

Washington State's Transition to Integrated Physical and Behavioral Health Care

Prior to 2016, Washington Medicaid enrollees with co-occurring physical and behavioral health conditions had to navigate separate systems to access needed physical health, specialty mental health, and substance use disorder services. Managed care organizations (MCOs) managed physical health care, along with mild to moderate behavioral health care. Individuals meeting the criteria for serious mental illness (SMI) or serious emotional disturbance (SED) — which was determined through the “Access to Care Standards” — received mental health care managed by Regional Support Networks (RSNs).¹ County governments managed substance use disorder services.

As in many states, these different services were also fragmented in their administration and funding. At the state level, the Washington State Health Care Authority contracted with MCOs, while the Department of Social and Health Services oversaw specialty behavioral health services through the RSNs and counties. The RSNs managed a range of federal and state contracts to deliver care and supportive services for both Medicaid enrollees and safety-net populations, and contracted with community mental health providers to deliver care. SUD services were administered at the county level on a grant-funded and fee-for-service basis.

Under this approach, stakeholders reported poor coordination of care and health outcomes for individuals with co-occurring conditions, as the delivery systems for physical health, mental health, and SUD services were not designed to share information across systems. MCOs did not receive information about their members' behavioral health treatment, and RSNs received no information about physical health conditions — with providers unable to address the whole person needs of individuals. Medicaid enrollees also experienced limited access to care. The state reported that only half of adult Medicaid enrollees with mental illness received mental health services, and about a third of those with an indication of SUD received Medicaid-funded SUD services.² The rate of children with serious emotional disturbances receiving care varied widely between regions, with leaders citing the Access to Care Standards as a barrier to children receiving needed treatment.³

In Brief

- Between 2016 and 2020, Washington State transitioned from separate Medicaid systems for managing physical health, mental health, and substance use disorder care to a single system of integrated managed care organizations for physical and behavioral health needs.
- In designing this new system, the state sought to advance more integrated, coordinated care for individuals with co-occurring physical and behavioral health conditions living in the state.
- Implementation of this model, known as fully integrated managed care, was phased in with regional adaptations that created new roles for public regional behavioral health systems. Initial evaluations demonstrate promising outcomes.
- This case study describing Washington State's journey to integrated care offers lessons for designing and implementing state efforts to advance physical-behavioral health integration, as well as in tailoring regional approaches to use the expertise of local behavioral health stakeholders.

Designing a Fully Integrated Model of Care

In response to the challenges created by uncoordinated systems for physical and behavioral health care, Washington State set the goal of implementing integrated care, where all health needs are addressed within a single system with an integrated provider network. The state designed a phased approach to implementing this system, by bringing the community behavioral health system into an integrated managed care framework with the interim step of integrating mental health and SUD care. Within this approach, the state provided regional flexibilities for the timing of the transition, and in the ongoing role of the respective behavioral health entities in each region.

Washington's transition to integrated care began in 2014, when Governor Jay Inslee requested legislation to advance whole person care. The Legislature then passed Senate Bill 6312, which directed the state to fully integrate all Medicaid physical health, mental health, and SUD services through managed care by 2020.⁴ This legislation also required: (1) integrated purchasing of mental health and SUD services by 2016 and replacing all RSNs with Behavioral Health Organizations (BHOs) as a temporary entity; and (2) options for "early adopter" or "mid adopter" regions to integrate purchasing of physical health, mental health, and SUD services by 2016 or 2019, respectively.

Additional legislation advanced clinical integration and required access to additional recovery support services. A bipartisan task force then developed recommendations for implementation of these changes to achieve full integration by 2020.⁵

Under the fully integrated managed care system, MCOs coordinate care across the full continuum of physical and behavioral health services. Each region contracts with between three and five MCOs, chosen from a competitive bidding process among the existing Medicaid MCOs.⁶

A First Step: Integrating Mental Health and SUD Care

As an interim step toward full physical-behavioral health integration, the state created single regional systems and accountable entities for behavioral health care in all regions except for the early-adopting region, which transitioned directly to integrated MCOs.⁷ BHOs were developed to replace the RSNs, and became fully at risk for SUD services in addition to mental health services. Only the current RSNs could apply to become BHOs at this time, to maintain continuity in the leadership of the public behavioral health system. These BHOs were designed to be temporary, as the responsibility for managing behavioral health care in each region would ultimately transition to the integrated MCOs.

The transition to BHOs led to significant changes for behavioral health providers as well as for the counties managing these entities. BHOs became newly at risk for inpatient and outpatient SUD treatment, and needed to expand their provider networks, develop data systems that integrate mental health and SUD data, and integrate administrative functions. SUD providers had to shift to managed care contracts with regions.

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The Role of Medicaid Transformation Initiatives in Supporting Integration

The transition to fully integrated managed care has been supported by two broad transformation initiatives: (1) a State Innovation Model (SIM) grant from the Center for Medicare & Medicaid Innovation from 2015 – 2019; and (2) an 1115 waiver demonstration beginning in 2017 and ending in 2021. The SIM plan proposed a core strategy for system transformation of integrating care for individuals with both physical and behavioral health conditions.⁸ Under the SIM plan, the state designed a test model of an early adopting region transitioning to fully integrated managed care.

The SIM plan also included targeted investments in developing Accountable Communities of Health (ACHs) in each region of the state, which were then supported through the 1115 waiver. Through ACHs, the state aims to advance a more extensive transformation than could be achieved through either financial or clinical integration alone.⁹ These ACHs do not take on any financial risk, but instead bring together cross-sector regional stakeholders to implement practice transformation efforts across three domains: (1) health systems capacity building; (2) care delivery redesign; and (3) prevention and health promotion. All ACHs must pursue a project to promote integration of physical and behavioral health services at the service delivery level, with the goal of aligning clinical integration efforts with financial integration. ACHs have led provider operational support projects for the transition to fully integrated managed care, including by engaging providers in transition planning, conducting provider readiness assessments, providing technical assistance for changing billing systems, and developing early warning systems for any transition issues.¹⁰ ACHs also support care coordination initiatives, including strengthening linkages between providers and social service organizations.

Regional Approaches and Early Outcomes

Following the flexibilities laid out in the initial legislation, Washington State's 10 designated regions differed in their transitions to fully integrated managed care in two key ways: (1) the transition timeline; and (2) the new roles adopted by each of the regional/county behavioral health entities (*See Table 1, next page*). To encourage the transition, the state provided financial incentives for regions to transition to fully integrated managed care prior to the 2020 deadline. Regional Accountable Communities of Health then used this funding in part to support provider readiness for administrative and billing changes. County commissioners within each region determined when to adopt fully integrated managed care, with Southwest Washington as the sole region opting in as an early adopter in 2016. A mid-adopter region, North Central Washington, followed in 2018, with the remaining eight regions all transitioning in the final year before the deadline of January 2020.

Leveraging Regional Expertise to Manage Crisis Services

When designing the integrated managed care model, Washington State needed to develop a plan for management of the continuum of crisis services available to all statewide residents, regardless of insurance status. These crisis services, such as a 24/7/365 regional crisis hotline and mobile crisis outreach teams, require broad accessibility among all residents, regardless of insurance coverage. Historically, the regionally based public entities (first RSNs, then transitioned to BHOs) received both Medicaid and other sources of public funding to manage and administer these services. Moving forward, the state recognized that managing crisis functions would require a single regional entity to administer

this emergency response system, as it would create challenges to split this funding and function across multiple MCOs and potentially other parties.

Accordingly, the state decided to contract with one Behavioral Health Administrative Services Organization (BH-ASO) in each region. These BH-ASOs manage: (1) crisis services for all populations regardless of insurance status; (2) some non-crisis behavioral health services for uninsured populations; (3) regional functions, such as a behavioral health ombudsman and community behavioral health advisory board; and (4) funding from block grants and criminal justice treatment account funds. Integrated MCOs are required to contract with the BH-ASOs for crisis services for all covered Medicaid members, with requirements for coordination and data-sharing.

Washington State’s plan for crisis services was designed to preserve part of the role and expertise of public behavioral health entities in managing services for highly vulnerable populations. BHOs had the right of first refusal to transition to BH-ASOs, and seven out of 10 regions did opt into becoming BH-ASOs. In the other three regions, Beacon Health Options, a national managed behavioral health care organization, was selected as the BH-ASO.

Region	Transition Date	Role of public behavioral health entities, including as Behavioral Health - Administrative Services Organizations (BH-ASOs)
Southwest	April 2016	The counties in this region opted to not form a BH-ASO, and the state selected Beacon Health Options as the BH-ASO in this three county region.
North Central	January 2018	The counties in this region opted to not form a BH-ASO, and the state selected Beacon Health Options as the BH-ASO in this four county region.
Greater Columbia	January 2019	The Greater Columbia BH-ASO is governed by the nine counties in this region.
King County	January 2019	King County governs the BH-ASO and continues to manage specialty Medicaid behavioral health services by contracting with MCOs to manage behavioral health providers.
Pierce County	January 2019	Pierce County opted to not form a BH-ASO, and the state selected Beacon Health Options as the BH-ASO.
Spokane	January 2019	Spokane County Regional Behavioral Health (ASO) is governed by the six counties in this region.
North Sound	July 2019	The North Sound BH-ASO is governed by the five counties in this region.
Great Rivers	January 2020	The Great Rivers BH-ASO is governed by the five counties in this region.
Salish	January 2020	The Salish BH-ASO is governed by the three counties in this region.
Thurston-Mason	January 2020	The Thurston-Mason BH-ASO is governed by the two counties in this region.

Identifying and Addressing Challenges in the Transition

Each transitioning region set up an “early warning system” to identify and resolve transition issues, and formed a cross-sector steering committee inclusive of providers, MCOs, state and county representatives, and criminal justice system representatives to address emergent issues. In Southwest Washington, the steering committee developed “early warning indicators” to track payment and utilization, client experience of care, and crisis and jail system metrics that would indicate decreases in access to services or lack of coordination.¹¹ This region also created a clinical rapid response group, comprised of

representatives of the MCOs and BH-ASO, to resolve any difficult clinical scenarios where the financial obligation for services was unclear. The goals during the first 90 days after the transition were defined as: (1) ensuring continuity of care and access to care for consumers; (2) ensuring that behavioral health providers received timely payments; and (3) reducing administrative burdens for behavioral health providers. Notably, an evaluation of the transition found success in meeting these goals, though it also identified challenges for some providers in transitioning contracts and payments from counties to the integrated MCOs.¹²

Adapting Integration in King County for Centralized County Management of Behavioral Health

The King County region, which includes the city of Seattle, became a mid-adopter and chose to transition in 2019 — with this county being the only region to continue to centrally coordinate behavioral health services. In establishing this model, an Integration Design Committee comprised of behavioral health stakeholders proposed “a shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County resources and other resources necessary to support a clinically integrated system of care.”¹³ The county sought to leverage its significant local funds allocated for behavioral health, including a countywide behavioral health sales tax fund, and wanted to continue to manage a braided funding stream for behavioral health services across Medicaid and other safety-net populations.¹⁴ When Medicaid funding for behavioral health services transferred in 2019 from King County to the MCOs as part of the transition to integrated managed care, the plans agreed to contract with the county to manage and deliver behavioral health services. The state approved this arrangement initially for a one-year period, but it has since been extended.

King County manages three initiatives to coordinate behavioral health care across populations: (1) a BH-ASO for crisis services; (2) locally funded services such as education and workforce development; and (3) a new entity called the King County Integrated Care Network (KCICN). Through KCICN, MCOs contract with King County to continue to manage Medicaid behavioral health services. KCICN contracts with providers to deliver Medicaid-funded services, with the county playing a role similar to the network manager of an independent practice association. The county has cited benefits of this arrangement for Medicaid enrollees, providers, and MCOs.¹⁵ Consumers can access a more robust and stable provider network that is consistent across MCOs, while providers benefit from reduced administrative burden and streamlined processes to work with one MCO rather than five for contracting and credentialing, as well as technical assistance with data submission, and greater timeliness of payments. King County’s five MCOs can experience potential benefits from KCICN’s ready-made network, a streamlining of provider payments, and a single contract and negotiated rate for the over 40 network providers. Similar to other regions, King County’s adaptation of fully integrated managed care allows for greater integration of care as MCOs have access to the full range of integrated data that reflects utilization and client risk. A care coordination team at the county communicates closely with each MCO to coordinate across physical and behavioral health needs, with a focus on high-risk patients. This arrangement presents some challenges to integration. For example, mild-to-moderate behavioral health services are managed by the MCO, while severe behavioral health services are managed by the county, which can lead to difficulties in integrating care across the continuum of needs.

Preliminary evaluations of the early- and mid-adopting regions have shown some results of positive impacts for Medicaid enrollees, including those with behavioral health conditions.

Outcomes

While the transition to fully integrated managed care has only been in place statewide since January 2020, preliminary evaluations of the early- and mid-adopting regions have shown some results of positive impacts for Medicaid enrollees, including those with behavioral health conditions. First, an evaluation conducted by the state reported improved health and social outcomes for Medicaid enrollees in the Southwest Washington region, as compared to the rest of the state, during the first year after that region's transition. While 21 out of 29 measures did not show a statistically significant change, seven measures showed a statistically significant improvement and one showed a statistically significant relative decline.¹⁶ This region saw statistically significant improvements in most measures of access to care among all Medicaid enrollees, including access to ambulatory and preventive care and mental health treatment penetration, as well as in social outcomes such as rates of homelessness and criminal justice interactions. Notably, the subgroups of Medicaid enrollees with SMI and those with co-occurring mental illness and SUD also experienced significant improvements in some access to care measures. Across populations, the impact on quality, coordination of care, and utilization metrics was more modest, and most measures showed no significant change.

In the second region to transition to fully integrated managed care (the North Central region), changes in the reported outcome measures were again mostly not statistically significant. Of the 32 measures examined, four showed statistically significant improvement and three showed a statistically significant relative decline. Similar to Southwest Washington, the metrics to show improvement included mental health services penetration as well as measures of follow-up after emergency department visit for alcohol or drug dependence and rates of criminal justice interactions.¹⁷ Future evaluations will provide additional evidence on how the fully integrated care model in different regions affects access to care, care coordination, health outcomes, and social outcomes over time for Medicaid enrollees.

Conclusion

As of 2020, all regions in Washington State have transitioned to integrated financing and management of physical and behavioral health care, with some key differences between regions in both the ongoing role of their respective public behavioral health systems, and in their implementation timelines. All regions are continuing to pursue initiatives to advance clinical integration at the point of care, and will be closely monitoring the impact of the fully integrated managed care system on the health and social outcomes of Medicaid enrollees with behavioral health needs. Moving forward, lessons from Washington State's multi-phase, regional approach embedded in broad Medicaid transformation initiatives can inform other state efforts to integrate care for individuals with behavioral health needs.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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ENDNOTES

- ¹ For more information on Access to Care Standards, see: Washington State Health Care Authority. Available at: <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/access-care-standards-acs-and-icd-information>.
- ² Washington State Medicaid Transformation Waiver Application. Washington State Health Care Authority and Department of Social and Health Services, August 2015. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/medicaid-transformation/wa-medicaid-transformation-state-demo-app-82415.pdf>.
- ³ W. Ellis, C. Huebner, A. Vander Stoep, and M. Williams. "Washington State Exhibits Wide Regional Variation In Proportion Of Medicaid-Eligible Children Who Get Needed Mental Health Care." *Health Affairs*, 31, no.5 (2012): 990-999.
- ⁴ <http://lawfilesexternal.wa.gov/biennium/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf>
- ⁵ Adult Behavioral Health System Task Force Final Report. Washington State Legislature, December 2015. Available at: <http://leg.wa.gov/JointCommittees/Archive/ABHS/Documents/ABHS%20TF%20Final%20Report.pdf>.
- ⁶ The state developed the Behavioral Health Services Only (BHSO) program to manage behavioral health services for Medicaid enrollees who receive physical health coverage from either the fee-for-service system or other coverage sources, such as for dually eligible individuals and youth in foster care. The BHSO program maintained the same level of coverage of behavioral health services as under the prior system, where these populations accessed behavioral health care through BHOs.
- ⁷ As Southwest Washington moved immediately to full integration including physical health care services in 2016, this region did not employ the interim step of a BHO.
- ⁸ Washington State Innovation Model Test Grant Application. Washington State Health Care Authority, July 2014. Available at: <https://www.hca.wa.gov/assets/program/original-sim-test-grant-application.pdf>.
- ⁹ Washington State Medicaid Transformation Waiver Application. Washington State Health Care Authority and Department of Social and Health Services, August 2015. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/medicaid-transformation/wa-medicaid-transformation-state-demo-app-82415.pdf>.
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- ¹¹ Regional Health Alliance and Healthier Washington. "Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care." August 2016. Available at: <https://www.hca.wa.gov/assets/program/early-adopter-report.pdf>.
- ¹² Ibid.
- ¹³ King County Integration Design Committee. "Fully Integrated Managed Care in King County: A Recommended Path Forward." January 2017. Available at: <https://www.kingcounty.gov/~media/elected/executive/constantine/initiatives/hhs-transformation/documents/committee-report.ashx?la=en>.
- ¹⁴ Ibid.
- ¹⁵ "King County Integrated Managed Care (IMC) and Integrated Care Network (KICN) Overview." King County webinar presentation. Available at: <https://kingcounty.gov/~media/depts/community-human-services/behavioral-health-recovery/documents/Webinar%20Attachments/BasicIMCICNtrainingv4.ashx?la=en>. King County. "King County and Molina Healthcare of Washington Reach Groundbreaking Three-year Behavioral Health Care Agreement." June 2020. Available at: <https://www.kingcounty.gov/elected/executive/constantine/news/release/2020/June/17-behavioral-health.aspx>.
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- ¹⁷ D. Mancuso. "Evaluation of Integrated Managed Care in North Central: Findings through March 2019." Washington State Department of Social and Health Services. Received by e-mail from A. Lind, March 13, 2020.