish</td>
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*Apple Health Foster Care is a statewide program, provided through Apple Health Core Connections (Coordinated Care of Washington).*
Medicaid Benefits Remain the Same

- All Medicaid benefits continue to be defined by the State Plan.
- MCOs provide all Medicaid physical, mental health, and substance use disorder (SUD) services.
- MCOs also receive general fund state dollars for medically necessary services not covered by Medicaid.
  - Examples: room and board for mental health residential settings or freestanding evaluation and treatment centers, rehabilitation case management to those in hospitals or jails, non-Medicaid UA’s, non-Medicaid PACT team costs, etc.
Provide crisis services to all individuals, regardless of insurance
  ▶ Crisis line
  ▶ Face-to-face crisis intervention services

Administer Involuntary Treatment Act (ITA)
  ▶ Conduct ITA investigations
  ▶ Write ITA petitions and detain individuals when indicated
  ▶ Monitor compliance with less restrictive treatment services
  ▶ Coordinate necessary services include due process
Contracting and Services Structure

HCA

- Fully Integrated MCO
- County or Procured Organization

- HCA Contract with BH-ASO
- Required sub-contract

Continuum of Integrated Clinical Services

Individual Client
Processes to Ensure Successful Transition

- Targeted readiness processes for each newly integrated region
- Processes to ensure a successful transition
  - Interlocal Leadership Structure
  - Rapid response calls – frequent check-ins with each region as it implements IMC
  - Early warning system metrics
  - Monthly early warning system webinars
- Contract compliance monitoring
- Data and outcomes
Early Adopter Region Successes

Research and Data Analysis compared findings in SWWA to the rest of the state from implementation of IMC through CY 2017

Eleven indicators show favorable change at the 95% confidence level, e.g.:
- Substance Use Disorder Treatment Penetration
- Mental Health Treatment Penetration - Broad Definition
- Follow-up after ED Visit for AOD Dependence - Within 7 and 30 Days
- Follow-up after ED Visit for Mental Illness - Within 7 and 30 Days
- Inpatient Utilization per 1000 Coverage Months – Combined Medical and Psychiatric
- Percent Employed

Two indicators show favorable change at the 90% confidence level:
- Plan All-Cause 30-Day Readmission
- Percent Arrested

Only two indicators show unfavorable change (95% confidence level)
North Central Region

Comparison of relative change across 32 metrics

- Change measured from CY 2017 baseline period to 12-month period ending March 31, 2019
- Of the 32 outcome measures analyzed:
  - 4 showed statistically significant relative improvement, e.g. Mental Health Service Penetration; Follow-up after ED visit for AOD; Percent Arrested.
  - 25 showed no significant difference between the North Central region and balance of state
  - 3 showed a statistically significant relative decline in the North Central region, e.g. Follow-up after ED visit for Mental Illness after 7 days.
Questions?

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Regional Approaches to Integration

Joe Valentine, MSW, Executive Director, North Sound Behavioral Health Administrative Services Organization

Isabel Jones, MPP, Deputy Director, Behavioral Health and Recovery Division, King County Washington
Medicaid Physical –Behavioral Health Integration in Washington State: Experience of the North Sound Region

September 22, 2020
Joe Valentine, Director
North Sound Behavioral Health Administrative Services Organization
Apple Health managed care
Service area map - January 2020

Integrated managed care regions
- Greater Columbia
- King
- North Sound
- Salish
- Great Rivers
- Pierce
- Spokane
- Southwest Washington
- North Central
- Thurston-Mason
- Apple Health Foster Care (statewide)

Health plans offered
- AMG – Amerigroup Washington
- CCW – Coordinated Care of Washington
- CHPW – Community Health Plan of Washington
- MHW – Molina Healthcare of Washington
- UHC – United Healthcare Community Plan

† Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CCW).
Evolution of Public Behavioral Health Services
North Sound Region

• **1989** – Legislature allows counties to form “Regional Support Networks” for mental health services
• **1991** – formation of the North Sound Regional Support Network
• **2006** – transition to mental health managed care for RSNs
• **2014** – legislature directs the integration of mental health and chemical dependency services into behavioral health managed care
• **2016** – North Sound Behavioral Health Organization
• **July 2019** – North Sound Behavioral Health Administrative Services Organization [BH-ASO]
Integrated Managed Care: Behavioral Health Services

- Responsibility for Medicaid Funded Behavioral Health Care integrated into the contracts with “Apple Health” managed care organizations
- Non-Medicaid Services contracted with Behavioral Health Administrative Services Organizations – in most but not all counties these were the same entities as the former BHOs
- The North Sound BHO became the North Sound BH-ASO
- Continues to be overseen by a Board of Directors representing county elected officials form the 5 North Sound Counties
What is the BH-ASO responsible for?

- Behavioral Health Crisis Services
- Behavioral Health Services for low-income non-Medicaid persons
- Federal Block Grant Funded Services
- Discharge of non-Medicaid persons from state psychiatric hospitals
- Community Planning
- Behavioral Health Advisory Board
Planning For Implementation

• Interlocal leadership structure
• Joint operating committee
• “Knowledge transfer” webinars
• Behavioral health agency provider forums
• Tribal coordination
• Crisis services leadership
• County crisis services oversight
Challenges Encountered

• Inadequate electronic infrastructure to submit claims & encounters
• 5 different [MCOs] with different billing and reporting requirements
• Primary reliance on “fee for service” reimbursement inadequate for services that require capacity funding, e.g., Crisis Facilities
• Balkanization of funding – non-Medicaid and Medicaid funding split
• Little pre-existing on-site integration of physical and behavioral health
• Individual MCO purchasing networks vs. community system of care
Opportunities Created

• Supported improved access to physical health care
• Integrated Care Coordination for high risk persons
• Additional benefits for MCO “members,” e.g., cell phones, food vouchers, etc.
• Flexible funding support for BHAs during COVID
• Standardized, “NCQA” level standards to support quality of care
• Move farther along the path to integration of physical and behavioral health care
Lessons Learned

• Don’t underestimate level of technical and financial assistance needed for BHAs
• Hold harmless significant negative financial impacts
• Match the funding mechanism to the needs of the program, e.g., some programs will need “capacity” payments
• Create strong and locally responsive planning and coordination structures
• Pay special attention to integrating care for persons with severe behavioral health disorders
• Develop new data exchange strategies that can follow the persons as they move between payers

• Invest more in building capacity for physical/behavioral health care integration at the primary clinic/behavioral health clinic level
Integrated Managed Care in King County

September 22, 2020

Isabel Jones
Deputy Director
Behavioral Health & Recovery Division
King County
King County: Overview

- 14th largest county in the U.S.
- Home to Seattle, Washington
- Most populous county.
- Large urban population.
- Most diverse county in Washington state.
- Large representation of vulnerable populations such as those experiencing behavioral health issues, homelessness, etc.
- Increasing population of minorities especially foreign-born (2017 = 23.6%) which require culturally-appropriate services.
- Large local investment in behavioral health services and social determinants of health.
King County’s Vision:

King County believes in an integrated approach to whole-person care that includes:

- Access to a wide range of agencies and providers that serve all parts of our population across all levels of care,
- Connection to social determinants of health programs (largely managed at the city- and county-level),
- “No wrong door” to access needed services,
- A crisis system that adequately and appropriately serves the King County Region, and
- Use of local funding (MIDD) to continue to strengthen our King County services and fill in funding gaps not otherwise met with other funding.
What is the King County Integrated Care Network? (KCICN)

A new partnership between King County Behavioral Health and Recovery Division (BHRD) and Provider Agencies to serve the Medicaid population in the King County Region.

All 5 MCOs contract with King County to manage the KCICN network and provide access to services via this network for Medicaid members.
KCICN – Benefits & Impact to Stakeholders

- Administrative Simplification
- Clinical Integration & Elimination of Access to Care Barriers
- Local + Medicaid Braided Funding Models
Lessons Learned & Challenges

- Importance of collaborative, partnership approach with MCOs and providers
- Significant effort to meet NCQA and MCO delegation requirements and transition systems
- New program start-up: Benefits and challenges
- Implementing physical health benefits: Benefits and challenges
What’s Next?

- Use of data-driven population health stratification tool, inclusive of social determinants of health and criminal justice system data
- Value-based payment agreements across payers and standardized performance metrics
- Expanding access to mild-to-moderate services within the ICN Network
- Demonstrate relationships with the primary care providers
- New braided funding models: Outreach and engagement
Question & Answer
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