Systems to Support Integrated Physical and Behavioral Health Care in Washington Medicaid

Options for the Future
October 2013

manatt

Table of Contents

Definition of Integration

We use the following definitions of integration, adapted from the Agency for Healthcare Research and Quality's *Lexicon for Behavioral Health and Primary Care Integration*:

Integrated System

Administrative structures with supportive reimbursement arrangements that facilitate and enable the delivery of integrated and coordinated care by providers to people with behavioral and physical health needs.

Integrated Care

A practice 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.

We use the term "**coordination**" to refer to working relationships, information exchange, and shared planning and decision-making among separate entities and individuals.

We use the term "**integration**" to refer to coordination among entities and individuals under shared governance or administrative structures, or in shared physical space.

The Question

People

Physical Health, Mental Health, and Chemical Dependency Needs, Influenced by Social Determinants of Health

Providers

- Physical Health Providers
- Mental Health Providers
- Chemical Dependency Providers

Systems of Care

- Physical Health System
- Mental Health System
- Chemical Dependency System

Administration

- Physical Health Administration
- Mental Health Administration
- Chemical Dependency Administration

What system structures will support bi-directional integrated care delivered by providers to people with physical and behavioral health needs?

Integrated Care is Cost-Effective and Improves Outcomes

For patients with depression

"More than ten studies of collaborative care models for depression [with mental health specialists or trained primary care providers treating depression in primary care settings] in a wide range of health care systems have demonstrated that they are more effective than usual care. Such models have been shown to improve clinical outcomes, employment rates, functioning, and quality of life, and they are cost-effective compared with other commonly used medical interventions."

For patients with serious mental illness

"[F]or a cohort of patients with serious mental illness, integrated, on-site delivery of primary care was feasible, promoted greater access to primary care and preventive care, and resulted in a significantly larger improvement in health status than usual care."

For patients with substance abuse-related comorbidities

Trials integrating primary care into specialty mental health settings "were consistent in reporting improvements in medical care, quality of care, and patient outcomes. Two programs were found to be cost-neutral ... There was also a significant decline in annual costs for a subsample of patients with substance-related mental and medical comorbidities compared to the control group."

Sources: Unützer, JU, M Schoenbaum, BG Druss, and WJ Katon. January 2006. Transforming Mental Health Care at the Interface with General Medicine: Report for the Presidents Commission. Psychiatric Services 57:1, 37-47. Druss, BG, RM Rohrbaugh, CM Levinson, and RA Rosenheck. September 2001. Integrated Medical Care for Patients With Serious Psychiatric Illness: A Randomized Trial. Archives of General Psychiatry 58:9, 861-868. Butler, M, et al. October 2008. Evidence Report/Technology Assessment No. 173: Integration of Mental Health/Substance Abuse and Primary Care. Rockville: AHRQ.

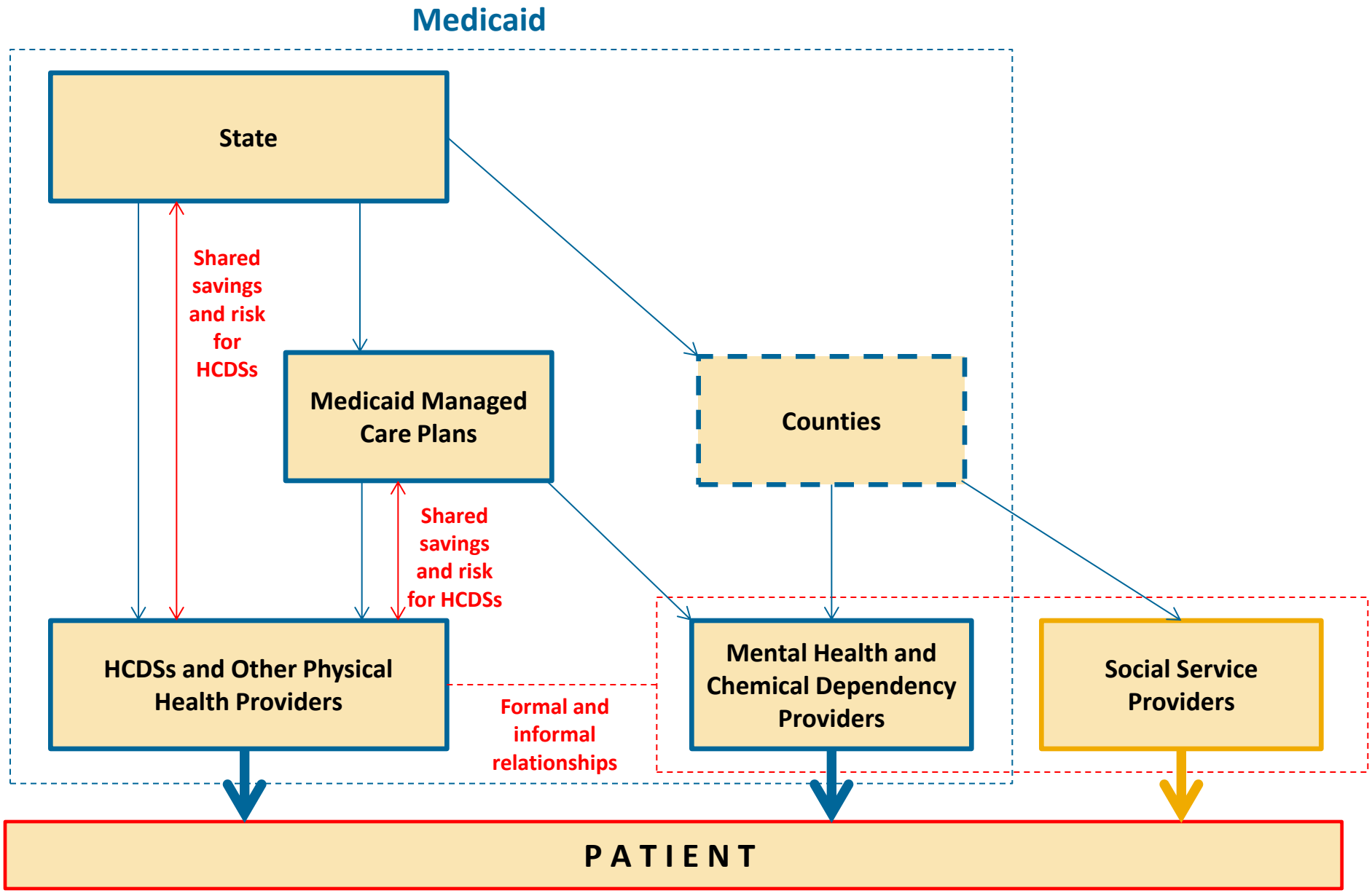
Table of Contents

Minnesota Health Care Delivery System Demonstration

Integration Supported at Provider Level Across FFS and MMC

Financial Accountability for All Services at Provider Level	▪ Minnesota contracts with Medicaid Health Care Delivery Systems (HCDSs) accountable for total cost of care, including physical health, MH, and CD services; the model is similar to an accountable care organization ○ *Financial accountability for intensive residential MH and CD services is currently optional for HCDSs* ▪ MMC plans contractually required to use same payment methodologies as fee-for-service (FFS) Medicaid for HCDSs in their networks
Flexible Relationships Between Physical Health, MH, and CD Providers	▪ Integrated HCDSs provide a broad spectrum of care as a common financial and organizational entity ▪ "Virtual" HCDSs include providers not part of a formal integrated delivery system
Coordination Incentivized through Shared Savings and Risk	▪ HCDSs in formally integrated delivery systems with 2,000 or more attributed participants are eligible for shared savings progressing to symmetrical shared savings and risk ▪ HCDSs not in formal integrated delivery systems, or with 1,000 to 1,999 attributed participants, are eligible only for shared savings
Agnostic to FFS or Managed Care Funding Stream	▪ HCDSs are eligible to share in savings (and, if eligible, risk) regardless of whether enrollees are in fee-for-service (FFS) Medicaid or MMC
Provides for Partnerships Between Providers and Social Services	▪ HCDSs must incorporate formal and informal partnerships with community-based organizations, social service agencies, counties, and public health resources as part of care model ▪ HCDSs are encouraged to incorporate entities directly into payment model

MN Health Care Delivery System Demonstration (cont.)



MN Health Care Delivery System Demonstration (cont.)

Potential Advantages

- Provider integration supported at delivery system level regardless of FFS or MMC
- State can hold a single organization accountable regardless of FFS or MMC financing streams
- Opportunity for shared savings promotes whole-person orientation with regard to care, outcomes, and performance accountability
- May provide for greater provider buy-in

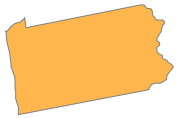
Potential Disadvantages

- May not address coordination and integration challenges posed by separate payment streams and associated regulatory requirements, especially around data sharing
- Coordinating care may be a challenge where care falls outside of HCDS, especially in FFS

Other State Integration Efforts

- Hennepin Health "Safety-Net ACO" Demonstration focuses on integration through county-based health plan, hospital and clinics, incentivizing savings in corrections, social services
- Integrated Dual Disorders Treatment program for MH and CD services
  - New rules require individuals who perform CD or MH assessments to use standardized screening tools for co-occurring mental illness or CD
  - New proposed rules would allow for certification of dual diagnosis treatment programs

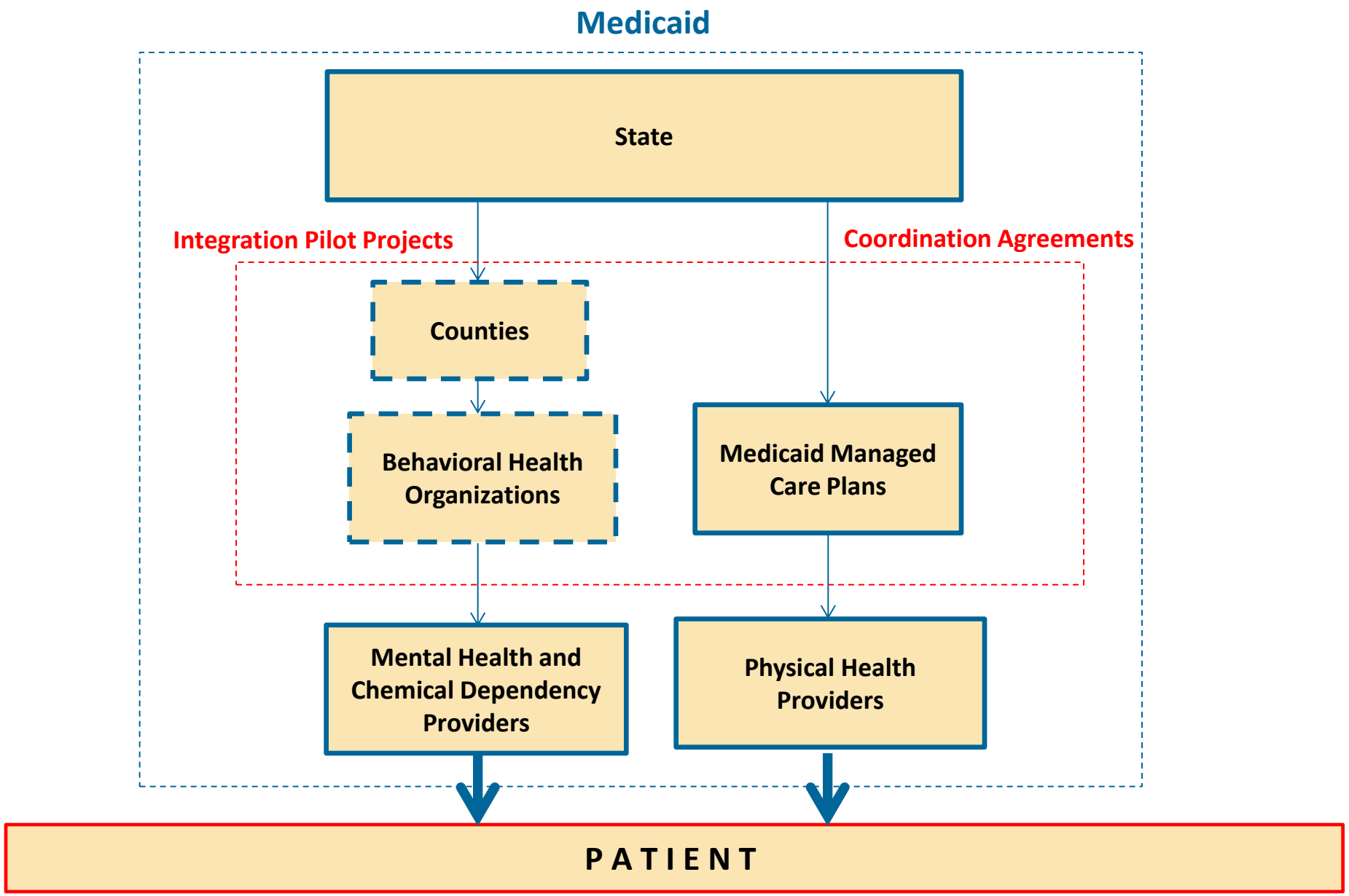
Pennsylvania HealthChoices Behavioral Health Program



Carved Out MH and CD Services Offered through BHO

Physical Health Services Delivered through FFS Medicaid or Medicaid Managed Care	▪ HealthChoices Physical Health MMC plans are responsible for all pharmacy services, with the exception of methadone ▪ Enrollment in MMC is mandatory in all counties
Statewide, Carved Out Managed Behavioral Health Care Program	▪ All mental health and chemical dependency services are provided through behavioral health organizations, with the exception of non-methadone pharmacy services, which are provided through physical health MMC plans ▪ 1915(b) waiver program
BH Services Administered through State Contracts with Counties, County Consortia, or Directly with BHOs	▪ Counties have "right of first opportunity" to administer BH services ▪ About two-thirds of counties have chosen to administer BH services, as individual counties or consortia, through a contract with a BHO ▪ In remaining counties, State contracts directly with BHO
Coordination Agreements and Pilot Programs Link Physical Health and Behavioral Health Managed Care Systems	▪ Physical and behavioral health managed care organizations required to develop and implement written coordination agreements ▪ SMI Innovations Project aimed to improve coordination of physical and behavioral health services for people with SMI in two regions o Region- and county-specific collaborations between physical and behavioral health managed care organizations and county BH offices o Common State framework between regions for integrated care

PA HealthChoices Behavioral Health Program (cont.)



PA HealthChoices Behavioral Health Program (cont.)

Potential Advantages

- Provides integrated financing and administration for mental health and chemical dependency services
- Ensures that beneficiaries access services through an entity focused on behavioral health

Potential Disadvantages

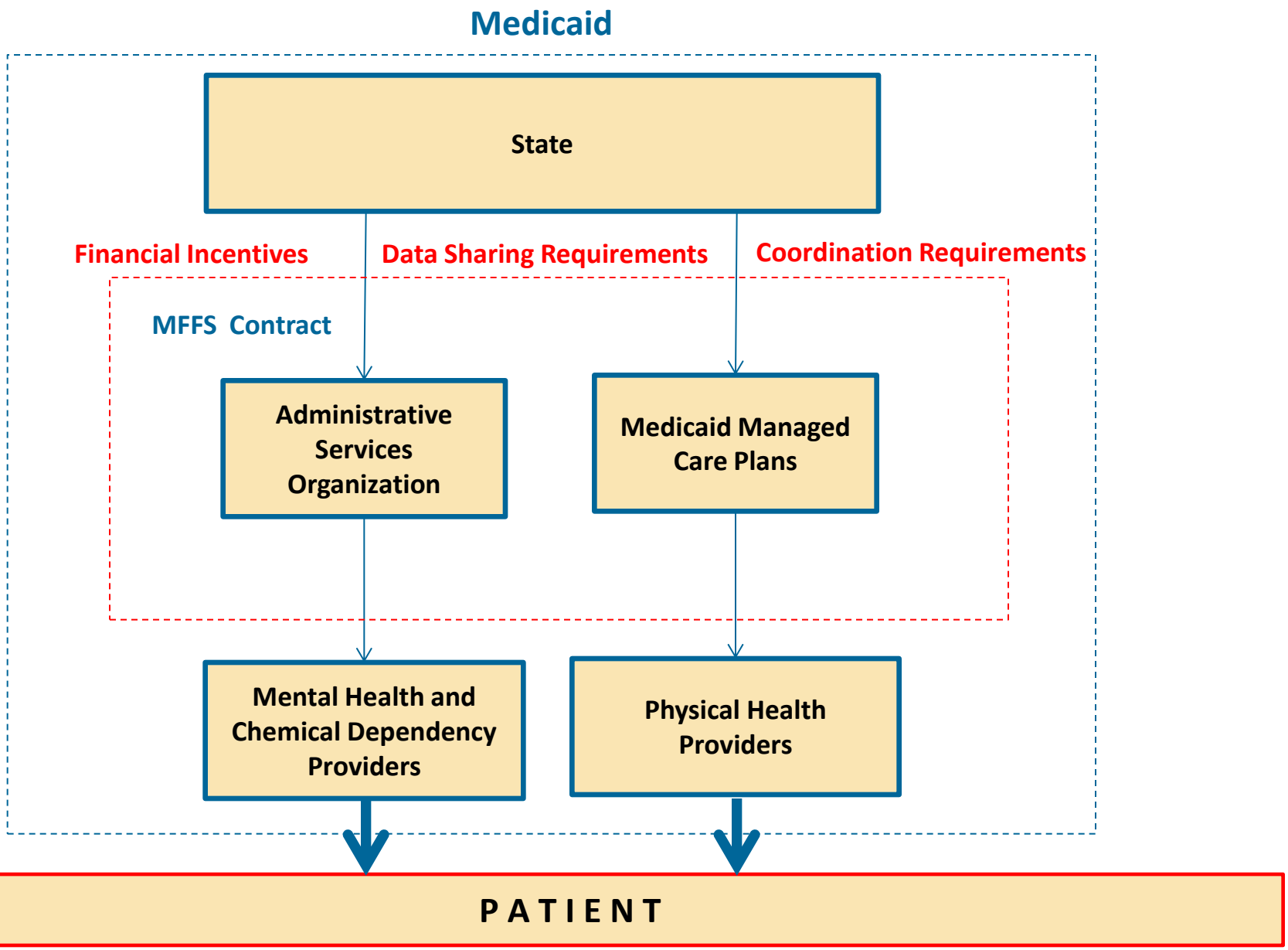
- Coordination with physical health remains a challenge, requiring additional efforts through contractual requirements and pilot projects

Maryland Performance-Based ASO Carve-Out

Carved Out MH and CD Services Offered through ASO

Physical Health Services Delivered through MMC	▪ Statewide mandatory MMC program enrolls children and adults, with and without disabilities (excluding dual eligibles, the institutionalized, children with special health care needs) ▪ PCPs may provide limited BH services
Specialty MH Services Carved out and Provided MFFS through ASO	▪ ValueOptions contracts with the Mental Hygiene Administration to manage specialty MH services (i.e., services for people with SMI, mental health drugs) on a managed FFS basis
CD Services to Transition from MMC to ASO	▪ CD services currently included in MMC benefit package ▪ In 2014, Maryland will procure an ASO to provide both MH and CD services on a managed FFS basis, beginning in 2015 ▪ Medicaid agency will monitor ASO contract
Financial Incentives and Coordination Requirements will Encourage Integrated Care	▪ Financial performance incentives (e.g., shared savings) for ASOs will encourage reductions in hospitalizations ▪ ASO and MCOs will be required to have care coordinators for individuals served in both systems ▪ MH clinics and methadone clinics eligible to participate in Maryland Health Home program targeted at people with SMI and SUD ▪ MMC and ASO systems will be required to share data using statewide HIE

Maryland Performance-Based ASO Carve-Out (cont.)



Maryland Performance-Based ASO Carve-Out (cont.)

Potential Advantages

- Covers populations excluded from MMC, including dual eligibles
- Single ASO reduces administrative burden on providers with respect to credentialing, prior authorization, utilization review, payment rates, and contracting practices
- Offers single point of transition for individuals churning in and out of Medicaid eligibility

Potential Disadvantages

- Coordination of care and data sharing across systems may pose challenges
- Early identification and prevention for BH conditions is more difficult when primary care is provided through a separate system

Other State Integration Efforts

- Maryland will merge its Mental Hygiene Administration and Alcohol and Drug Abuse Administration in 2014
- Maryland is attempting to reduce duplicative and burdensome regulatory requirements for BH agencies by increasing the role of accreditation and minimizing the role of regulations in licensing

New York State Medicaid Managed Care

Integration of Physical Health and BH in MMC

MMC Plans Responsible for All Physical and Behavioral Health Services

- All mental health and chemical dependency services will be "carved in" to MMC plans; MMC plans will be capitated for comprehensive benefits, including physical and behavioral health
- Implementation is currently scheduled for 2015
- Will be implemented under amendment to 1115 Partnership Plan waiver

Heightened Plan Requirements to Serve Individuals with MH and CD Needs

- Person-centered, individual plans of care and care coordination, including coordination of non-plan services (e.g., housing)
- Enhanced quality metrics
- Interfaces with social service systems, counties, and State psychiatric centers

Two Plan Types

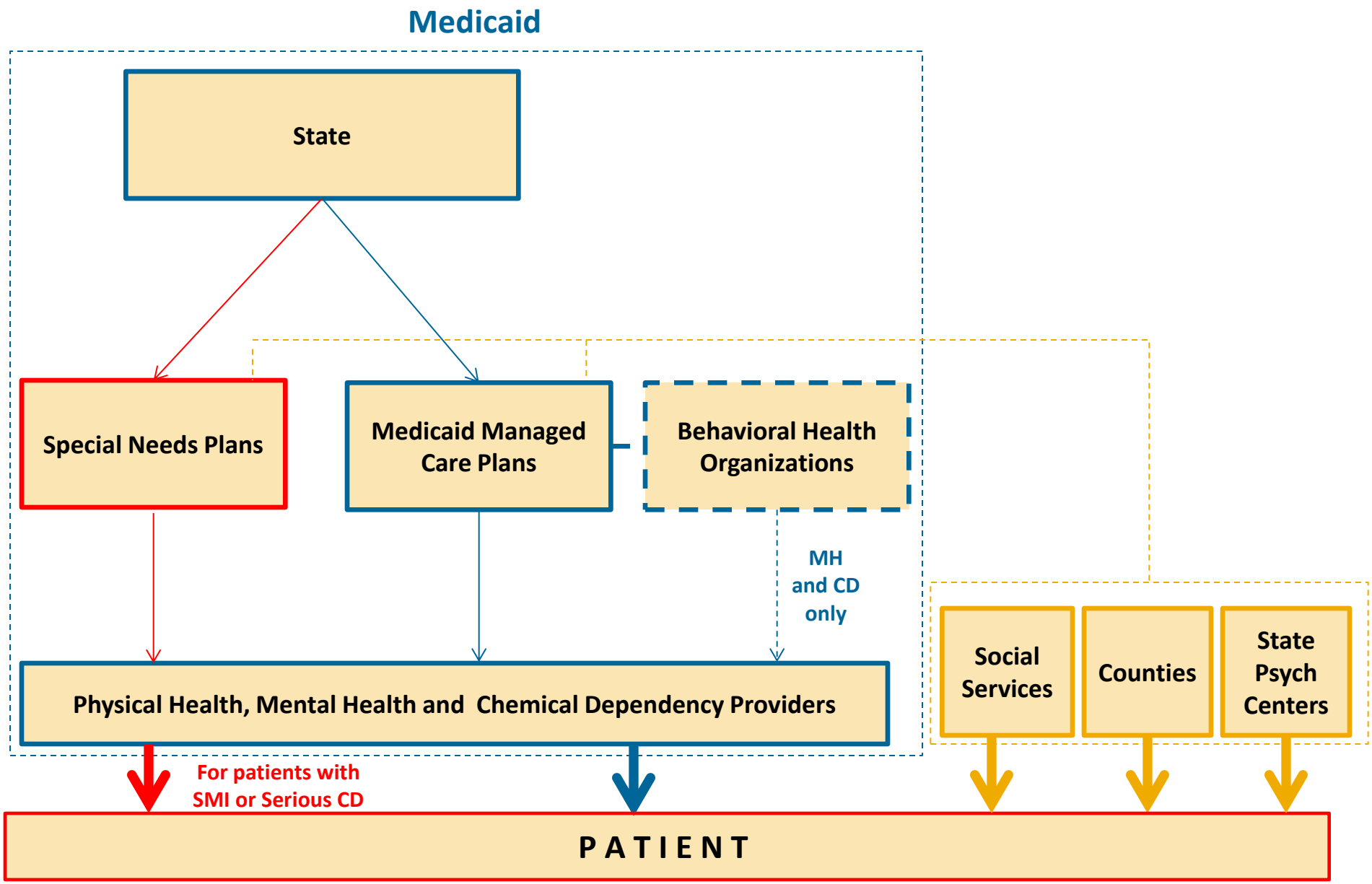
Traditional Medicaid Managed Care Plans Serve Individuals with MH and CD Needs

- Plans unable to meet heightened requirements on their own will be required to contract with qualifying behavioral health organizations

New Special Needs Plans Serve Individuals with Serious MH and CD Needs

- Must offer additional recovery-oriented services subject to specialized medical and social necessity/utilization review approaches
- Subject to additional quality metrics and incentives
- Anticipated that many, if not all, will be existing MMC plans

New York State Medicaid Managed Care Program (cont.)



New York State Medicaid Managed Care Program (cont.)

Potential Advantages

- One entity has responsibility for physical health, mental health, and chemical dependency services
- Patients have an integrated source of care for physical and behavioral health needs at all levels
- People with serious behavioral health needs may receive additional services through a plan with focused expertise

Potential Disadvantages

- Medicaid managed care plans have limited experience with behavioral health service providers
- Disruption of current pathways to access services and navigating MMC may pose challenges for enrollees, especially those with serious behavioral health needs

Other State Integration Efforts

- New York has implemented health homes as networks of providers that contract with the State and MMC plans to provide care management and coordination to enrollees with SMI or multiple chronic conditions, including mental illness and chemical dependency
  - Establish relationships between physical and behavioral health providers who have not previously worked together, supported by PMPM payments

Oregon's Coordinated Care Organizations (CCOs)

Capitated Model with Integration of Physical Health and BH

Community-Based Entities Governed by a Partnership of Providers, Community Members, and Risk-Bearing Entities

- Governance structure must include a mental health or chemical dependency treatment providers

Receive Capitated Payments to Provide Physical Health, Mental Health, and Chemical Dependency Services to Members

- Includes services previously provided through separate physical health organizations (including CD), mental health organizations (carved out MH services), and dental care organizations
  - *Mental health drugs are not included in CCO budgets*
- Payment anticipated to move toward more cost and quality accountability over time
- Operated under Oregon Health Plan Waiver

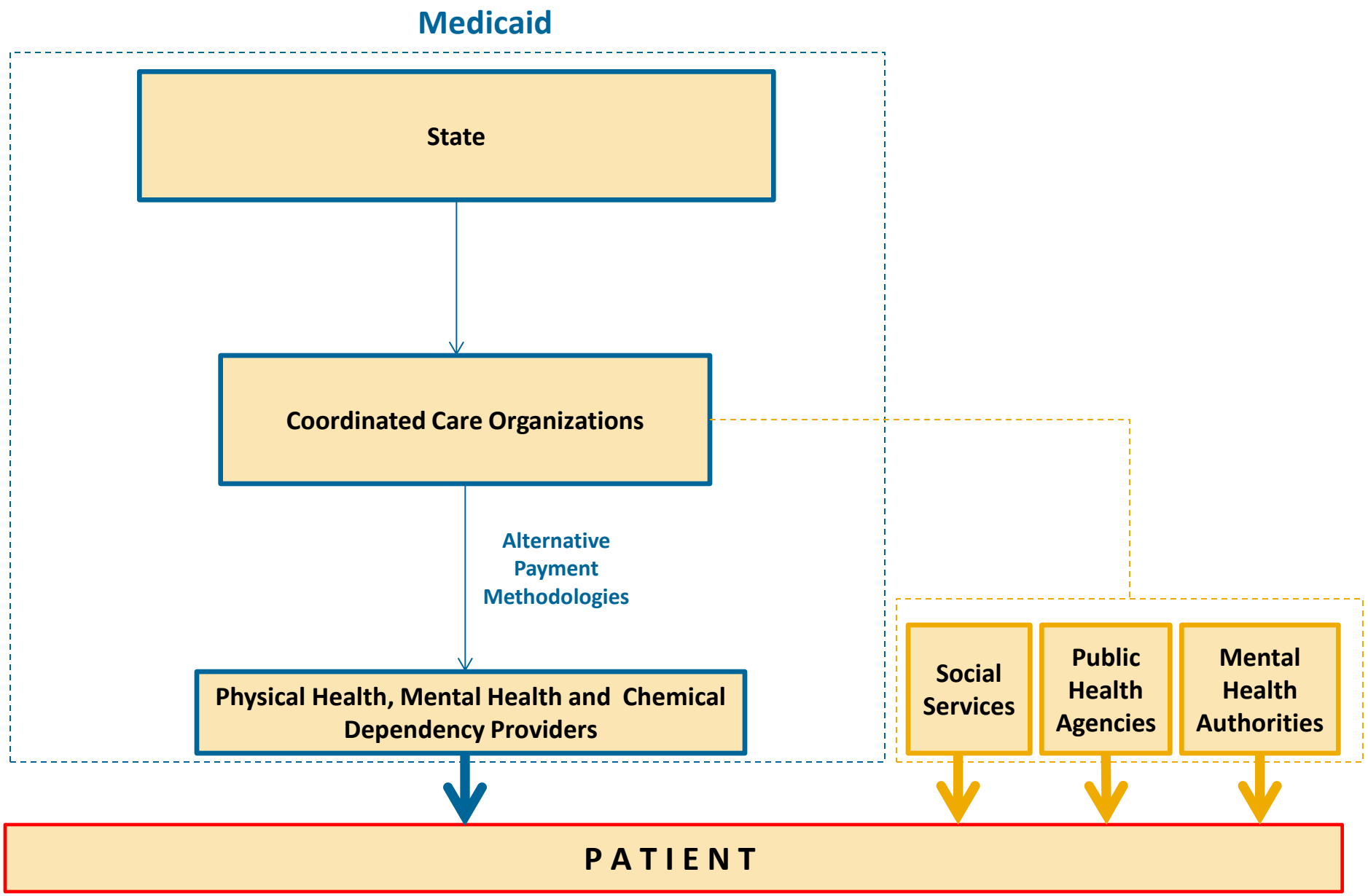
Institute Payment and Delivery Reforms with Providers Individually

- CCOs will, by contract, transition to "alternative payment methodologies" with contracted providers over time

Collaborate with Local Stakeholders to Meet Community Needs

- CCOs expected to develop community health assessments and improvement plans in consultation with local hospitals, public health agencies, social services organizations, and mental health authorities
- CCOs required to establish agreements with local mental health authorities and county governments regarding maintenance of non-Medicaid mental health safety net

Oregon's Coordinated Care Organizations (cont.)



Oregon's Coordinated Care Organizations (cont.)

Potential Advantages

- Requires representation of major components of the health care delivery system in governance structure, in addition to entities bearing risk
- Involvement of mental health community stakeholders in governance and community health improvement planning provides for a local role in capitated model

Potential Disadvantages

- Requires dramatic system transformation dependent upon new partnerships

Other State Integration Efforts

- County-level, non-Medicaid publicly-funded behavioral health service system undergoing parallel system change aligned with movement to CCOs, including global budgeting and outcomes-based accountability
- Integrated Services and Supports Rule targeted at reducing and streamlining paperwork for providers and patients, including through consolidated screening, so that patients are able to receive treatment sooner

Arizona Integrated Care System for People with SMI

Capitated Model for Physical Health and BH Services through Regional BH Authority for People with SMI

Regional Behavioral Health Authority (RBHA) Responsible for BH Services in Maricopa County

- Department of Health Services/Division of Behavioral Health Service contracts with RBHA to provide coordination, planning, administration, regulation and monitoring for BH system,
- Includes BH services carved out of MMC program

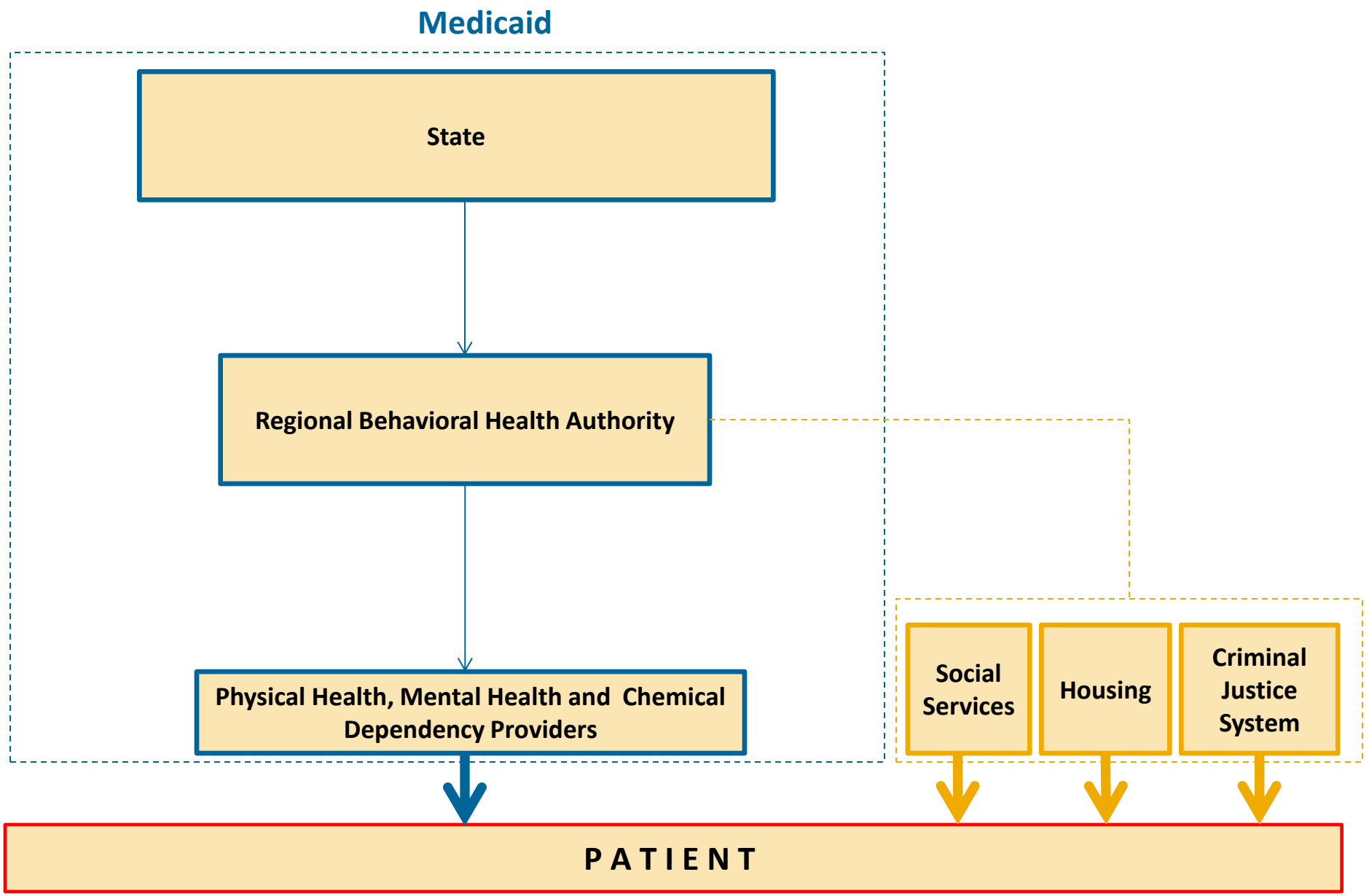
RBHA will be at Risk for All Physical and BH services for Medicaid Enrollees with SMI

- Under 1115 waiver amendment and recent procurement, Maricopa RBHA will assume responsibility for physical health services for Medicaid enrollees with SMI
- Implementation is anticipated in October 2014
- State intends to introduce similar procurements in the rest of the state

Scope of RBHA Responsibilities Includes Connections to Social Services, Housing, Peers, and Criminal Justice

- At least 25 percent of RBHA board's voting members must be peers and family members who are or have been active participants in the Maricopa County BH system
- RBHA required to develop and manage housing and employment services
- RBHA must have collaborative protocols with state agencies, criminal justice, and local law enforcement
- RBHA required to hold periodic meetings to gather input from providers, peers, and family members

AZ Integrated Care System for People with SMI (cont.)



AZ Integrated Care System for People with SMI (cont.)

Potential Advantages

- One entity has responsibility for physical health, mental health, and chemical dependency services
- Provides a specialized service system attentive to the unique needs of people with SMI
- Includes specific requirements for connections to social services, housing, peers, and criminal justice

Potential Disadvantages

- Risks a stigmatizing effect due to creation of separate systems of physical health care for people with SMI and people without SMI
- RBHA may have limited experience contracting with physical health service providers
- Potential for churn as individuals fluctuate on the behavioral health status continuum over their lifetimes

Washington Medicaid Integration Partnership (WMIP)

Capitated Model with Comprehensive Benefit Package

Integrated Managed Care Pilot Program in Snohomish County

- Covers Medicaid beneficiaries with MH or CD needs
- Funding and enrollment caps apply
- Only SSI beneficiaries eligible
- Limited to Snohomish County and to one health plan
- Implemented using 1915(a) authority

Plans Responsible for Physical Health, MH, CD, and LTSS

- Responsibility for physical health, mental health, chemical dependency, *and* long-term services and supports (LTSS) falls under a single managed care entity

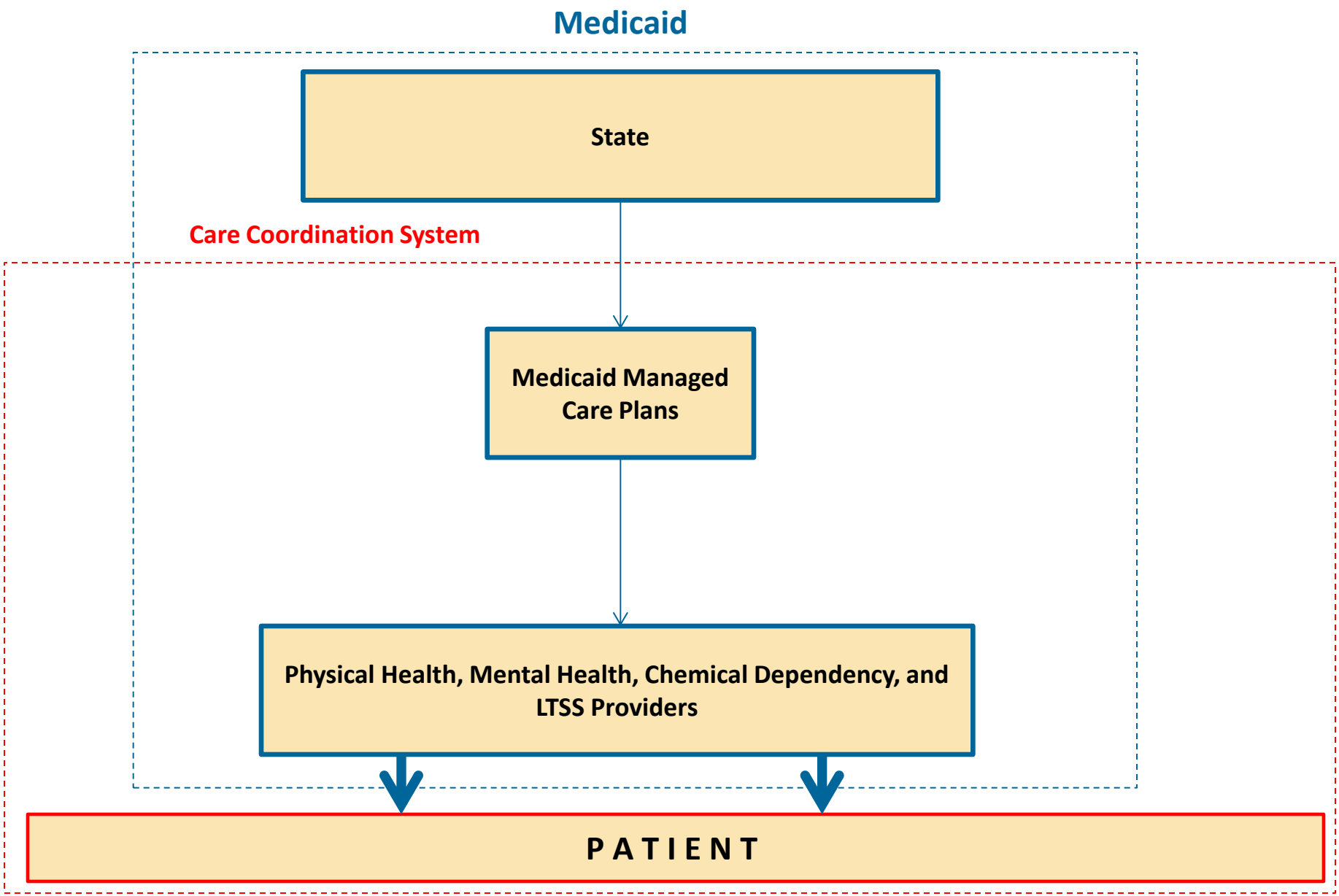
Plans Required to Implement Care Coordination System

- Health risk assessment
- Monitoring of patient symptoms
- Patient education
- Coordination of physical health, mental health, CD, and LTSS
- 24/7 nurse line for all members

Plan Required to Ensure Access to and Integration of All Covered Services

- Plans must:
  - Ensure communication and coordination of an enrollee's care across network provider types and settings
  - Ensure smooth transitions for enrollees who move among various care settings
  - Assist enrollees in maintaining program eligibility

Washington Medicaid Integration Partnership (cont.)



Washington Medicaid Integration Partnership (cont.)

Potential Advantages

- One entity has responsibility for physical health, mental health, and chemical dependency services
- Added responsibility for long-term services and supports ensures that plans are responsible for the full spectrum of Medicaid services
- Enrollees have integrated source of care for physical and behavioral health needs at all levels

Potential Disadvantages

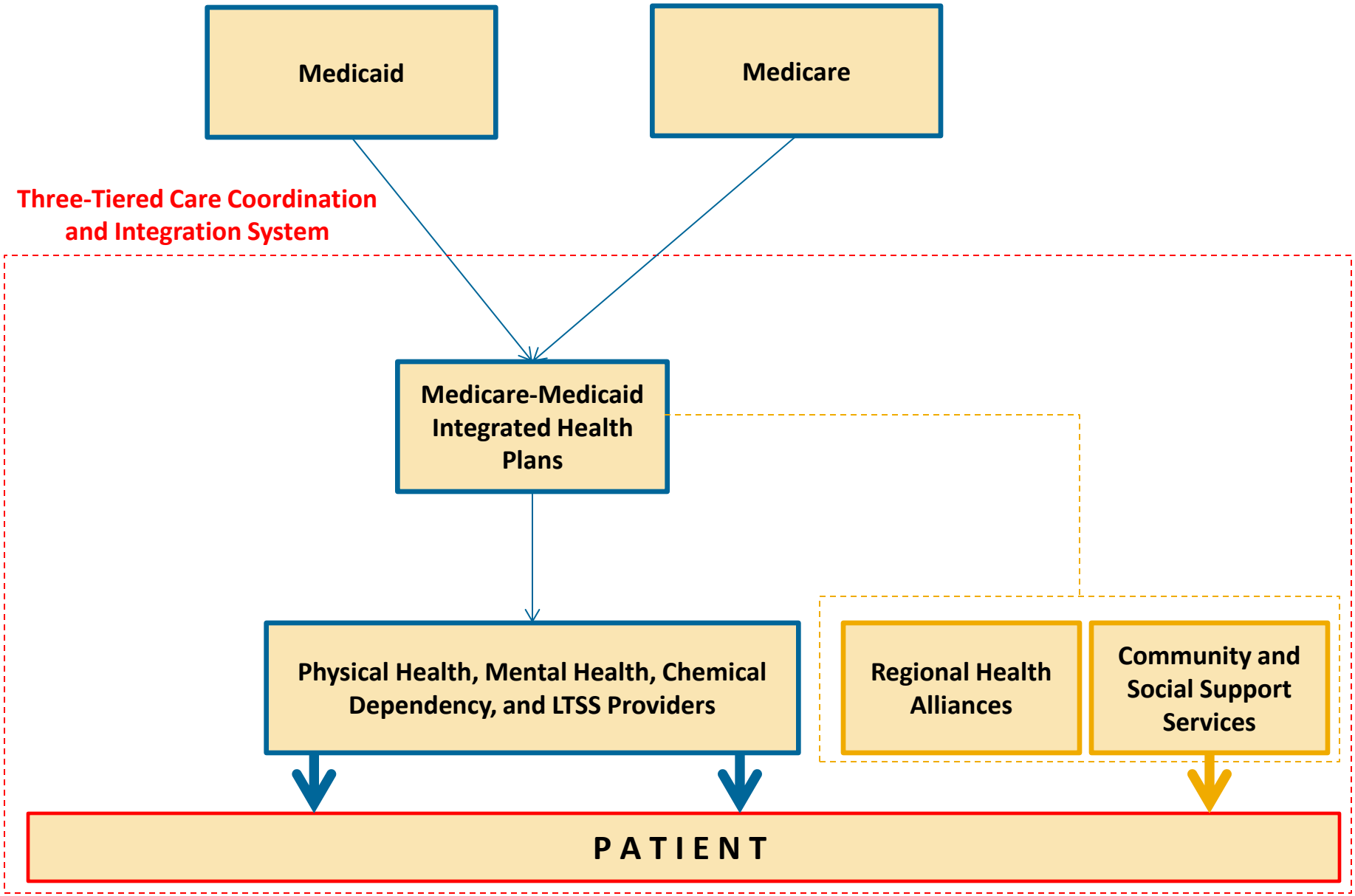
- Healthy Options plans have limited experience with behavioral health service providers
- Disruption of current pathways for enrollees to access services may pose a challenge, especially for individuals with serious behavioral health needs
- Requires large ramp up of small demonstration program
- There have been longstanding concerns among stakeholders regarding the quality of care coordination and service delivery in WMIP

HealthPath Washington Capitated Demonstration

Integrated Medicare-Medicaid Health Plans Cover All Services for Dual Eligibles in King, Snohomish Counties

Medicare-Medicaid Integrated Health Plans Responsible for Physical Health, MH, CD, and LTSS	▪ Coverage of physical health, mental health, chemical dependency, and long-term services and supports (LTSS) falls under a single managed care entity
Final MOU and Initial Roll-Out Pending	▪ Limited to dual Medicare-Medicaid enrollees in King and Snohomish counties ▪ In other counties, Washington will pursue integration for high-cost, high-risk dual eligibles through a managed FFS Health Home program
Three-Tiered Care Coordination and Integration System Dependent on Level of Need	▪ Level One: Supported Self-Care Management ▪ Level Two: Disease/Episodic Care Management ▪ Level Three: Intensive Care Management for Enrollees with Special Health Care Needs
Intensive Care Management Includes Referrals to Community and Social Support Services	▪ Comprehensive care management ▪ Care coordination and health promotion ▪ Comprehensive transitional care between care settings ▪ Individual and family support (including authorized representatives) ▪ Referral to community and social support services ▪ Use of health information technology to link services

HealthPath Washington Capitated Demonstration (cont.)



HealthPath Washington Capitated Demonstration (cont.)

Potential Advantages

- One entity has responsibility for physical health, mental health, and chemical dependency services
- Added responsibility for long-term services and supports ensures that plans are responsible for the full spectrum of Medicaid and Medicare services
- Addresses lack of financial alignment and responsibility across federal and state government, in addition to different state service systems
- Tiered care coordination and integration system targets dual eligible individuals at all levels of need, focusing resources on individuals with the greatest need

Potential Disadvantages

- Plans have limited experience with behavioral health service providers
- Plans have limited experience administering integrated Medicare and Medicaid services
- Disruption of current pathways for enrollees to access services may pose a challenge, especially for individuals with serious behavioral health needs
- Requires significant ramp up from limited demonstration

Table of Contents

State Drivers of Integration

Strong Executive with a Clear Vision

New York

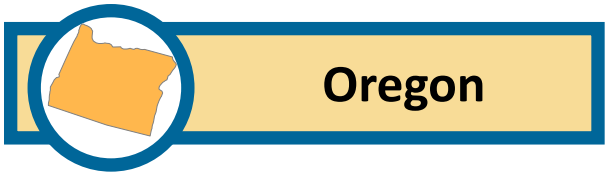
- Upon taking office in **January 2011**, Governor Andrew Cuomo established a Medicaid Redesign Team (MRT) of state officers, members of the Legislature, plans, providers, business, labor, and consumer representatives.
- In a **2-month** period, the MRT developed a set of recommendations for inclusion in the 2011-2012 Executive Budget.
- In **March 2011**, the Legislature adopted nearly all MRT recommendations from the Executive Budget, including the establishment of BHOs to perform concurrent review of FFS BH services as a one-year bridge to an integrated MMC program.
- New York's Medicaid agency, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services have collaborated to present a unified vision for integrated managed care options for people with mental health and substance abuse needs.

Oregon

- In **January 2011** Governor John Kitzhaber requested that the Oregon Health Policy Board charter a Health System Transformation Team (HSTT) to identify elements of successful delivery system transformation, a budget and value proposition, and draft legislative language.
- Between **January and March 2011**, the HSTT met eight times to develop a straw proposal for CCOs, which was submitted to the Legislature **March 23rd** and formed the basis of enabling legislation for CCOs.
- Governor Kitzhaber has publicly championed Oregon's Medicaid CCOs and their extension to the state's public employees and the state at large. He was personally involved in negotiating the state's receipt of $1.9 billion in 1115 waiver funding for implementation.

State Drivers of Integration

Legislative Mandate



Oregon

- In **June 2011,** HB 3650, with bipartisan support, established legislative authority for CCOs and directed the Oregon Health Policy Board to produce an implementation plan by **January 2012.**
- In **February 2012**, again with bipartisan support, the Legislature passed SB 1580, which approved the establishment of CCOs and directed the state to examine how to spread the Coordinated Care Model to state employees.

Maryland

- In language accompanying Maryland's **April 2011** budget bill for SFY 2012, the chairmen of the budget committees requested that the Department of Health and Mental Hygiene (DHMH) "convene a workgroup of interested parties to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues," requesting recommendations by December 15, 2011.
- After consultant engagement, stakeholdering, and DHMH endorsement of a combined MH/CD ASO, **March 2013** budget language required DHMH make a decision on implementation of the ASO, submitting a report to the chairmen by December 2013.

Minnesota

- In **May 2010,** the Minnesota Legislature passed and the Governor signed legislation compelling Department of Human Services to develop and authorize the HCDS demonstration.

State Drivers of Integration

Stakeholder Engagement

New York

- New York's MRT continues to shape the development of New York's integrated Medicaid managed are program for people with behavioral health needs.
- From **June to September 2011**, an MRT behavioral health work group composed of State and New York City officials, providers, managed care organizations, advocates, and other stakeholders met four times to develop recommendations on transformation of behavioral health services in New York.
- From **October to December 2011,** the work group issued and the MRT adopted a series of recommendations for integrated managed care that continue to guide the State's development of the model.
- The work group reconvened in **October 2012** and **May 2013** to discuss the model proposed by the State.

Maryland

- From **April to December 2011**, Maryland engaged a consultant to examine its current system, consider integration options, and provide recommendations on financing structures. The consultant:
  - Conducted five structured group interviews
  - Held three listening sessions
  - Held meetings to review proposed options
  - Produced a report summarizing findings and presenting two integration options
- From **March to September 2012,** DHMH held six public stakeholder meetings to inform model selection, collected public comments, and established four workgroups that met 3-4 times to address specific issue areas
- From **June 2013 to present**, Maryland has held 4 stakeholder meetings on details of the ASO procurement

Table of Contents

Managed Care Contract Provisions: Governance

Require peer and family representation

Arizona (Maricopa County Regional Behavioral Health Authority Scope of Work)

"The Contractor shall . . . Include in its Governance Board or governance structure at least twenty-five per cent (25%) of the voting members to be equally divided between peers and family members who are or have been active participants in the Maricopa County Behavioral Health system."

Require provider and community representation

Oregon (CCO Model Contract)

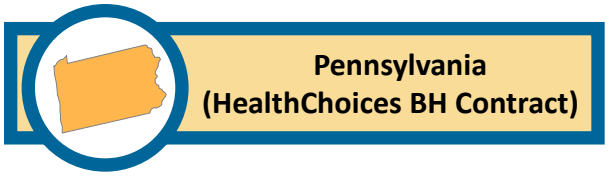
"Contractor shall establish, maintain and operate with a governance structure that complies with the requirements of ORS 414.625(1)(o)."

ORS 414.625(1)(o):
"Each coordinated care organization has a governance structure that includes:
(A) A majority interest consisting of the persons that share in the financial risk of the organization;
(B) The major components of the health care delivery system; and
(C) The community at large, to ensure that the organizations decision-making is consistent with the values of the members and the community."

Note: Regional Behavioral Health Authorities (RBHAs) coordinate, plan, administer, regulate, and monitor the state public behavioral health system in Arizona, acting as regional BHOs for Medicaid and non-Medicaid services. Under the recent Maricopa County RBHA procurement, the RBHA will be at risk for all physical and behavioral health services for Medicaid enrollees with SMI.

Managed Care Contract Provisions: County Collaboration

Require coordination agreements with local government agencies



Pennsylvania (HealthChoices BH Contract)

"The Primary Contractor or its BH-MCO is required to coordinate service planning and delivery with human services agencies. The Primary Contractor or its BH-MCO is required to have a letter of agreement with:

a. Area Agency on Aging.
b. County Juvenile Probation Office ...
c. County Drug and Alcohol Agency…
d. County offices of MH and ID, including coordination with the Health Care Quality Unit (HCQU)...
e. Each school district in the county.
f. County MH/ID Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.
g. Early intervention…"

Require participation in existing local planning process

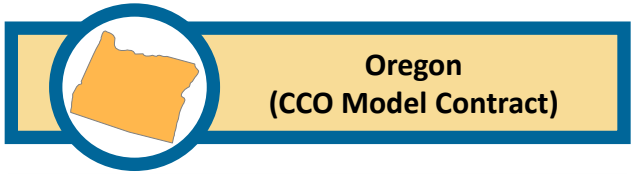
New York (Current MMC Contract)

Current MMC contract:

"The Contractor also agrees to participate in the local planning process for serving persons with chemical dependence, to the extent requested by [a local department of social services (LDSS)]. At the LDSS's discretion, the Contractor will develop linkages with local governmental units on coordination procedures and standards related to Chemical Dependence Services and related activities."

Under State guidance, county governments, Health Homes, and managed care organizations locally determine how individuals receiving involuntary treatment, exiting jail, or existing institutions for mental disease are prioritized for enrollment in Health Home care management.

Create new local planning process



Oregon (CCO Model Contract)

"Contractor shall establish a [Community Advisory Council (CAC)] that includes appropriate community representation in each Service Area. The duties of the CAC shall include, the following, in collaboration with community partners:

a. Identifying and advocating for preventive care practices to be utilized by the Contractor;
b. Overseeing a Community Health Assessment and adopting a Community Health Improvement Plan [developed in collaboration with the local public health authority, local mental health authority, community based organizations and hospital systems] to serve as a strategic plan for addressing health disparities and meeting health needs for the communities in the Service Area(s); and
c. Annually publishing a report on the progress of the community health improvement plan."

Managed Care Contract Provisions: Social Services

Require physical or behavioral health provider networks to coordinate with social service providers

Pennsylvania (HealthChoices BH Contract)

"The Primary Contractor or its BH-MCO must ensure management of the Provider network through agreements which include the following provisions…

- Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice."

Oregon (CCO Model Contract)

"Contractor's employees or Subcontractors providing substance use disorder services shall provide to Member, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services."

"Contractor shall work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded long term care services and mental health crisis management services."

Require development and management of housing and employment services

Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Develop and manage state and federal housing programs and deliver housing related services…
- Develop and manage a continuum of vocational employment and business development services to assist SMI members, including transition age youth to achieve their employment goals."

Managed Care Contract Provisions: Community Linkages

Require collaborative protocols with state agencies, criminal justice, and local law enforcement

Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Address …Procedures to have providers co-located at [Child Protective Services] offices, juvenile detention centers or other agency locations as directed by [the State]…
- Address in the collaborative protocol with the Administrative Office of the Courts, Juvenile Probation and Adult Probation strategies for the Contractor to optimize the use of services in connection with Mental Health Courts and Drug Courts…
- Meet, agree upon and reduce to writing collaborative protocols with local law enforcement and first responders, which, at a minimum, shall address:
  - Continuity of covered services during a crisis;
  - Information about the use and availability of Contractor's crisis response services;
  - Jail diversion and safety;
  - Strengthening relationships between first (1st) responders and providers when support or assistance is needed in working with or engaging members; and
  - Procedures to identify and address joint training needs."

Require periodic meetings to gather input from providers, peers, and family members

Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Periodically meet with a broad spectrum of behavioral and physical health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the integrated health care service delivery…
- Periodically meet with a broad spectrum of behavioral health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the behavioral health service delivery…
- Periodically meet with a broad spectrum of peers, family members, peer and family run organizations, advocacy organizations or any other persons that have an interest in participating in improving the system. The purpose of these meetings is to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the service delivery system."

Managed Care Contract Provisions: Provider Reimbursement

Require alternative payment arrangements with network providers

Oregon (CCO Model Contract)

- "Contractor shall demonstrate how it will use alternative payment methodologies alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for Members.

  Contractor shall define its schedule for Contractor implementation of alternative payment methodologies, with benchmarks and evaluation points identified. Contractor shall assign a high priority to payments to Patient-Centered Primary Care Homes for individuals with chronic conditions. Contractor shall develop a protocol for ensuring prompt payments to Patient-Centered Primary Care Homes for implementation in the first year of Contractor operations."
- "'Alternative Payment Methodology' means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services. 'Alternative Payment Methodology' includes, but is not limited to:

  (1) Shared savings arrangements;

  (2) Bundled payments; and

  (3) Payments based on episodes."

Require participation in a State-administered alternative payment methodology

Minnesota (Medical Assistance and MinnesotaCare MMC Contract)

"The MCO and the STATE will participate in a shared savings and losses payment methodology through the Health Care Delivery Systems (HCDS) Demonstration with the STATE's contracted HCDS Entities in the MCO's provider network, in accordance with Minnesota Statutes, § 256B.0755…

The STATE will notify the MCO in writing of the shared savings for the interim and final payments to be paid to the HCDS Entity or Entities. The MCO shall issue payment to the HCDS Entity as identified by the STATE within thirty (30) days from the date of the notification from the STATE…

The MCO shall work with the STATE on the development of the allocation methodology across the MCOs for the shared savings payment to the HCDS Entities."

Table of Contents

Levels of Integration at the System Level: Framework

Minimal Coordination	Basic Coordination	Close Coordination	Full Integration
▪ Have separate systems	▪ Have separate systems	▪ Some shared systems and workarounds	▪ Function as one integrated system
▪ Limited understanding of each other's roles and resources	▪ Appreciation of each other's roles as resources	▪ Understanding of each other's roles and culture	▪ Roles and cultures that blur or blend
▪ Communicate rarely, typically under compelling circumstances only	▪ Communicate periodically about shared patients, driven by specific patient needs	▪ Frequent communication and collaboration	▪ Consistent communication and collaboration
▪ Physical and behavioral health needs treated as separate issues	▪ Physical and behavioral health needs treated separately	▪ Physical and behavioral health needs treated collaboratively for certain sets of patients	▪ Physical and behavioral health needs treated collaboratively for all patients
▪ No coordination or management of collaborative efforts	▪ Some leadership efforts around systematic information sharing	▪ Leadership support for integration through mutual problem-solving	▪ Leadership support for integration as driving model of operations
▪ Separate funding streams, and no resource sharing	▪ Separate funding streams with some shared resources	▪ Blended funding streams, with some shared expenses	▪ Integrated funding, with shared resources, expenses

While there are some instances of integrated service infrastructure, Washington's overall physical, mental health and substance abuse service systems largely reflect "basic coordination" at the administrative and system levels

Note: Levels of integration adapted from the SAMHSA-HRSA Center for Integrated Health Solutions' *A Standard Framework for Levels of Integrated Healthcare*

Beyond the Status Quo: New Options for Washington

1 Maintain Existing Structure; Address Major Obstacles

- Retain current division of responsibility between Healthy Options, RSNs/BHOs, and counties
- Competitively procure BHO contracts
- Resolve impediments to better coordination and integration including:
  - Data sharing
  - State reporting infrastructure
  - Streamlined/coordinated assessment tools
  - Aligned and simplified regulatory requirements
  - Strengthen requirements and accountability (including incentives and penalties) in state contracts

2 Integrate Mental Health and Chemical Dependency Systems

- Establish behavioral health organizations (BHOs) or Administrative Services Organization (ASO) with responsibility for MH *and* CD*
- Carve out all CD and BH benefits to BHO or ASO:
  - Counties could organize and form a BHO or ASO, or could be contracted providers to a BHO or ASO
  - Require BHOs/ASO and physical health systems to coordinate with non-Medicaid county services (jails, courts, EMS, etc.)
- Develop stringent coordination and data sharing requirements subject to incentives and penalties between BHOs or ASO and physical health systems
- Competitively procure contracts under risk-bearing arrangements (e.g., shared savings, capitation), integrating financial incentives:
  - Reinvest savings
  - Define performance requirements, incentives and enforceable penalties

Examples: Pennsylvania HealthChoices, Arizona RBHAs (currently), Maryland performance-based ASO (forthcoming; managed FFS model without full risk)

3 Centralize Responsibility for all MH, CD & Physical Health

- Accountability for full spectrum of physical health, MH, and CD services in accountable risk bearing entities
- Agreements with "accountable communities of health" to coordinate with non-covered or non-Medicaid services
- Competitively procure contracts under global capitation, shared savings or other risk bearing arrangements supported by subcontracts where warranted:
  - Reinvest savings
  - Consider special arrangements for targeted populations (e.g., dual eligibles, people with SMI)
  - Define performance requirements, incentives and enforceable penalties
- Define sustainable community level resource linkages

Examples: NY MMC (forthcoming), OR CCOs, MN Hennepin, AZ Maricopa RBHA (forthcoming)

Lower **Level of Integration and System Change Effort** ***Higher***

***ASO would coordinate care & providers would bill on a FFS basis; BHO would be capitated, coordinates care while providers bill the BHO**

Option 1: Address Barriers, but Maintain Existing Framework

(1) Develop competitive procurement of MH services if required by CMS

(2) Enable data sharing between physical health, MH, and CD systems

- Develop data use agreements, defined safe harbor, and incentives to use infrastructure to share data
- Consider whether legislation is needed to facilitate sharing of sensitive information

(3) Streamline reporting requirements and update State reporting and querying infrastructure

(4) Develop a unified assessment tool for MH and CD systems and require use statewide through contracting

(5) Establish a BH professional "dual diagnosis treatment" license for providers to serve individuals with MH and CD conditions, with rational experience requirements

- Stakeholder review period for regulations may be necessary based on past rulemaking

(6) Modify Healthy Options, RSN, and county contracts to provide financial and other incentives and penalties (e.g., holds on enrollment, shared savings) related to both physical and BH outcomes

Timeline

Total Time: 18-24 months

Regulatory changes include stakeholdering process and public comment and may require over two years to implement. The development of regulations aligning BH agency licensing requirements took three years to implement in Washington.

Option 2: Integrate MH and CD Services; Maintain PH System

(1) Implement Option 1 steps #2-#5 enabling data sharing, streamlining reporting, developing unified assessments and establishing dual diagnosis treatment license

(2) Convene stakeholders; evaluate and compare FFS arrangement with ASO and capitated BHO carve-out options; address issue of linkages with physical health and counties; staging of roll-out (if not statewide); select preferred approach

(3) Secure authorizing legislation

(4) Secure any necessary waivers

(5) Develop and release RFP; select ASO or BHO; develop contract provisions and execute contracts

Timeline

Year 1: Stakeholder Process

- Reach agreement on option and legislation

Year 2: Legislation

- If waivers needed, secure approval

Year 3: Procurement/Implementation

- Select entities to provide integrated MH and CD services

Option 3: Centralize Responsibility for PH, MH and CD Services

(1) Implement Option 1 steps #2-#5 enabling data sharing, streamlining reporting, developing unified assessments and establishing dual diagnosis treatment license

(2) Convene stakeholders; evaluate fully integrated model addressing key issues including: staging of rollout, integration of LTSS, crisis services, and involuntary treatment and linkages with social supports, criminal justice, etc.

(3) Evaluate role for "accountable communities of health" to coordinate non-covered or non-Medicaid services (e.g., county services such as jails, courts, EMS) with risk bearing entities responsible for Medicaid services

(4) Secure authorizing legislation

(5) Secure any necessary waivers

(6) Determine contract provisions; develop RFP; and select accountable risk bearing entities

Timeline

Year 1: Stakeholder Process

- Reach consensus on options (focusing on steps 2 and 3 above) and legislation

Year 2: Legislation

- If waivers needed, secure approval

Years 3-4: Phased Procurement/Implementation

- Phase implementation by county or region, based on county/regional readiness

Available Resources

Potential Funding Sources to Support Integration

- 1115 waiver funding may provide opportunities to invest in infrastructure and alternative payment arrangements to support development of bidirectional integrated care.
  - Oregon received $1.9 billion to support implementation of CCOs.
  - California and Texas received billions of dollars to expand enrollment in Medicaid managed care and promote health care delivery system reform.
  - Citing savings from its MRT initiatives, New York has requested $10 billion from CMS, including investments in supportive housing and care management infrastructure for Health Homes (Waiver request has been pending for more than a year).
- Ninety percent federal matching funds for Health Homes under ACA Section 2703 could provide transitional support for two years. (Two year period has commenced at least in part in State).
- CMMI State Innovation Model funding can support development and implementation of Washington's integration initiatives.

Thank You

Deborah Bachrach

Jonah Frohlich

Sandra Newman

Andrew Detty

Manatt Health Solutions